Healthy Past 100 Explanation and Consent Form

Please take the time to thoroughly read the Explanation and Consent Form before completing the personal history section.

Healthy Past 100 is Dr. Teagarden's proprietary health and wellness optimizing program. By addressing the key areas that lead to optimal health and wellness, which are referred to as the *Short List*, it's possible to improve and optimize your health and wellness. Focusing on the Short List leads to what science refers to as *lifestyle interventions*. Lifestyle interventions occur when you simultaneously improve your diet, exercise regularly, reduce stress and improve your psychological or spiritual health. *Healthy Past 100* thus concentrates on these key areas of your life.

To give rise to lifestyle interventions, the Short List focuses on diet, metabolism, nutrition, supplementation, chronic inflammation, gut health, thyroid function, psychological and spiritual wellness, exercise, oxidative stress and detoxification. Lifestyle interventions are scientifically proven to minimize the risk of common diseases, positively affect several important measures of health, e.g., biomarkers, and increase the chances of maintaining excellent health into advanced age.

The World Health Organization (WHO) in 1946 put forth this groundbreaking definition of health: health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Furthermore, the McKinley Health Center, University of Illinois, defines *wellness* as

> *A state of optimal well-being that is oriented toward maximizing an individual's potential. This is a life-long process of moving towards enhancing your physical, intellectual, emotional, social, spiritual, and environmental well-being.*

Finally, the University of East Carolina defines wellness as

> *The integration of mind, body and spirit. Optimal wellness allows us to achieve our goals and find meaning and purpose in our lives. Wellness combines seven dimensions of well-being into a quality way of living. Overall, wellness is the ability to live life to the fullest and to maximize personal potential in a variety of ways. Wellness involves continually learning and making changes to enhance your state of wellness. When we balance the physical, intellectual, emotional, social, occupational, spiritual, and environmental aspects of life, we achieve true wellness.*

The above definitions demonstrate that the terms *health and wellness* encompass all aspects of our lives, and aren't limited to a state free of symptoms and disease. *Healthy Past 100* uses the terms *health* and *wellness* in the same spirit as expressed in the above definitions. Thus *Healthy Past 100* does not focus on treating and eliminating physical symptoms and disease, but rather on optimizing overall health and wellness by addressing the key areas of health included in the Short List.

To reiterate, *Healthy Past 100* does not diagnose or treat any diseases, conditions or illnesses. *Healthy Past 100* is not a substitute for any form of medical care. There are too many variables involved to accurately predict what the outcome of following *Healthy Past 100* or any other healing art will be. The nature of your condition, the timing of when you seek help, your current state of health, your history, attitude and compliance factor into the state of health and wellness that you're able to develop and maintain.

Conditions and symptoms you're experiencing or have experienced in the past may temporarily intensify or intermittently resurface when you elect to utilize *Healthy Past 100*. Symptoms and conditions commonly develop as health and wellness deteriorate, and may be experienced as health and wellness are regained. The absence of symptoms does not correlate with health and wellness, and it's common for symptoms to develop or temporarily intensify during the process of healing. If you're experiencing symptoms that are new, have been experienced previously, that you don't understand, or if you experience symptoms you find concerning, please speak with Dr. Teagarden about them. If your symptoms and concerns persist, it's essential to seek advice or treatment from a professional(s) who specializes in treating your particular symptoms or conditions to your fullest degree of satisfaction.

Healthy Past 100 requires your active participation on a daily basis. A goal of *Healthy Past 100* is helping you develop the capacity to take empowered action to ensure lasting health and wellness. This will occur naturally as your health and wellness gradually move toward a greater state of optimization, allowing you to trust more fully in your innate healing capacities. If you feel uncomfortable with any aspect of *Healthy Past 100*, or if at any time you think it is adversely affecting any part of your health or wellness, it's essential that you speak with Dr. Teagarden about your concerns and cease employing those aspects which are causing your concerns.

Confidentiality

All client information and records provided will be kept confidential except under circumstances detailed in state or federal statutes, laws and regulations. Your information will not be released to individuals or agencies without your signed authorization, except in those legal situations, as noted. Client files are maintained in strict confidence, in accordance with applicable state and federal laws and professional standards.

I have carefully and thoroughly read the Consent and Explanation for *Healthy Past 100*. I hereby consent to begin addressing the items on its Short List.

