

Binkley Healing Center

Nutrition Patient Questionnaire

Name _____ Date of Birth _____

Address _____ City/State/Zip _____

E-mail _____

Phone - Home _____ Work _____ Cell _____

Employer _____ Occupation _____

Sex: M F Married _____ Single _____ Divorced _____ Widow(er) _____ # of Children _____

Spouse _____ Employer _____

In Case of Emergency, who should we contact?

Name _____ Phone _____ Relationship _____

How did you hear about our office? _____

I, the undersigned, clearly understand that all services rendered to me are my responsibility and that payment is expected at the time of service:

Patient's Signature _____ Date _____

Nutritional Informed Consent

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: "*Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease.*" A vitamin is not a drug; NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy. Although a Vitamin, a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom. Nutritional counseling, advice, and supplement recommendations are provided solely to upgrade the quality of foods in a patient's diet, and to supply nutritional support for the physiological and biomechanical processes of the human body. Nutritional advice and supplementation may also enhance the stabilization of the benefits of chiropractic care.

I have read and understand the above:

Signature _____ Date _____

PATIENT SYMPTOM SURVEY

DATE _____

PATIENT'S NAME _____ AGE _____

WEIGHT _____ HEIGHT _____ BLOOD PRESSURE _____ PULSE _____ O₂ _____

This is a confidential patient symptom survey. Please check each condition which is true for you. If the condition does not apply to you or you do not understand a term or if you are not sure if a condition applies to you, then do not check the box. Use common sense. For example, Insomnia once in the last month probably isn't that important and would not be marked. However, Insomnia occurring 1-2 times per week is notable and would be marked. Please take your time...

