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General Information

Today's Date _____

Name _____ Age ____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Phone (Home) _____ (Cell)_____ Email _____

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? _____

Current Health Concerns

Please rank current and ongoing health concerns in order of priority

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Current Prescription Medications

Name of Medication	*Dosage/Strength*	*Directions*

Current Supplements

Name of Supplements (including brand name)	*Dosage/Strength*	*Directions*

Allergies

Name of Medication/Supplement/Food	*Reaction*

Surgical History

Type	*Date*	*Comments*
Appendectomy		
Dental		
Gallbladder		
Hernia		
Tonsillectomy		
Joint Replacement		
Heart Surgery		
Hysterectomy		
Other:		
Other:		

Hospitalizations

Date	*Reason*

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		
Other:		

Family History

Please check below if any blood relatives have any of the following:

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

History

Patient's Birth/Childhood History:

You were born: ▢ Term ▢ Premature ▢ Unknown

Were there any pregnancy or birth complications? ▢ Yes ▢ No ▢ Unknown

If yes, explain: _____

You were: ▢ Breast-fed/ How long? _____ ▢ Bottle-fed/type of formula?_____ ▢ Unknown

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

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

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

If yes, what foods and what symptoms? (example: Milk - gas and diarrhea) _____

_____

_____

What were your eating habits like as a child? (List types of food) _____

_____

_____

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 and how many _____

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 ▢ Paint

▢ Harsh chemicals *(solvents, glues, gas,acids, etc)* ▢ Cleaning chemicals ▢ Airplane Travel

▢ Heavy metals *(lead, mercury, etc.)* ▢ Plastic Food storage ▢ 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 use cosmetics? ▢ Yes ▢ No

If yes, which types and brands: _____

_____

Sex History: *(complete applicable questions)*

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 ▢ Nuvaring ▢ IUD

▢ Other _____ How long? _____

Any problems with hormonal birth control? ▢ Yes ▢ No

If yes, explain _____

Use of other contraception? ▢ Yes ▢ No ▢ Condoms ▢ Diaphragm ▢ Partner vasectomy ▢ Other_____

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 ▢Weight gain

▢ Vaginal dryness ▢ 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.)? _____

_____

Do you or have you ever had any sexually transmitted disease? ▢ Yes ▢ No

If yes, describe _____

Other Urogenital Symptoms: *(Check all that apply)*

▢ Endometriosis ▢ Infertility ▢ Fibrocystic breasts ▢ Vaginal infection ▢ Fibroids ▢ Ovarian cysts ▢ Pelvic inflammatory disease ▢ Reproductive Cancer ▢ Testicular Mass ▢ Testicular pain ▢ Prostate enlargement ▢ Prostate infection ▢ Change in sex drive ▢ Impotence ▢ Premature ejaculation ▢ Difficulty obtaining an erection ▢ Difficulty maintaining an erection ▢ Loss of control of urine ▢ Urinary urgency/hesitancy/change in stream ▢ Vasectomy

▢ Nocturia (urination at night) # of times per night _____

Screenings/Procedures (*If applicable, provide date)*

Last pap test: _____ ▢ Normal ▢ Abnormal

Last mammogram: _____ ▢ Normal ▢ Abnormal

Last bone density: _____ Results: ▢ High ▢ Low ▢ With Normal Range

Last PSA test: _____ PSA Levels: ▢ 0-2 ▢ 2-4 ▢ 4-10 ▢ >10

Other tests/procedures (list type and date) _____

_____

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: _____

Do you wake up during the night? ▢ Yes ▢ No

If yes, what time(s)? _____

What time do you go to bed? _____ What time do you typically wake-up? _____

Exercise

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 _____

Current Exercise Program:

Cardio/Aerobic:

Type:_____

(e.g walking, jogging, swimming)

Frequency: _____ Time/duration:_____
(#of times per week) *(minutes each day)*

Intensity: ▢ Low (*able to talk and/or sing)* ▢ Moderate *(able to talk but not sing)*
▢ Vigorous/hard (*difficulty talking)*

Strength/Resistance:

Type:_____
(e.g walking, jogging, swimming)