Printed client name: _____

Client signature: _____ Date: _____

Parent/Legal Guardian: _____ Date: _____

Health Past 100 Personal History Form

Name: Last_____ First: _____ Date:_____
Address:_____ City:_____
State:_____ Zip:_____ Email:_____
Cell: _____ Home: _____ Work:_____
Date of Birth: _____ Occupation: _____
Marital Status: ❒ Single ❒ Married ❒ Partnered ❒ Divorced ❒ Separated ❒ Widowed ❒ Other
Emergency Contact: _____ Phone:_____
How did you learn about *Healthy Past 100?* _____
Why are you seeking assistance? _____
_____
_____
_____
_____

Please list any health or life concerns you're experiencing and when they began:

1
2
3
4
5

1. Please describe:_____
_____
_____
_____
_____
_____

2. What have you done about your health/life concern(s)? _____
_____
_____

3. Did it help?_____
_____

4. What was different about *you* after treatment? _____
5. Have your concerns increased/decreased since treatment? _____
6. Why do you think this happened or continues to happen to you? _____
_____

7. If your health condition had a message for you, what would it be? _____
_____

8. What would have to change for you to experience optimal health? _____
_____

9. How would you describe your current state of health? _____
10. Do you feel like you're becoming healthier, staying about the same, or becoming less healthy?_____
11. When do you last remember feeling really great? _____
12. Do you feel more same less vital than one year ago?_____
13. Did something trigger a change in your health?_____
14. Childhood health: (Poor) 1 2 3 4 5 6 7 8 9 10 (Excellent) Placed lived in childhood:_____
15. Birth History: ❒ Healthy labor and birth ❒ Vaginal birth ❒ Difficult labor ❒ Breech ❒ C-section ❒ Premature
16. ❒ Breastfed ❒ Bottle fed ❒ Formula ❒ Colic ❒ Received antibiotics ❒ Childhood illness:_____
17. Did you eat sugar/candy as a child? (Yes) 10 9 8 7 6 5 4 3 2 1 (No) _____
18. Did you receive childhood immunizations?_____
19. Please list immunizations and flu shots received as an adult_____

Stress Survey

What are the major stressors in your life? ***Place a 0-10 next to each item, 10 indicating a maximal stressor***

Primary relationship	Finances	Declining health	Children
Work	Personal illness or injury	Parents	Psychological issues
Divorce/separation	Family illness	Death of loved one(s)	Loneliness
Legal issues	Caring for sick relative	Past trauma/abuse	Loss of job/career
Retirement	Change in living conditions	Addictions	Other

20. What do you do to relax/relieve stress?_____
21. What were the greatest stressors in your past?_____
22. Do you feel resolved with your past stressors?_____
23. Who is the most stressful person(s) in your life?_____
24. Why?_____
25. What's the worst thing you've experienced?_____
26. How could your life be more fulfilling? _____
27. Do you feel like you're in touch with your life purpose?_____
28. Does your life reflect this?_____
29. If you could change one thing in your life, what would it be? _____
30. How would this allow you to heal more deeply?_____
31. Is having a deep, meaningful life important to you?_____
32. What do you do currently that brings you joy?_____
33. If you did things in the past that brought you joy and you aren't doing them now, why?_____

I have an excessive amount of stress in my life	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I experienced excessive stress in the recent/not so recent past	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
Dealing with stressful situations is wearing me out	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
The bulk of my time and money is spent fulfilling my responsibilities	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I have been abused, experienced a violent crime or traumatic event	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I have experienced long periods of very high stress	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)

I felt safe growing up	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I feel safe in my experience of life now	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I've driven myself to exhaustion at times	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I often feel anxious and have no idea why	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I often feel drained and have no idea why	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)

I often become tired in the afternoon	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
My energy tends to increase around bedtime	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I experience brain fog, i.e., confusion, inability to focus, feeling foggy headed	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
My mind isn't as clear as it used to be	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
My lack of mental clarity concerns me	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I'm sensitive to light and often need sunglasses when outside	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I overwork with little play or relaxation for extended periods	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I'm exhausted and irritable a lot of the time and don't know why	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I experience chronic or recurrent infections, colds or flu	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I have one or more chronic illness, e.g., cancer, heart disease, diabetes	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I've undergone repeated steroid therapy (corticosteroids)	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I tend to gain weight, especially around the midsection	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
Temperature fluctuations are challenging for me	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I'm frequently cold and don't tolerate cold well	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I'm usually warm, even in cool environments	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I'm environmentally/chemically sensitive	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I experience low back pain	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I have unexplained fears/anxieties	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I get lightheaded or dizzy when rising rapidly from a sitting or lying position	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I have dark circles under my eyes	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I am chronically fatigued and sleep doesn't refresh me	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I wake up exhausted but can get myself going and make it through the day	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I rely on caffeine, sugar, carbohydrates, energy drinks or soda to keep going	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
My sex drive isn't what it used to be	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
It's hard to meet my daily responsibilities due to low energy	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I feel unwell much of the time	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I need a nap during the day	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
My ankles become swollen, especially in the evening	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)