Primary Complaints

- | | | |
|---|--|--|
| <p>090 <input type="checkbox"/> General Good Health</p> <p>091 <input type="checkbox"/> Desires Nutritional & Metabolic Analysis</p> <p>001 <input type="checkbox"/> Skin Disorder 692.9</p> <p>002 <input type="checkbox"/> Acne 706.1</p> <p>003 <input type="checkbox"/> Psoriasis 696.1</p> <p>004 <input type="checkbox"/> Urticaria (Hives) 708.9</p> <p>005 <input type="checkbox"/> ADD/ADHD 314.00/314.01</p> <p>006 <input type="checkbox"/> Allergies, Unspecified 477.9</p> <p>007 <input type="checkbox"/> Allergic Rhinitis from food 477.1</p> <p>008 <input type="checkbox"/> Sinusitis 461.9</p> <p>009 <input type="checkbox"/> Alzheimer's 331.0</p> <p>010 <input type="checkbox"/> Poor Concentration/ Memory 310.1</p> <p>011 <input type="checkbox"/> Parkinson's Disease 332.0</p> <p>012 <input type="checkbox"/> Anemia 285.9</p> <p>013 <input type="checkbox"/> Arthritic Disorder 716.90</p> <p>014 <input type="checkbox"/> Osteoporosis 733.00</p> <p>015 <input type="checkbox"/> Asthma 493.90</p> <p>016 <input type="checkbox"/> Emphysema 492.8</p> <p>017 <input type="checkbox"/> Cancer</p> <p style="padding-left: 20px;">018 <input type="checkbox"/> Breast 174.9female 175.9male</p> <p style="padding-left: 20px;">019 <input type="checkbox"/> Prostate 185</p> <p style="padding-left: 20px;">020 <input type="checkbox"/> Lung 162.9</p> <p style="padding-left: 20px;">021 <input type="checkbox"/> Colon and Rectal 153.9</p> <p style="padding-left: 20px;">022 <input type="checkbox"/> Skin 173.9</p> <p style="padding-left: 20px;">023 <input type="checkbox"/> Leukemia w/o remission 208.90
Leukemia w/ remission 208.91</p> <p style="padding-left: 20px;">024 <input type="checkbox"/> Lymphoma, malignant 202.8</p> <p style="padding-left: 20px;">025 <input type="checkbox"/> Brain Tumor, malignant 191.9</p> <p>027 <input type="checkbox"/> Anxiety Disorder 300.00</p> <p>028 <input type="checkbox"/> Autism 299.00</p> <p>033 <input type="checkbox"/> Edema 782.3</p> <p>034 <input type="checkbox"/> Eczema 692.9</p> <p>035 <input type="checkbox"/> Chronic Fatigue 780.71</p> <p>036 <input type="checkbox"/> Circulatory Disorder 459.9</p> <p>037 <input type="checkbox"/> Heart Disease 429.9</p> <p>038 <input type="checkbox"/> High Cholesterol 272.0</p> | <p>039 <input type="checkbox"/> High Blood Pressure 401.9</p> <p>040 <input type="checkbox"/> Low Blood Pressure 458.9</p> <p>041 <input type="checkbox"/> Tachycardia (High Heart Rate) 785.00</p> <p>042 <input type="checkbox"/> Numbness 782.0</p> <p>043 <input type="checkbox"/> Constipation 564.0</p> <p>044 <input type="checkbox"/> Indigestion 536.8</p> <p>045 <input type="checkbox"/> Ulcerative Colitis 556.9</p> <p>046 <input type="checkbox"/> Depression 311</p> <p>047 <input type="checkbox"/> Diabetes Mellitus 250.0</p> <p>030 <input type="checkbox"/> Diabetes Type I 250.01</p> <p>031 <input type="checkbox"/> Diabetes Type II 250.02</p> <p>029 <input type="checkbox"/> Hyperglycemia [high blood sugar] 790.29</p> <p>048 <input type="checkbox"/> Hypoglycemia [low blood sugar] 251.2</p> <p>049 <input type="checkbox"/> Dizziness/Balance Problem 780.4</p> <p>050 <input type="checkbox"/> Ear Infection 381.4</p> <p>051 <input type="checkbox"/> Epstein Barr 075</p> <p>052 <input type="checkbox"/> Eye Problems 379.91</p> <p>053 <input type="checkbox"/> Cataracts 366.9</p> <p>054 <input type="checkbox"/> Glaucoma 365.9</p> <p>055 <input type="checkbox"/> Macular Degeneration 362.50</p> <p>056 <input type="checkbox"/> Fever 780.6</p> <p>057 <input type="checkbox"/> Fibromyalgia 729.1</p> <p>058 <input type="checkbox"/> Gallbladder Disorder 575.9</p> <p>059 <input type="checkbox"/> Gout 274.9</p> <p>060 <input type="checkbox"/> Headaches 784.0</p> <p>061 <input type="checkbox"/> Hearing Loss 389.9</p> <p>062 <input type="checkbox"/> Infertility, male 606.9</p> <p>064 <input type="checkbox"/> Liver Disease 571.9</p> <p style="padding-left: 20px;">065 <input type="checkbox"/> Hepatitis 573.3</p> <p style="padding-left: 20px;">066 <input type="checkbox"/> Hepatitis B 070.30</p> <p style="padding-left: 20px;">067 <input type="checkbox"/> Hepatitis C 070.51</p> <p>068 <input type="checkbox"/> Kidney Disorder 593.9 or Bladder Disorder 596.9</p> <p>063 <input type="checkbox"/> Prostate Disorder 602.9</p> <p>069 <input type="checkbox"/> Hyperthyroidism 242.90</p> | <p>070 <input type="checkbox"/> Hypothyroidism 244.9</p> <p>071 <input type="checkbox"/> Systemic Lupus 710.0</p> <p>072 <input type="checkbox"/> Infertility, female 628.9</p> <p>073 <input type="checkbox"/> Interstitial Cystitis 595.1</p> <p>074 <input type="checkbox"/> Irregular Menstrual Cycle 626.4</p> <p>075 <input type="checkbox"/> Menopausal Symptoms 627.2</p> <p>076 <input type="checkbox"/> Hot Flashes 627.2</p> <p>077 <input type="checkbox"/> Mental Disorder 300.9</p> <p>078 <input type="checkbox"/> Insomnia 780.52</p> <p>079 <input type="checkbox"/> Mouth/Throat/Tongue</p> <p>080 <input type="checkbox"/> Canker Sores 528.2</p> <p>081 <input type="checkbox"/> Overweight 278.02</p> <p>082 <input type="checkbox"/> Underweight 783.22</p> <p>083 <input type="checkbox"/> Sexual Disorder 302.89</p> <p>084 <input type="checkbox"/> Spinal Problems 724.9</p> <p>085 <input type="checkbox"/> Obesity 278.00</p> <p>086 <input type="checkbox"/> GERD 530.81</p> <p>087 <input type="checkbox"/> HIV 042</p> <p>088 <input type="checkbox"/> Crohn's Disease 555.9</p> <p>089 <input type="checkbox"/> Irritable Bowel Syndrome 564.1</p> <p>092 <input type="checkbox"/> Normal Pregnancy v22.2
<i>**only applicable if currently pregnant</i></p> <p>093 <input type="checkbox"/> Shingles 053.9</p> <p>140 <input type="checkbox"/> Migraines 346.90</p> <p>141 <input type="checkbox"/> Rheumatoid Arthritis 714.0</p> <p>142 <input type="checkbox"/> Non-Systemic Lupus 695.4</p> <p>143 <input type="checkbox"/> Multiple Sclerosis 340</p> <p>144 <input type="checkbox"/> ALS Lou Gerigs disease 335.20</p> <p>145 <input type="checkbox"/> Polymyalgia Rheumatica 725</p> <p>146 <input type="checkbox"/> Scleroderma 710.1</p> <p>171 <input type="checkbox"/> Goiter 240.9</p> <p>178 <input type="checkbox"/> Raynaud's Syndrome 433.8</p> <p>179 <input type="checkbox"/> Hemochromatosis 275.0</p> <p>180 <input type="checkbox"/> Thalassemia 282.49</p> <p>181 <input type="checkbox"/> Brain aneurysm 431</p> |
|---|--|--|

