Female Intake Questionnaire

General Information

Name ____________________ Age ________ Today's Date ____________

Date of Birth ____________ Email ____________________

Address ____________ City ____________________

State ____________ Zip ____________________

Phone (Home) ____________ (Cell) ____________ (Work) ____________

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

When, where and from whom did you last receive medical or health care?

____

Emergency Contact: ____________ Relationship ____________ Phone (Home) ____________
(Cell) ____________ (Work) ____________

How did you hear about our practice?

Clinic website IFM website ☐Referral from doctor ☐Referral from friend/family member ☐ Social media
Other ____________________

Current Health Concerns

Please rank current and ongoing health concerns in order of priority

Describe Problem	Severity	Prior Treatment/Approach	Success
Example: Post Nasal Drip	Mild ☐Moderate ☐Severe	Elimination Diet	Good ☐Excellent ☐Fair
	☐Mild ☐Moderate ☐Severe		☐Good ☐Excellent ☐Fair
	☐Mild ☐Moderate ☐Severe		☐Good ☐Excellent ☐Fair
	☐Mild ☐Moderate ☐Severe		☐Good ☐Excellent ☐Fair
	☐Mild ☐Moderate ☐Severe		☐Good ☐Excellent ☐Fair
	☐Mild ☐Moderate ☐Severe		☐Good ☐Excellent ☐Fair
	☐Mild ☐Moderate ☐Severe		☐Good ☐Excellent ☐Fair
	☐Mild ☐Moderate ☐Severe		☐Good ☐Excellent ☐Fair
	☐Mild ☐Moderate ☐Severe		☐Good ☐Excellent ☐Fair
	☐Mild ☐Moderate ☐Severe		☐Good ☐Excellent ☐Fair
	☐Mild ☐Moderate ☐Severe		☐Good ☐Excellent ☐Fair

Allergies

1. Name of Medication/Supplement/Food: _____
   Reaction: _____
2. Name of Medication/Supplement/Food: _____
   Reaction: _____
3. Name of Medication/Supplement/Food: _____
   Reaction: _____
4. Name of Medication/Supplement/Food: _____
   Reaction: _____
5. Name of Medication/Supplement/Food: _____
   Reaction: _____

Lifestyle Review

Sleep

How many hours of sleep do you get each night on average? _____

Do you have problems falling asleep? Yes No Staying asleep? Yes No

Do you have problems with insomnia? Yes No Do you snore? Yes No

Do you feel rested upon awakening? Yes No

Do you use sleeping aids? Yes No

If yes, explain: _____

Exercise

Current Exercise Program:

Activity	Type	# of Times Per Week	Time/Duration (Minutes)
Cardio/Aerobic			
Strength/Resistance			
Flexibility/Stretching			
Balance			
Sports/Leisure (e.g., golf)			
Other:			

Do you feel motivated to exercise? Yes A little No

Are there any problems that limit exercise? Yes No

If yes, explain: _____

Do you feel unusually fatigued or sore after exercise? Yes No

If yes, explain: _____

Nutrition

Do you currently follow any of the following special diets or nutritional programs? (Check all that apply)

Vegetarian Vegan Allergy Elimination Low Fat Low Carb High Protein
Blood Type Low sodium No Dairy No Wheat Gluten Free
Other: _____

Do you have sensitivities to certain foods? Yes No
If yes, list food and symptoms: _____

Do you have an aversion to certain foods? Yes No
If yes, explain: _____

Do you adversely react to: (Check all that apply)

Monosodium glutamate (MSG) Artificial sweeteners Garlic/onion Cheese Citrus foods
Chocolate Alcohol Red wine Sulfite–containing foods (wine, dried fruit, salad bars)
Preservatives Food colorings Other food substances: _____

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

Do you eat 3 meals a day? Yes No If no, how many _____

Does skipping a meal greatly affect you? Yes No

How many meals do you eat out per week? 0-1 1-3 3-5 More than 5 meals per week

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

Fast eater
Eat too much
Late-night eating
Dislike healthy foods
Time constraints
Travel frequently
Eat more than 50% of meals away from home
Healthy foods not readily available
Poor snack choices
Significant other or family members don't like healthy foods
Significant other or family members have special dietary needs
Love to eat
Eat because I have to
Have negative relationship to food
Struggle with eating issues
Emotional eater (eat when sad, lonely, bored, etc.)
Eat too much under stress
Eat too little under stress
Don't care to cook
Confused about nutrition advice