I currently work or previously worked nights or swing shifts	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)

Dietary Habits

Please check all that apply

❒ Non-vegetarian	❒ Vegetarian	❒ Vegan	❒ Raw foods
❒ Paleo	❒ Ketogenic	❒ Dairy free	❒ Low carb diet
❒ Low fat diet	❒ High protein diet	❒ Gluten free	❒ Wheat restricted diet
❒ Low sodium diet	❒ No sugar diet	❒ GAPS diet	❒ Other

Please check all substances you consume

❒ Caffeine	❒ Soda or sweetened drinks	❒ Fruit juice
❒ Candy, sweets, desserts	❒ Sugar, honey, agave, maple syrup	❒ Fast food
❒ Processed foods	❒ Prepackaged meals	❒ Fruit
❒ Alcohol	❒ Vegetarian protein powder	❒ Bread and other baked goods
❒ Pasta	❒ Cereal/granola	❒ Grains, e.g., wheat or corn
❒ Gluten	❒ Energy or granola bars	❒ Prepackaged protein shakes/bars
❒ Potatoes/sweet potatoes	❒ Soy products	❒ Flaxseed
❒ Fish	❒ Beef	❒ Pork
❒ Poultry	❒ Eggs	❒ Salad dressing, mayonnaise
❒ Plant-based dairy alternatives	❒ Proinflammatory oils, e.g., canola	❒ Ultra-pasteurized dairy products
❒ Vegetables	❒ Protein shakes (homemade)	❒ Salads
❒ Snack foods, e.g., crackers	❒ Gluten-free products	❒ Other

34. My appetite is typically: ❒ Non-existent ❒ Weak ❒ Normal/consistent ❒ Strong ❒ Irregular ❒ Varies ❒ Unsure
35. Do you limit your salt intake? ❒ Yes ❒ No If yes, describe:_____
36. How much water do you drink?_____
37. Do you avoid certain foods? ❒ Yes ❒ No If yes, describe:_____
38. Are there any foods you have a reaction to?_____

Food and meals: check all that apply

❒ A healthy, nutritious diet is very important to me	❒ I'd eat better if I had more time to shop and cook
❒ I often overeat	❒ I eat mostly organic foods
❒ I eat so much that I'm uncomfortable after meals	❒ I have an unhealthy relationship with food
❒ I eat a healthy amount and stop	❒ I crave something sweet following lunch or dinner
❒ I love to eat	❒ I have strong cravings for unhealthy foods

❒ I crave healthy foods	❒ I dislike healthy foods
❒ I often get sleepy after lunch or dinner	❒ I often eat standing up or on the go
❒ I commonly eat convenience/prepackaged foods	❒ I don't like to cook
❒ I eat 50% or more of my meals away from home	❒ I travel frequently, which interferes with meal planning
❒ I cook most of my meals at home	❒ I struggle with eating issues (too much, wrong foods)
❒ I make poor snack choices	❒ I rarely snack between meals
❒ I rarely sit down and enjoy mealtimes	❒ I have to be very careful about my food choices
❒ I make it a priority to drink a lot of water	❒ I commonly drink coffee from Starbucks, Peets, etc.

❒ I have to eat something every 2-3 hours	❒ Skipping meals is hard for me
❒ My family members don't like to eat healthy foods	❒ My family members have special dietary needs
❒ I spend a lot of time thinking about food and eating	❒ I can't digest what I enjoyed when I was younger
❒ I'm confused about what's nutritious and what's not	❒ I've tried many diets with no lasting success
❒ Intermittent fasting has been helpful for me	❒ I need help with eating issues

Sleep/Energy Survey

Average number of hours you sleep per night:	>12 12 11 10 9 8 7 6 5 <5
Do you fall asleep easily?	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
Do you sleep soundly through the night?	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
Do you wake during the night?	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
Do you have trouble getting back to sleep once awakened?	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
Do you awaken in the morning feeling well rested?	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
Do you need caffeine to get going in the morning?	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
Do you require supplements or medication to sleep?	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
Do you experience disturbing dreams or restless sleep?	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
Do you get drowsy 2-4 hours after waking?	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
Do you get drowsy in the afternoon?	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
Does your partner, child or pet wake you during the night?	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
Do you experience leg cramps that wake you up?	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)

Please provide the following information

Height	Highest adult weight	When?
Weight	Lowest adult weight	When?
Weight 1 year ago	Usual weight range +/- 5 lbs	