If necessary, please state your most significant concern...

General Health

- | | |
|--|---|
| 100 <input type="checkbox"/> Fingernail base is pink | 124 <input type="checkbox"/> Unexplained weight loss of over 20lbs within the last 4 months |
| 101 <input type="checkbox"/> Fingernail base is purple | 125 <input type="checkbox"/> Energy level is worse than it was 5 years ago |
| 102 <input type="checkbox"/> Fingernails have ridges or white spots | 127 <input type="checkbox"/> Sleeps less than 6 hours per night |
| 103 <input type="checkbox"/> Fingernails are soft | 128 <input type="checkbox"/> Unable to recall dreams the next day |
| 104 <input type="checkbox"/> Fingernails are splitting | 129 <input type="checkbox"/> Sensitive to chemicals, paint, fumes, cologne |
| 105 <input type="checkbox"/> Fingernails peel | 130 <input type="checkbox"/> Had blood transfusion in the past |
| 106 <input type="checkbox"/> Pale fingernail beds | 131 <input type="checkbox"/> Had transplant in the past |
| 107 <input type="checkbox"/> Blacks out easily | 138 <input type="checkbox"/> Takes anti-rejection drugs |
| 108 <input type="checkbox"/> Balance problems | 132 <input type="checkbox"/> Had a major accident or injury |
| 109 <input type="checkbox"/> Difficulty walking | 137 <input type="checkbox"/> Sleep Apnea |
| 110 <input type="checkbox"/> Has tattoos | 139 <input type="checkbox"/> Toxic chemical exposure |
| 111 <input type="checkbox"/> Brittle hair | 175 <input type="checkbox"/> Has been out of the country recently |
| 112 <input type="checkbox"/> Dry hair | 176 <input type="checkbox"/> Had childhood vaccines |
| 113 <input type="checkbox"/> Thin hair | 177 <input type="checkbox"/> Had a vaccine in the last 12 months |
| 114 <input type="checkbox"/> Hair loss | 147 <input type="checkbox"/> Had a flu shot last year |
| 115 <input type="checkbox"/> Drinks alcoholic beverages daily | 182 <input type="checkbox"/> Had a pneumonia vaccine last year |
| 116 <input type="checkbox"/> Drinks less than 8 glasses of water per day | 183 <input type="checkbox"/> Had a Hepatitis B vaccine in the last 2 years. |
| 117 <input type="checkbox"/> Currently on Chemotherapy | Has a family history of: |
| 118 <input type="checkbox"/> Currently on radiation treatment | 184 <input type="checkbox"/> Cancer |
| 148 <input type="checkbox"/> Had radiation therapy in the last year | 185 <input type="checkbox"/> Heart Disease |
| 149 <input type="checkbox"/> Had chemotherapy in the last year | 186 <input type="checkbox"/> Diabetes |
| 119 <input type="checkbox"/> Had chemotherapy in the past | 187 <input type="checkbox"/> Alcoholism |
| 120 <input type="checkbox"/> Has had radiation treatments in the past | 188 <input type="checkbox"/> Depression |
| 121 <input type="checkbox"/> Gained over 20 lbs in the last 12 months | 189 <input type="checkbox"/> Obesity |
| 122 <input type="checkbox"/> Somewhat Overweight | |
| 123 <input type="checkbox"/> Somewhat Underweight | |