Diet

Please record what you eat in a typical day:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Fluids _____

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

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

Legumes (beans, peas, etc) _____ Red meat _____ Fish _____

Dairy/Alternatives _____ Nuts & Seeds _____ Fats & Oils _____

Cans of soda (regular or diet) _____ Sweets (candy, cookies, cake, ice cream, etc.) _____

Do you drink caffeinated beverages? Yes No If yes, check amounts:

Coffee (cups per day) 1 2-4 More than 4 Tea (cups per day) 1 2-4 More than 4

Caffeinated sodas—regular or diet (cans per day) 1 2-4 More than 4

Do you have adverse reactions to caffeine? Yes No

If yes, explain: _____

When you drink caffeine do you feel: Irritable or wired Aches or pains

Smoking

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

What type? Cigarettes Smokeless Pipe Cigar E-Cig

Have you attempted to quit? Yes No

If yes, using what methods: _____

If you smoked previously: Packs per day: _____ Number of years _____

Are you regularly exposed to second-hand smoke? Yes No

Alcohol

How many alcoholic beverages do you drink in a week? *(1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits)*

1-3 4-6 7-10 More than 10 None

Previous alcohol intake? Yes (Mild Moderate High) None

Have you ever had a problem with alcohol? Yes No

If yes, when? _____

Explain the problem: _____

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

Other Substances

Are you currently using any recreational drugs? Yes No

If yes, type: _____

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

Stress

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

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

How much stress do each of the following cause on a daily basis *(Rate on scale of 1-10, 10 being highest)*

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

Do you use relaxation techniques? Yes No

If yes, how often? _____

Which techniques do you use? *(Check all that apply)*

Meditation Breathing Tai Chi Yoga Prayer Other: _____

Have you ever sought counseling? Yes No

Are you currently in therapy? Yes No

If yes, describe: _____

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

What are your hobbies or leisure activities? _____

Relationships

Marital status: Single Married Divorced Gay/Lesbian Long-Term Partner Widow/er

With whom do you live? (Include children, parents, relatives, friends, pets)

_____

Current occupation: _____

Previous occupations: _____

Do you have resources for emotional support? Yes No *(Check all that apply)*

Spouse/Partner Family Friends Religious/Spiritual Pets Other: _____

Do you have a religious or spiritual practice? Yes No

If yes, what kind? _____

How well have things been going for you?

*(Enter score on scale of 1-10, with 1 being **poorly**, 5 being **fine**, and 10 being **very well**; choose **N/A** if not applicable)*

How Well Have Things Been Going for You?		
Overall	N/A	Score_____
At school	N/A	Score_____
In your job	N/A	Score_____
In your social life	N/A	Score_____
With close friends	N/A	Score_____
With sex	N/A	Score_____
With your attitude	N/A	Score_____
With your boyfriend/girlfriend	N/A	Score_____
With your children	N/A	Score_____
With your parents	N/A	Score_____
With your spouse	N/A	Score_____

History

Patient's Birth/Childhood History:

You were born: Term Premature Don't know

Were there any pregnancy or birth complications? Yes No

If yes, explain: _____

You were: Breast-fed/How long? _____ Bottle-fed/Type of formula: _____ Don't know

Age of introduction of: Solid food: _____ Wheat _____ Dairy _____

As a child, were there any foods that were avoided because they gave you symptoms? Yes No

If yes, what foods and what symptoms? (Example: milk—gas and diarrhea)

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

Dental History:

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

Silver mercury fillings _____ Gold fillings _____ Root canals _____ Implants _____
Caps/Crowns _____ Tooth pain _____ Bleeding gums _____ Gingivitis _____
Problems with chewing _____ Other dental concerns (explain): _____

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

How many fillings did you have as a kid? _____

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

Environmental/Detoxification History

Do any of these significantly affect you?

