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)

**How did you hear about our practice?**

(Cell)

(Work)

 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** | **Mild** | **Moderate** | **Severe** | **Prior Treatment/Approach Success** | **Excellent** | **Good** | **Fair** |
| *Example: Post Nasal Drip* | *X* |  |  | *Elimination Diet* | *X* |  |  |
| **1.** |  |  |  |  |  |  |  |
| **2.** |  |  |  |  |  |  |  |
| **3.** |  |  |  |  |  |  |  |
| **4.** |  |  |  |  |  |  |  |
| **5.** |  |  |  |  |  |  |  |
| **7.** |  |  |  |  |  |  |  |
| **8.** |  |  |  |  |  |  |  |
| **9.** |  |  |  |  |  |  |  |
| **9.** |  |  |  |  |  |  |  |
| **10.** |  |  |  |  |  |  |  |



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# Allergies

|  |  |
| --- | --- |
| **Name of Medication/Supplement/Food:** | **Reaction:** |
| **1.** |  |
| **2.** |  |
| **3.** |  |
| **4.** |  |
| **5.** |  |

**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  >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) Dairy/Alternatives

Red meat Nuts & Seeds

Fish

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  >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: 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  >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?*** *(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 boyfriend/girlfriend |  | 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 |
| With your spouse |  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

# 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 Any problems with hormonal birth control?  Yes  No

How Long

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: Last mammogram: Last bone density:

* Normal  Abnormal
* Normal  Abnormal

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** | **Father** | **Brother (s)** | **Sister (s)** | **Child** | **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 |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 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** | **Yes** | **Past** |
| Irritable bowel syndrome |  |  |
| GERD (reflux) |  |  |
| Crohn’s disease/ulcerative colitis |  |  |
| Peptic ulcer disease |  |  |
| Celiac disease |  |  |
| Gallstones |  |  |
| Other: |  |  |
| **Respiratory** |  |  |
| Bronchitis |  |  |
| Asthma |  |  |
| Emphysema |  |  |
| Pneumonia |  |  |
| Sinusitis |  |  |
| Sleep apnea |  |  |
| Other: |  |  |
| **Urinary/Genital** |  |  |
| Kidney stones |  |  |
| Gout |  |  |
| Interstitial cystitis |  |  |
| Frequent yeast infections |  |  |
| Frequent urinary tract infections |  |  |
| Sexual dysfunction |  |  |
| Sexually transmitted diseases |  |  |
| Other: |  |  |
| **Endocrine/Metabolic** |  |  |
| Diabetes |  |  |
| Hypothyroidism (low thyroid) |  |  |
| Hyperthyroidism (overactive thyroid) |  |  |
| Polycystic Ovarian Syndrome |  |  |
| Infertility |  |  |
| Metabolic syndrome/insulin resistance |  |  |
| Eating disorder |  |  |
| Hypoglycemia |  |  |
| Other: |  |  |
| **Inflammatory/Immune** |  |  |
| Rheumatoid arthritis |  |  |
| Chronic fatigue syndrome |  |  |
| Food allergies |  |  |
| Environmental allergies |  |  |
| Multiple chemical sensitivities |  |  |
| Autoimmune disease |  |  |
| Immune deficiency |  |  |
| Mononucleosis |  |  |
| Hepatitis |  |  |
| Other: |  |  |

|  |  |  |
| --- | --- | --- |
| **Musculoskeletal** | **Yes** | **Past** |
| Fibromyalgia |  |  |
| Osteoarthritis |  |  |
| Chronic pain |  |  |
| Other: |  |  |
| **Skin** |  |  |
| Eczema |  |  |
| Psoriasis |  |  |
| Acne |  |  |
| Skin cancer |  |  |
| Other: |  |  |
| **Cardiovascular** |  |  |
| Angina |  |  |
| Heart attack |  |  |
| Heart failure |  |  |
| Hypertension (high blood pressure) |  |  |
| Stroke |  |  |
| High blood fats (cholesterol, triglycerides) |  |  |
| Rheumatic fever |  |  |
| Arrythmia (irregular heart rate) |  |  |
| Murmur |  |  |
| Mitral valve prolapse |  |  |
| Other: |  |  |
| **Neurologic/Emotional** |  |  |
| Epilepsy/Seizures |  |  |
| ADD/ADHD |  |  |
| Headaches |  |  |
| Migraines |  |  |
| Depression |  |  |
| Anxiety |  |  |
| Autism |  |  |
| Multiple sclerosis |  |  |
| Parkinson’s disease |  |  |
| Dementia |  |  |
| Other: |  |  |
| **Cancer** |  |  |
| Lung |  |  |
| Breast |  |  |
| Colon |  |  |
| Ovarian |  |  |
| Skin |  |  |
| Other: |  |  |

**Medical History** *(cont.)*

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

# Symptom Review

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

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

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

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

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

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

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

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

**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?**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **< 5** | **> 5** | **Reason for Use** |
| Infancy/Childhood |  |  |  |
| Teen |  |  |  |
| Adulthood |  |  |  |

Have you ever taken long term antibiotics?  Yes  No

If yes, explain:

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

|  |  |  |  |
| --- | --- | --- | --- |
|  | **< 5** | **> 5** | **Reason for Use** |
| Infancy/Childhood |  |  |  |
| Teen |  |  |  |
| Adulthood |  |  |  |

**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 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?  **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

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?