Lifestyle Habits

- | | | |
|--|--|--|
| 380 <input type="checkbox"/> Drinks beverages from a can | 379 <input type="checkbox"/> Drinks 1 or more pop/sodas per day | 385 <input type="checkbox"/> Smokes more than 1 pack per day |
| 370 <input type="checkbox"/> Drinks alcohol | I had 4 alcoholic drinks in one day: | 126 <input type="checkbox"/> Rarely exercises |
| 371 <input type="checkbox"/> Drinks caffeinated coffee | 172 <input type="checkbox"/> never | 133 <input type="checkbox"/> Regularly exercises |
| 372 <input type="checkbox"/> Drinks caffeinated pop/soda | 173 <input type="checkbox"/> more than 3 months ago | 386 <input type="checkbox"/> Takes Vitamins |
| 373 <input type="checkbox"/> Drinks caffeinated tea | 174 <input type="checkbox"/> less than 3 months ago | 134 <input type="checkbox"/> Vegetarian |
| 374 <input type="checkbox"/> Drinks decaffeinated coffee | 381 <input type="checkbox"/> Has more than 5 alcoholic drinks per week | 135 <input type="checkbox"/> Eats no red meat |
| 375 <input type="checkbox"/> Drinks decaffeinated pop/soda | 391 <input type="checkbox"/> Craves sugar / starches | 136 <input type="checkbox"/> Eats no meat, no dairy |
| 376 <input type="checkbox"/> Drinks decaffeinated tea | 382 <input type="checkbox"/> Currently smokes | 387 <input type="checkbox"/> Frequent use of artificial sweeteners |
| 377 <input type="checkbox"/> Drinks more than 3 cups of coffee per day | 383 <input type="checkbox"/> Quit smoking in the last 5 years | 389 <input type="checkbox"/> Anorexia |
| 378 <input type="checkbox"/> Drinks more than 3 cups of tea per day | 384 <input type="checkbox"/> Smoked for more than 5 years | 390 <input type="checkbox"/> Bulimic |
| 388 <input type="checkbox"/> Drinks diet pop/soda | | |

Surgeries

- 700 ☐ Tonsillectomy and/or Adenoids
- 701 ☐ Appendix
- 702 ☐ Gallbladder
- 703 ☐ Thyroid
- 715 ☐ Radiated thyroid
- 708 ☐ Cancer

- 704 ☐ Hysterectomy, complete
- 705 ☐ Hysterectomy, partial
- 706 ☐ Tubal ligation
- 707 ☐ Breast implants
- 709 ☐ Coronary by-pass
- 710 ☐ Spinal surgery

- 711 ☐ Extremity surgery
- 712 ☐ Hip replacement
- 713 ☐ Knee replacement
- 714 ☐ Splenectomy
- 716 ☐ Cataract surgery
- 717 ☐ Hemorrhoidectomy

Gastrointestinal

- 265 ☐ 4-5 bowel movements per week
- 266 ☐ 3 or less bowel movements per week
- 267 ☐ 6 or more bowel movements per week
- 268 ☐ Black tarry stools
- 269 ☐ Pale or yellow colored stool
- 270 ☐ Blood stools
- 271 ☐ Constipation
- 272 ☐ Hemorrhoids
- 273 ☐ Loose bowel movements
- 274 ☐ Frequent diarrhea
- 275 ☐ Frequent nausea
- 276 ☐ Frequent vomiting
- 277 ☐ Abdominal gas
- 278 ☐ Belching and burping after eating
- 279 ☐ Bloating after eating
- 280 ☐ Severe abdominal pains
- 281 ☐ Stomach ulcers
- 282 ☐ Uses digestive aids
- 283 ☐ Uses laxatives