Cigarette smoke Perfume/colognes Auto exhaust fumes Other: _____

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

Mold Water leaks Renovations Chemicals Electromagnetic radiation
Damp environments Carpets or rugs Old paint Stagnant or stuffy air Smokers
Pesticides Herbicides Harsh chemicals (solvents, glues, gas, acids, etc) Cleaning chemicals
Heavy metals (lead, mercury, etc.) Paints Airplane travel Other _____

Have you had a significant exposure to any harmful chemicals? Yes No

If yes: Chemical name, length of exposure, date: _____

Do you have any pets or farm animals? Yes No

If yes, do they live: Inside Outside Both inside and outside

Women's History

Obstetric History: *(Check box and provide number if applicable)*

Pregnancies _____ ☐ Miscarriages _____ Abortions _____ Living children _____
Vaginal deliveries _____ Cesarean _____ Term births _____ Premature birth _____
Birth weight of largest baby _____ Birth weight of smallest baby _____

Did you develop any problems in or after pregnancy, for example, toxemia (high blood pressure), diabetes, post-partum depression, issues with breast feeding, etc.? ☐ Yes ☐ No
If yes, please explain _____

Menstrual History:

Age at first period _____ Date of last menstrual period _____
Length of cycle _____ Time between cycles _____

Cramping? Yes No Pain? Yes No

Have you ever had premenstrual problems (bloating, breast tenderness, irritability, etc.)? Yes No
If yes, please describe: _____

Do you have other problems with your periods (heavy, irregular, spotting, skipping, etc.)? Yes No
If yes, please describe: _____

Use of hormonal birth control: Birth control pills Patch Nuva ring
Other How Long _____

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

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

Are you in menopause? Yes No If yes, age at last period: _____

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

Do you currently have symptomatic problems with menopause? *(Check all that apply)*

Hot flashes Mood swings Concentration/memory problems Headaches Joint pain
Vaginal dryness Weight gain Decreased libido Loss of control of urine Palpitations

Are you on hormone replacement therapy? Yes No
If yes, for how long and for what reason (hot flashes, osteoporosis prevention, etc.)?

_____

Other Gynecological Symptoms: *(Check if applicable)*

Endometriosis Infertility Fibrocystic breasts Vaginal infection Fibroids
Ovarian cysts Pelvic inflammatory disease Reproductive cancer
Sexually transmitted disease *(describe)*:

_____

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

Last Pap test: _____ Normal Abnormal
Last mammogram: _____ Normal Abnormal
Last bone density: _____ Results: High Low Within Normal Range
Other tests/procedures (list type and dates):

Family History

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

Mother

Age (if still alive)_____ Age at death (if deceased)_____

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

Other:

Father

Age (if still alive)_____ Age at death (if deceased)_____

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

Other:

Brother

Age (if still alive)_____ Age at death (if deceased)_____

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

Other:

Sister

Age (if still alive)_____ Age at death (if deceased)_____

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

Other:

Child

Age (if still alive)_____ Age at death (if deceased)_____

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

Other:

Family History *(continued)*

Child

Age (if still alive)____________ Age at death (if deceased)____________

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

Child

Age (if still alive)____________ Age at death (if deceased)____________

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

Child

Age (if still alive)____________ Age at death (if deceased)____________

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

Child

Age (if still alive)____________ Age at death (if deceased)____________

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

Maternal Grandmother

Age (if still alive)____________ Age at death (if deceased)____________

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

Family History *(continued)*

Maternal Grandfather

Age (if still alive)_____ Age at death (if deceased)_____

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

Other:

Paternal Grandmother

Age (if still alive)_____ Age at death (if deceased)_____

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

Other:

Paternal Grandfather

Age (if still alive)_____ Age at death (if deceased)_____

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

Other:

Other

Age (if still alive)_____ Age at death (if deceased)_____

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

Other:

Medical History: Illnesses/Conditions

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

Gastrointestinal		
Irritable bowel syndrome	☐ Yes	☐ Past
GERD (reflux)	☐ Yes	☐ Past
Crohn's disease/ulcerative colitis	☐ Yes	☐ Past
Peptic ulcer disease	☐ Yes	☐ Past
Celiac disease	☐ Yes	☐ Past
Gallstones	☐ Yes	☐ Past
Other:	☐ Yes	☐ Past
Respiratory		
Bronchitis	☐ Yes	☐ Past
Asthma	☐ Yes	☐ Past
Emphysema	☐ Yes	☐ Past
Pneumonia	☐ Yes	☐ Past
Sinusitis	☐ Yes	☐ Past
Sleep apnea	☐ Yes	☐ Past
Other:	☐ Yes	☐ Past
Urinary/Genital		
Kidney stones	☐ Yes	☐ Past
Gout	☐ Yes	☐ Past
Interstitial cystitis	☐ Yes	☐ Past
Frequent yeast infections	☐ Yes	☐ Past
Frequent urinary tract infections	☐ Yes	☐ Past
Sexual dysfunction	☐ Yes	☐ Past
Sexually transmitted diseases	☐ Yes	☐ Past
Other:	☐ Yes	☐ Past
Endocrine/Metabolic		
Diabetes	☐ Yes	☐ Past
Hypothyroidism (low thyroid)	☐ Yes	☐ Past
Hyperthyroidism (overactive thyroid)	☐ Yes	☐ Past
Polycystic ovarian syndrome	☐ Yes	☐ Past
Infertility	☐ Yes	☐ Past
Metabolic syndrome/insulin resistance	☐ Yes	☐ Past
Eating disorder	☐ Yes	☐ Past
Hypoglycemia	☐ Yes	☐ Past
Other:	☐ Yes	☐ Past
Inflammatory/Immune		
Rheumatoid arthritis	☐ Yes	☐ Past
Chronic fatigue syndrome	☐ Yes	☐ Past
Food allergies	☐ Yes	☐ Past
Environmental allergies	☐ Yes	☐ Past
Multiple chemical sensitivities	☐ Yes	☐ Past
Autoimmune disease	☐ Yes	☐ Past
Immune deficiency	☐ Yes	☐ Past
Mononucleosis	☐ Yes	☐ Past
Hepatitis	☐ Yes	☐ Past
Other:		
Musculoskeletal		
Fibromyalgia	☐ Yes	☐ Past
Osteoarthritis	☐ Yes	☐ Past
Chronic pain	☐ Yes	☐ Past
Other:	☐ Yes	☐ Past
Skin		
Eczema	☐ Yes	☐ Past
Psoriasis	☐ Yes	☐ Past
Acne	☐ Yes	☐ Past
Skin cancer	☐ Yes	☐ Past
Other:	☐ Yes	☐ Past
Cardiovascular		
Angina	☐ Yes	☐ Past
Heart attack	☐ Yes	☐ Past
Heart failure	☐ Yes	☐ Past
Hypertension (high blood pressure)	☐ Yes	☐ Past
Stroke	☐ Yes	☐ Past
High blood fats (cholesterol, triglycerides)	☐ Yes	☐ Past
Rheumatic fever	☐ Yes	☐ Past
Arrythmia (irregular heart rate)	☐ Yes	☐ Past
Murmur	☐ Yes	☐ Past
Mitral valve prolapse	☐ Yes	☐ Past
Other:	☐ Yes	☐ Past
Neurologic/Emotional		
Epilepsy/Seizures	☐ Yes	☐ Past
ADD/ADHD	☐ Yes	☐ Past
Headaches	☐ Yes	☐ Past
Migraines	☐ Yes	☐ Past
Depression	☐ Yes	☐ Past
Anxiety	☐ Yes	☐ Past
Autism	☐ Yes	☐ Past
Multiple sclerosis	☐ Yes	☐ Past
Parkinson's disease	☐ Yes	☐ Past
Dementia	☐ Yes	☐ Past
Other:	☐ Yes	☐ Past
Cancer		
Lung	☐ Yes	☐ Past
Breast	☐ Yes	☐ Past
Colon	☐ Yes	☐ Past
Ovarian	☐ Yes	☐ Past
Skin	☐ Yes	☐ Past
Other:	☐ Yes	☐ Past