Desired weight	Do you have weight fluctuations in excess of 10 pounds? ❒ Yes ❒ No
Blood pressure	Is your blood pressure trending up/down?
Resting pulse	Is your resting pulse trending up/down?
Cholesterol HDL LDL	Do you carry weight around your abdomen? ❒ Yes ❒ No # of years:

Cigarettes, alcohol and recreational substances

I smoke ❒ Yes ❒ No I smoked previously ❒ Yes ❒ No	For how many years? ❒ < 1 yr ❒ 1-2 ❒ 3-5 ❒ 5+
Packs per day? ❒ <1/2 ❒ 1/2 ❒ 1 ❒ 2 ❒ 2+	# attempts to quit: Date quit:
Have you been exposed to 2nd hand smoke? ❒ Yes ❒ No	❒ Minimal ❒ Moderate ❒ High ❒ Excessive
Do you drink alcohol? ❒ Yes ❒ No # of drinks per week:	❒ None ❒ 1-2 ❒ 3-5 ❒ 6-9 ❒ 10-12 ❒ 12+ per week
Previous alcohol intake: ❒ None ❒ Occasional	❒ Low ❒ Moderate ❒ High ❒ Excessive

Did your mother smoke while pregnant with you?	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
Did your mother drink alcohol while pregnant with you?	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
Did your mother take prescription medications while pregnant with you?	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
Did your mother use recreational drugs while pregnant with you?	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
Were you exposed to 2nd hand smoke as a baby?	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
Do you smoke or use marijuana?	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
Did you smoke or use marijuana in the past?	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
Please list other substances you've used:	
Have you been addicted to any substances?	

Please check all that apply and provide year of onset (if known)

❒ Hashimoto's	❒ Hypothyroidism	❒ Graves' Disease
❒ Hyperthyroidism	❒ Anemia	❒ Epstein Barr Virus (EBV)
❒ Mononucleosis	❒ Cytomegalovirus (CMV)	❒ Fibromyalgia
❒ Chronic fatigue syndrome	❒ Lupus	❒ Rheumatoid arthritis
❒ Multiple sclerosis	❒ Myasthenia gravis	❒ Celiac disease
❒ Non-celiac gluten sensitivity	❒ Autoimmune disease (other)	❒ Lyme disease
❒ Polycystic ovarian syndrome	❒ Arthritis	❒ Diabetes ❒ Type1 ❒ Type2
❒ Non-alcoholic fatty liver disease	❒ Metabolic syndrome	❒ Insulin resistance
❒ Obesity	❒ Elevated A1c	❒ Elevated blood sugar
❒ High blood pressure	❒ Cancer	❒ Cardiovascular disease
❒ Stroke or cerebrovascular disease	❒ Vascular disease	❒ Atherosclerosis

❒ Neurological condition or disease	❒ Chronic respiratory disease	❒ Kidney disease
❒ Chronic infection(s)	❒ Eczema, psoriasis, skin eruptions	❒ Allergies
❒ Frequent colds	❒ Single nucleotide polymorphism(s)	❒ MTHFR SNP
❒ Cystathione beta synthase SNP	❒ Headaches or migraines	❒ Chronic joint pain
❒ Chronic muscle pain	❒ Low back pain	❒ Spinal degeneration
❒ Osteopenia	❒ Osteoporosis	❒ Hair loss
❒ HIV	❒ AIDS	❒ Conjunctivitis
❒ Frequent fevers	❒ Night sweats	❒ Gingivitis
❒ Cavities or tooth decay	❒ Dental infections	❒ Toothaches or sensitivity
❒ Stomach aches or gut symptoms	❒ Nausea	❒ Dysbiosis
❒ H pylori	❒ Clostridium Difficile	❒ Irritable bowel syndrome (IBS)
❒ SIBO	❒ SIFO	❒ Gerd
❒ Nerd	❒ Ulcers	❒ Functional dyspepsia
❒ Bloating	❒ Diarrhea	❒ Gas
❒ Constipation	❒ Poor digestion	❒ Frequent desire to empty bowels
❒ Athlete's foot	❒ Toenail fungus	❒ Covid

Please list sprains, broken bones, accidents, injuries, surgeries, hospitalizations (include dates)

39. ❒ Yes ❒ No Have you sustained head trauma or traumatic brain injury?_____

_____

40. ❒ Yes ❒ No Have you had x-ray, MRI, CT, PET, ultrasounds or other radiological tests performed? If so, please make photocopies of any radiological reports and include them with your initial paperwork.