- 284 ☐ Immediate indigestion upon eating
- 285 ☐ Indigestion in 2 hours or more after meals
- 286 ☐ Indigestion within 1 hour after meals
- 287 ☐ Difficulty swallowing
- 288 ☐ Eating relieves fatigue
- 289 ☐ Eats when nervous
- 290 ☐ Excessive hunger
- 291 ☐ Poor appetite
- 292 ☐ Experiences fainting spells when hungry
- 293 ☐ Feels shaky when hungry
- 294 ☐ Frequently drowsy after eating a meal
- 295 ☐ Gall bladder disease
- 296 ☐ Has had intestinal worms
- 297 ☐ Reflux/Hiatal hernia
- 298 ☐ Liver disease
- 299 ☐ Irritable Bowel Syndrome
- 300 ☐ Diverticulitis
- 301 ☐ Diverticulosis

Respiratory

- 485 ☐ Catches severe colds
- 486 ☐ Chronic chest condition
- 487 ☐ Chronic cough
- 488 ☐ Constant runny nose
- 489 ☐ COPD
- 490 ☐ Difficulty breathing

- 491 ☐ Frequent colds
- 492 ☐ Frequent nose bleeds
- 493 ☐ Frequent sinus infections
- 494 ☐ Frequent stuffy nose
- 495 ☐ Hay fever
- 496 ☐ Nasal polyps

- 497 ☐ Night sweats
- 498 ☐ Post nasal drip
- 499 ☐ Sneezing spells
- 500 ☐ Spits up blood
- 501 ☐ Spits up phlegm
- 502 ☐ Wheezes

Mouth and Throat

- 400 ☐ Bad breath
- 401 ☐ Bitter taste in the mouth
in the morning
- 402 ☐ Dry mouth
- 403 ☐ Excessive saliva
- 404 ☐ Sores or cracks in the
corners of the mouth
- 405 ☐ Glands often swell
- 406 ☐ Frequent canker sores

- 407 ☐ Frequent fever blisters
- 408 ☐ Frequent sore throats
- 409 ☐ Frequently has a sore
tongue
- 410 ☐ Sore gums
- 411 ☐ Swollen gums
- 412 ☐ Swollen tongue
- 413 ☐ Tongue burns

- 414 ☐ Tongue has grooves or fissures
- 415 ☐ Tongue is coated
- 416 ☐ Gums bleed when brushing teeth
- 417 ☐ Toothaches
- 418 ☐ Amalgam dental fillings
- 420 ☐ Other dental fillings
(gold, composite, etc)
- 419 ☐ Has had root canal(s)

Endocrine

- | | | |
|---|---|---|
| 245 <input type="checkbox"/> Coarse hair | 249 <input type="checkbox"/> Frequently feels cold | 253 <input type="checkbox"/> Unusually jumpy or nervous |
| 246 <input type="checkbox"/> Coarse skin | 250 <input type="checkbox"/> Frequently feels hot | 254 <input type="checkbox"/> Unusually tired most of the time |
| 247 <input type="checkbox"/> Diabetic | 251 <input type="checkbox"/> Gets lightheaded when standing quickly | |
| 248 <input type="checkbox"/> Excessive thirst | 252 <input type="checkbox"/> Heals slowly | |

Cardiovascular

- | | |
|--|--|
| 190 <input type="checkbox"/> Cold feet | 198 <input type="checkbox"/> Pain in leg/hips when walking |
| 191 <input type="checkbox"/> Cold hands | 199 <input type="checkbox"/> Frequent swollen ankles |
| 192 <input type="checkbox"/> Experiences shortness of breath while sitting still | 200 <input type="checkbox"/> Pains in the heart or chest |
| 193 <input type="checkbox"/> Heart skips beats | 201 <input type="checkbox"/> Spells of rapid heart rate |
| 194 <input type="checkbox"/> Tendency of High blood pressure | 202 <input type="checkbox"/> Troubled with blood clots |
| 195 <input type="checkbox"/> Leg cramps during bedtime | 203 <input type="checkbox"/> Unusually slow pulse rate |
| 196 <input type="checkbox"/> Leg cramps during daytime | 204 <input type="checkbox"/> Varicose veins |
| 197 <input type="checkbox"/> Low blood pressure at times | 205 <input type="checkbox"/> Heart palpitations |