Medical History *(continued)*

Diagnostic Studies		
Bone Density	Date:	Comments:
CT scan	Date:	Comments:
Colonoscopy	Date:	Comments:
Cardiac stress test	Date:	Comments:
EKG	Date:	Comments:
MRI	Date:	Comments:
Upper endoscopy	Date:	Comments:
Upper GI series	Date:	Comments:
Chest X-ray	Date:	Comments:
Other X-rays	Date:	Comments:
Barium enema	Date:	Comments:
Other:	Date:	Comments:
Injuries		
Broken bone(s)	Date:	Comments:
Back injury	Date:	Comments:
Neck injury	Date:	Comments:
Head injury	Date:	Comments:
Other:	Date:	Comments:
Surgeries		
Appendectomy	Date:	Comments:
Dental	Date:	Comments:
Gallbladder	Date:	Comments:
Hernia	Date:	Comments:
Hysterectomy	Date:	Comments:
Tonsillectomy	Date:	Comments:
Joint Replacement	Date:	Comments:
Heart surgery	Date:	Comments:
Other:	Date:	Comments:
Hospitalizations		
	Date:	Reason:
	Date:	Reason:
	Date:	Reason:
	Date:	Reason:
	Date:	Reason:

Symptom Review

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

General			
Cold hands and feet	Mild	Moderate	Severe
Cold intolerance	Mild	Moderate	Severe
Daytime sleepiness	Mild	Moderate	Severe
Difficulty falling asleep	Mild	Moderate	Severe
Early waking	Mild	Moderate	Severe
Fatigue	Mild	Moderate	Severe
Fever	Mild	Moderate	Severe
Flushing	Mild	Moderate	Severe
Heat intolerance	Mild	Moderate	Severe
Night waking	Mild	Moderate	Severe
Nightmares	Mild	Moderate	Severe
Can't remember dreams	Mild	Moderate	Severe
Low body temperature	Mild	Moderate	Severe
Head, Eyes, and Ears			
Conjunctivitis	Mild	Moderate	Severe
Distorted sense of smell	Mild	Moderate	Severe
Distorted taste	Mild	Moderate	Severe
Ear fullness	Mild	Moderate	Severe
Ear ringing/buzzing	Mild	Moderate	Severe
Eye crusting	Mild	Moderate	Severe
Eye pain	Mild	Moderate	Severe
Eyelid margin redness	Mild	Moderate	Severe
Headache	Mild	Moderate	Severe
Hearing loss	Mild	Moderate	Severe
Hearing problems	Mild	Moderate	Severe
Migraine	Mild	Moderate	Severe
Sensitivity to loud noises	Mild	Moderate	Severe
Vision problems	Mild	Moderate	Severe
Musculoskeletal			
Back muscle spasm	Mild	Moderate	Severe
Calf cramps	Mild	Moderate	Severe
Chest tightness	Mild	Moderate	Severe
Foot cramps	Mild	Moderate	Severe
Joint deformity	Mild	Moderate	Severe
Joint pain	Mild	Moderate	Severe
Joint redness	Mild	Moderate	Severe
Joint stiffness	Mild	Moderate	Severe
Muscle pain	Mild	Moderate	Severe
Muscle spasms	Mild	Moderate	Severe
Muscle stiffness	Mild	Moderate	Severe
Muscle twitches	Mild	Moderate	Severe
Around eyes	Mild	Moderate	Severe
Arms or legs	Mild	Moderate	Severe