Frequency: _____ Time/duration:_____
(#of times per week) *(minutes each day)*

Intensity: ▢ Low (*able to talk and/or sing)* ▢ Moderate *(able to talk but not sing)*
▢ Vigorous/hard (*difficulty talking)*

Flexibility/Stretching:

Type:_____
(e.g walking, jogging, swimming)

Frequency: _____ Time/duration:_____
(#of times per week) *(minutes each day)*

Intensity: ▢ Low (*able to talk and/or sing)* ▢ Moderate *(able to talk but not sing)*
▢ Vigorous/hard (*difficulty talking)*

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 ▢ No Dairy

▢ Low Sodium ▢ No Wheat ▢ Gluten Free ▢ Blood Type _____ ▢ Other: _____

Do you have sensitivities to certain foods? ▢ Yes ▢ No

If yes, list food and symptoms: _____

_____

Do you have an aversion to certain foods or textures? ▢ 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 crave sugar? ▢ Yes ▢ No Do you crave salt? ▢ Yes ▢ No

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

How many meals are home cooked per week? ▢ 0-1 ▢ 1-3 ▢ 3-5 ▢ >5 meals per week

What are the three worst foods you eat each week? _____

_____

What are the three healthiest foods you eat each week? _____

_____

Do you feel tired, bloated and/or gassy after meals? ▢ Yes ▢ No

If yes, please explain _____

_____

Do you feel excessively hungry? ▢ Yes ▢ No

If yes, please explain _____

Do you have a poor appetite? ▢ Yes ▢ No

If yes, please explain _____

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 ▢ Poor snack choices

▢ Health foods not readily available ▢ Significant other or family members don't like healthy foods

▢ Significant other or family members have special dietary needs ▢ Eat because I have to ▢ Love to eat

▢ Have a negative relationship to food ▢ Struggle with eating issues ▢ Don't care to cook

▢ Emotional eater (eat when sad, longley, bored, etc) ▢ Confused about nutrition advice

▢ Eat too much under stress ▢ Eat too little under stress ▢ Multitask during meals

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

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

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

Nuts & Seeds _____ Dairy/Alternatives _____

Fish _____ Cans of soda (regular or diet) _____

Sweets (candy, cookies, cake, ice cream, etc) _____

How many ounces of water do you drink daily? _____ oz/day

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

Coffee (ounces per day) _____ oz/day Tea (ounces per day) _____ oz/day

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 ▢ Wired ▢ Aches or pains

Tobacco Use

Do you smoke currently? ▢ Yes ▢ No # packs per day _____ # of years _____

What type? ▢ Cigarettes ▢ Smokeless ▢ Pipe ▢ Cigar ▢ Vape

Have you attempted to quit? ▢ Yes ▢ No

If yes, using what methods: _____

If you smoked previously: # packs per day _____ # 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 oz of wine, 12 oz of beer, 1.5 oz of 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, please explain _____

_____

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 and frequency: _____

_____

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 the highest)*

Work _____ Family _____ Social _____ Finances _____ Health _____

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 significant trauma? ▢ Yes ▢ No

What lifts your spirits and gives you strength? _____

_____

_____

What is the most pleasing aspect of your life right now? _____

_____

_____

What is the most unsatisfactory part of your life? _____

_____

_____

How much responsibility do you assume for the pleasing and unsatisfactory aspects of your life? _____

_____

_____

What is the best thing that could happen to you as a result of our experience working together? _____

_____

_____

What is the worst thing that could happen? _____

_____

_____

What do you like most about your life? _____

_____

_____

What do you like least about your life? _____

_____

_____

How do your health concerns make you feel imbalanced?

Mentally: _____

_____

_____

Emotionally: _____

_____

_____

Physically: _____

_____

_____

Spiritually: _____

_____

_____

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 occupation: _____

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 kinds? _____

How important are spiritual matters to you? _____

_____

_____

Would you like your spiritual/religious beliefs to be included in our work? If yes, how much? _____

_____

_____

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

Health Goals

What results or outcome do you hope to achieve from working together? _____

_____

_____

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? _____

_____

_____

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 every 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

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 you 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 _____

_____