Skin

- | | | |
|---|--|---|
| 520 <input type="checkbox"/> Bruises easily | 526 <input type="checkbox"/> Itchy skin | 529 <input type="checkbox"/> Skin eruptions |
| 521 <input type="checkbox"/> Excessive perspiration | 527 <input type="checkbox"/> Problems with Eczema | 531 <input type="checkbox"/> Skin is tender |
| 522 <input type="checkbox"/> Frequent goose bumps | 528 <input type="checkbox"/> Has moles which are changing in size and/or color | 532 <input type="checkbox"/> Sores that heal slowly |
| 523 <input type="checkbox"/> Has acne | 530 <input type="checkbox"/> Skin is rough, especially on the back of the arms | 533 <input type="checkbox"/> Troubled with boils |
| 524 <input type="checkbox"/> Has Psoriasis | | 534 <input type="checkbox"/> Dry skin |
| 525 <input type="checkbox"/> Hives | | |

Ears

- | | | |
|--|--|--|
| 220 <input type="checkbox"/> Discharge from ears | 222 <input type="checkbox"/> Punctured ear drum | 224 <input type="checkbox"/> Ringing or noises in the ears |
| 221 <input type="checkbox"/> Hard of hearing | 223 <input type="checkbox"/> Recurrent ear infection | 225 <input type="checkbox"/> Tinnitus |

Eyes

- | | | |
|---|---|--|
| 320 <input type="checkbox"/> Bloodshot eyes | 325 <input type="checkbox"/> Eyes watery | 329 <input type="checkbox"/> Mild Macular degeneration |
| 321 <input type="checkbox"/> Blurred vision | 326 <input type="checkbox"/> Mild Glaucoma | 330 <input type="checkbox"/> Itchy eyes |
| 322 <input type="checkbox"/> Cross eyes | 327 <input type="checkbox"/> Far sighted | 331 <input type="checkbox"/> Near sighted |
| 323 <input type="checkbox"/> Eye pain | 328 <input type="checkbox"/> Developing cataracts | 332 <input type="checkbox"/> Dry Eyes |
| 324 <input type="checkbox"/> Eyes feel gritty | | |

Feet

- | | | |
|---|--|---|
| 350 <input type="checkbox"/> Corns | 353 <input type="checkbox"/> Painful feet | 355 <input type="checkbox"/> Swelling in the feet and/or ankles |
| 351 <input type="checkbox"/> Frequent foot cramps | 354 <input type="checkbox"/> Plantar warts | 356 <input type="checkbox"/> Plantar fascitis |
| 352 <input type="checkbox"/> Heel spurs | | 357 <input type="checkbox"/> Fungal Infection |

Neuromuscular

- | | | |
|---|---|--|
| 440 <input type="checkbox"/> Bites nails | 449 <input type="checkbox"/> Has motion sickness | 457 <input type="checkbox"/> Low back pain |
| 441 <input type="checkbox"/> Frequent muscle soreness | 450 <input type="checkbox"/> Has Osteoarthritis | 458 <input type="checkbox"/> Neck pain |
| 442 <input type="checkbox"/> Muscle spasms | 451 <input type="checkbox"/> Has Rheumatism | 459 <input type="checkbox"/> Pain between the shoulders |
| 443 <input type="checkbox"/> Muscle weakness | 452 <input type="checkbox"/> Rheumatoid Arthritis | 460 <input type="checkbox"/> Shoulder/arm pain |
| 444 <input type="checkbox"/> Tremors | 453 <input type="checkbox"/> Joint stiffness in the morning | 461 <input type="checkbox"/> Numbness/tingling in the body |
| 445 <input type="checkbox"/> Frequent headaches | 454 <input type="checkbox"/> Swollen joints | 462 <input type="checkbox"/> Sleep walks |
| 446 <input type="checkbox"/> Often dizzy | 455 <input type="checkbox"/> Leg pain at rest | 463 <input type="checkbox"/> Stutters or stammers |
| 447 <input type="checkbox"/> Frequently feels faint | 456 <input type="checkbox"/> Spinal curvature | 464 <input type="checkbox"/> Nerve pain |
| 448 <input type="checkbox"/> Has Epilepsy | | |