Musculoskeletal *(continued)*			
Muscle weakness	☐ Mild	☐ Moderate	☐ Severe
Neck muscle spasm	Mild	Moderate	Severe
Tendonitis	Mild	Moderate	Severe
Tension headache	Mild	Moderate	Severe
TMJ problems	Mild	Moderate	Severe
Mood/Nerves			
Agoraphobia	Mild	Moderate	Severe
Anxiety	Mild	Moderate	Severe
Auditory hallucinations	Mild	Moderate	Severe
Blackouts	Mild	Moderate	Severe
Depression	Mild	Moderate	Severe
Difficulty:			
Concentrating	Mild	Moderate	Severe
With balance	Mild	Moderate	Severe
With thinking	Mild	Moderate	Severe
With judgment	Mild	Moderate	Severe
With speech	Mild	Moderate	Severe
With memory	Mild	Moderate	Severe
Dizziness (spinning)	Mild	Moderate	Severe
Fainting	Mild	Moderate	Severe
Fearfulness	Mild	Moderate	Severe
Irritability	Mild	Moderate	Severe
Light-headedness	Mild	Moderate	Severe
Numbness	Mild	Moderate	Severe
Other phobias	Mild	Moderate	Severe
Panic attacks	Mild	Moderate	Severe
Paranoia	Mild	Moderate	Severe
Seizures	Mild	Moderate	Severe
Suicidal thoughts	Mild	Moderate	Severe
Tremor/trembling	Mild	Moderate	Severe
Visual Hallucinations	Mild	Moderate	Severe
Cardiovascular			
Angina/chest pain	Mild	Moderate	Severe
Breathlessness	Mild	Moderate	Severe
Heart attack	Mild	Moderate	Severe
Heart murmur	Mild	Moderate	Severe
High blood pressure	Mild	Moderate	Severe
Irregular pulse	Mild	Moderate	Severe
Mitral valve prolapse	Mild	Moderate	Severe
Palpitations	Mild	Moderate	Severe
Phlebitis	Mild	Moderate	Severe
Swollen ankles/feet	Mild	Moderate	Severe
Varicose veins	Mild	Moderate	Severe

Symptom Review *(continued)*

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

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

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

Symptom Review *(continued)*

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

Nails			
Bitten	Mild	Moderate	Severe
Brittle	Mild	Moderate	Severe
Curve Up	Mild	Moderate	Severe
Frayed	Mild	Moderate	Severe
Fungus – fingers	Mild	Moderate	Severe
Fungus – toes	Mild	Moderate	Severe
Pitting	Mild	Moderate	Severe
Ragged cuticles	Mild	Moderate	Severe
Ridges	Mild	Moderate	Severe
Soft	Mild	Moderate	Severe
Thickening of:			
Fingernails	Mild	Moderate	Severe
Toenails	Mild	Moderate	Severe
White spots/lines	Mild	Moderate	Severe
Lymph Nodes			
Enlarged/neck	Mild	Moderate	Severe
Tender/neck	Mild	Moderate	Severe
Other enlarged/tender lymph nodes	Mild	Moderate	Severe
Skin, Dryness of			
Eyes	Mild	Moderate	Severe
Feet	Mild	Moderate	Severe
Any cracking?	Mild	Moderate	Severe
Any peeling?	Mild	Moderate	Severe
Hair	Mild	Moderate	Severe
And unmanageable?	Mild	Moderate	Severe
Hands	Mild	Moderate	Severe
Any cracking?	Mild	Moderate	Severe
Any peeling?	Mild	Moderate	Severe
Mouth/throat	Mild	Moderate	Severe
Scalp	Mild	Moderate	Severe
Any dandruff	Mild	Moderate	Severe
Skin in general	Mild	Moderate	Severe
Skin Problems			
Acne on back	Mild	Moderate	Severe
Acne on chest	Mild	Moderate	Severe
Acne on face	Mild	Moderate	Severe
Acne on shoulders	☐ Mild	☐ Moderate	☐ Severe
Athlete's foot	Mild	Moderate	Severe
Bumps on back of upper arms	Mild	Moderate	Severe
Cellulite	Mild	Moderate	Severe
Dark circles under eyes	Mild	Moderate	Severe
Ears get red	Mild	Moderate	Severe
Easy bruising	Mild	Moderate	Severe

Skin problems *(continued)*			
Eczema	Mild	Moderate	Severe
Herpes – genital	Mild	Moderate	Severe
Hives	Mild	Moderate	Severe
Jock itch	Mild	Moderate	Severe
Lackluster skin	Mild	Moderate	Severe
Moles w color/size change	Mild	Moderate	Severe
Oily skin	Mild	Moderate	Severe
Pale skin	Mild	Moderate	Severe
Patchy dullness	Mild	Moderate	Severe
Psoriasis	Mild	Moderate	Severe
Rash	Mild	Moderate	Severe
Red face	Mild	Moderate	Severe
Sensitive to bites	Mild	Moderate	Severe
Sensitive to poison ivy/oak	Mild	Moderate	Severe
Shingles	Mild	Moderate	Severe
Skin cancer	Mild	Moderate	Severe
Skin darkening	Mild	Moderate	Severe
Strong body odor	Mild	Moderate	Severe
Thick calluses	Mild	Moderate	Severe
Vitiligo	Mild	Moderate	Severe
Itching Skin			
Anus	Mild	Moderate	Severe
Arms	Mild	Moderate	Severe
Ear canals	Mild	Moderate	Severe
Eyes	Mild	Moderate	Severe
Feet	Mild	Moderate	Severe
Hands	Mild	Moderate	Severe
Legs	Mild	Moderate	Severe
Nipples	Mild	Moderate	Severe
Nose	Mild	Moderate	Severe
Genitals	Mild	Moderate	Severe
Roof of mouth	Mild	Moderate	Severe
Scalp	Mild	Moderate	Severe
Skin in general	Mild	Moderate	Severe
Throat	Mild	Moderate	Severe