Behavior Patterns

- 150 ☐ Afraid to eat anywhere except home
- 151 ☐ Always needs someone to advise
- 152 ☐ Cries often
- 153 ☐ Difficulty concentrating
- 154 ☐ Difficulty falling asleep
- 155 ☐ Difficulty staying asleep
- 156 ☐ Easily angered
- 157 ☐ Feelings are easily hurt
- 158 ☐ Frequently becomes scared for no reason
- 159 ☐ Frequently miserable or blue
- 160 ☐ Has to be on guard even with friends
- 161 ☐ Often annoyed by people
- 162 ☐ Recurrent bad dreams
- 163 ☐ Sometimes wishes to be dead or away from it all
- 164 ☐ Upset by criticism
- 165 ☐ Poor memory
- 166 ☐ Scared to be alone
- 167 ☐ Strange people or places cause fear
- 168 ☐ Under considerable emotional stress
- 169 ☐ Unhappy when other are happy
- 170 ☐ Brain fog

Urinary

- 555 ☐ Urinates more than 2 times per night
- 556 ☐ Bed wetting
- 557 ☐ Blood in the urine
- 558 ☐ Difficulty starting urination
- 559 ☐ Painful urination
- 560 ☐ Frequent urination
- 561 ☐ Troubled by urgent urination
- 562 ☐ Incontinence when sneezing or laughing
- 563 ☐ Loses bladder control
- 564 ☐ Frequent bladder infections
- 565 ☐ Frequent kidney infections
- 566 ☐ Kidney stones

Men Only

- 585 ☐ Difficulty completing intercourse
- 586 ☐ Difficulty getting or keeping an erection
- 587 ☐ Discharge from the urethra
- 588 ☐ Had a vasectomy
- 589 ☐ Had difficulty fathering children
- 590 ☐ Lumps in the testicles
- 591 ☐ Painful genitals
- 592 ☐ Prostate troubles
- 593 ☐ Sores on external genitalia
- 594 ☐ Herpes
- 595 ☐ Sexual diseases

Women Only

- 610 ☐ Heavy hair growth on face or body
- 611 ☐ Cycles are every 27-29 days
- 612 ☐ Abnormal cycle >29 days and/or <26 days
- 613 ☐ PMS
- 614 ☐ Menstrual cramps
- 615 ☐ Painful periods
- 616 ☐ Acne worse at menstruation
- 617 ☐ Excessive menstrual flow
- 618 ☐ Retains fluid during periods
- 619 ☐ Pre-menstrual depression
- 620 ☐ Currently taking birth control medication
- 621 ☐ Has taken birth control medication more than 1 year
- 622 ☐ Has taken birth control medication within the last year
- 623 ☐ Has had miscarriage
- 624 ☐ Hot flashes
- 625 ☐ Takes hormone replacement medication
- 627 ☐ Diminished sexual desire
- 628 ☐ Painful intercourse
- 629 ☐ Poor or infrequent orgasm
- 630 ☐ Lumps in the breasts
- 631 ☐ Tender breasts
- 633 ☐ Vaginal discharge
- 634 ☐ Bloody spotting discharge
- 635 ☐ Yeast infections
- 636 ☐ Sores on external genitalia
- 637 ☐ Herpes
- 638 ☐ Sexual diseases
- 639 ☐ Endometriosis
- 640 ☐ Breast reduction
- 641 ☐ Breast augmentation
- 642 ☐ Abortion
- 643 ☐ D&C
- 644 ☐ Tubal pregnancy
- 645 ☐ Uterine fibroids
- 646 ☐ Ovarian fibroids
- 647 ☐ Breast fibroids
- 648 ☐ Currently Breastfeeding

Medications

Please list all drugs you are currently taking including over the counter drugs, aspirin, etc. Also, list how long you have taken each drug and the condition for which it was prescribed.

<u>DRUG</u>	<u>PRESCRIBED FOR:</u>	<u>HOW LONG</u>

Please list all drugs taken within the last five years including over the counter drugs, antibiotics, aspirin, inhalers, etc. Also, list how long you have taken each drug and the condition for which it was prescribed.

<u>DRUG</u>	<u>PRESCRIBED FOR:</u>	<u>HOW LONG</u>

Please list all vitamins/herbs/supplements you are currently taking. Also, list how much of each supplement you are taking.

VITAMIN/HOW MUCH/BRAND