Symptom Review *(continued)*

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

Female Reproductive			
Breast cysts	Mild	Moderate	Severe
Breast lumps	Mild	Moderate	Severe
Breast tenderness	Mild	Moderate	Severe
Ovarian cysts	Mild	Moderate	Severe
Poor libido (sex drive)	Mild	Moderate	Severe
Endometriosis	Mild	Moderate	Severe
Fibroids	Mild	Moderate	Severe
Infertility	Mild	Moderate	Severe
Vaginal discharge	Mild	Moderate	Severe
Vaginal odor	Mild	Moderate	Severe
Vaginal itch	Mild	Moderate	Severe
Vaginal pain	Mild	Moderate	Severe
Premenstrual:			
Bloating	Mild	Moderate	Severe
Breast tenderness	Mild	Moderate	Severe
Carbohydrate craving	Mild	Moderate	Severe
Chocolate craving	Mild	Moderate	Severe
Constipation	Mild	Moderate	Severe
Decreased sleep	Mild	Moderate	Severe
Diarrhea	Mild	Moderate	Severe
Fatigue	Mild	Moderate	Severe
Increased sleep	Mild	Moderate	Severe
Irritability	Mild	Moderate	Severe
Menstrual:			
Cramps	Mild	Moderate	Severe
Heavy periods	Mild	Moderate	Severe
Irregular periods	Mild	Moderate	Severe
No periods	Mild	Moderate	Severe
Scanty periods	Mild	Moderate	Severe
Spotting between	Mild	Moderate	Severe

Medications/Supplements

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

Medication	Dosage	Start Date (mo/yr)	Reason for Use

Nutritional supplements (vitamins/minerals/herbs etc.)

Name and Brand	Dosage	Start Date (mo/yr)	Reason for Use

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

If yes, describe: _____

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

NSAIDs (Advil, Aleve, etc.), Motrin, Aspirin? Yes No Tylenol (acetaminophen)? Yes No

Acid-blocking drugs (Zantac, Prilosec, Nexium, etc.)? Yes No

How many times have you taken antibiotics?

Infancy/childhood ☐ Less than 5 ☐ 5 or more Reason for use _____

Teen ☐ Less than 5 ☐ 5 or more Reason for use _____

Adulthood ☐ Less than 5 ☐ 5 or more Reason for use _____

Have you ever taken long term antibiotics? Yes No

If yes, explain: _____

How often have you taken oral steroids (e.g., cortisone, prednisone, etc.)?

Infancy/childhood ☐ Less than 5 ☐ 5 or more Reason for use _____

Teen ☐ Less than 5 ☐ 5 or more Reason for use _____

Adulthood ☐ Less than 5 ☐ 5 or more Reason for use _____

Readiness Assessment and Health Goals

Readiness Assessment

Rate on a scale of 5 (very willing) to 1 (not willing):

In order to improve your health, how willing are you to:

- Significantly modify your diet _____
- Take several nutritional supplements each day _____
- Keep a record of everything you eat each day _____
- Modify your lifestyle (e.g., work demands, sleep habits) _____
- Practice a relaxation technique _____
- Engage in regular exercise _____

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? _____

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to follow through?

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

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? _____

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? _____

Comments:

Health Goals

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

When was the last time you felt well?

Did something trigger your change in health?

What makes you feel better?

What makes you feel worse?

How does your condition affect you?

What do you think is happening and why?

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