Physical, mental, emotional, spiritual assessment

I'm free of chronic aches, pains, ailments, and diseases	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I believe it's possible to change my life, circumstances, health, etc.	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I'm willing to put forth the energy required to become healthier than ever	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)

I'm open to doing things differently to become and remain healthy	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I have health conditions/diseases that have proven difficult to overcome	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I can easily lose weight and have no trouble maintaining an optimal weight	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
Losing weight has become difficult, even impossible	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I have been diagnosed with an autoimmune condition/disease(s)	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I understand the causes of my chronic physical problems (if applicable)	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I'm physically strong enough to accomplish activities of daily life	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I have good endurance and aerobic capacity	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I engage in regular physical workouts and push myself hard	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I have become sedentary and don't engage in strenuous exercise	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I could do physically exhausting work for days on end if necessary	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I regularly engage in activities that significantly increase my heart rate	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I can run a mile without stopping	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I make time for yoga, meditation, spiritual practice, psychotherapy, etc.	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I have an awareness of energy, life force, chi, kundalini	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I make it a priority to schedule regular bodywork sessions, e.g., massage	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I feel a strong connection with and have great appreciation for my life/health	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I make time to walk, garden, be in nature, etc.	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I feel energized when I'm in nature	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I feel better when I move my body, exercise, hike, do yoga, etc.	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I'm usually optimistic	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I usually give myself more supportive messages than critical messages	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I have a hard time with negative self-talk	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I notice the shortcomings of others	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I have healthy self-esteem	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I'm happy with my body image	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I usually feel physically attractive	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I'm willing to make mistakes, take risks and change my mind about things	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I routinely experience feelings of exhilaration	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I listen to and act upon my intuition	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I routinely experience gratitude	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I can let go of attachment to specific outcomes and embrace uncertainty	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I typically maintain peace of mind and tranquility	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)

I regularly commit time to my spiritual or religious life	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I have faith in God or a higher power	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
It's very important to me to avoid confrontation and conflict	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I refrain from saying things that people don't want to hear	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I have a good sense of humor	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)

I can laugh at myself	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I tend to take things personally	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I'm often frustrated or angry	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I lash out at others in anger	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
People are sometimes frightened by my anger	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
It's difficult for me to get in touch with anger	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I am good at letting people know where I stand and easily set firm boundaries	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I'm able to set boundaries with difficult or demanding people	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I give myself permission to feel my feelings and express them appropriately	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
It's hard for me to cry or express my feelings	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I commonly put other people's feelings and needs before my own	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
Putting the needs of others before my own has been detrimental to my life	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I'm able to say *yes* when I mean yes and *no* when I mean no	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I have a strong need to be right	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I tend to be controlling of myself and others	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I'm a perfectionist	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I sometimes talk over others	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I'm better at giving advice than taking it	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I make it a point to listen more than I speak	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I try to influence people and bring them around to my point of view	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
There are events and people that I've had difficulty forgiving	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
These events and people are often on my mind	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I've done things that are difficult for me to forgive myself for and move through	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
These things are often on my mind	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I go out of my way to help others	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I have a supportive group of friends/community in whom I can confide	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I have/had a good relationship with my mother	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I have/had a good relationship with my father	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)

I routinely experience depression	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I routinely experience anxiety	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
My job utilizes my greatest talents and brings out the best in me	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
My occupation is enjoyable and fulfilling	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I have goals in my personal and professional life	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
These goals have proven helpful	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
These goals have proven to be more stressful than helpful	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I'm often stressed about money	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
My mind commonly skips from one thing to the next	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
It's difficult for me to still my mind and experience genuine peace	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I have the ability to concentrate for extended periods of time	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I watch TV	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I spend a lot of time doing non-essential things on the internet	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I sometimes wonder what to do with myself	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I need to be engaged in physical activity or moving my body to relax	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I pay attention to politics and issues that disrupt my peace of mind	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I initiate activities with others, e.g., lunch, dinner, movies, phone calls	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
I'm exhausted by and avoid people with outgoing personalities	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
❒ Yes No ❒ Are you in a romantic relationship?	
Are you happy with it?	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
If you're not in a relationship, would you like to be?	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
Do you experience intimacy, besides sex, in your committed relationships?	(Yes) 10 9 8 7 6 5 4 3 2 1 (No)
❒ Yes No ❒ Have you been given a psychiatric diagnosis?	
❒ Yes No ❒ Have you consulted with a physician in the last year?	

Please list any supplements you take. Use a separate sheet if necessary

Supplement	Dose	Frequency	Start date (month/year)	Reason for use

Please list all medications you're currently taking

Medication	Dose	Frequency	Start date (month/year)	Reason for use

Please list medications you've taken in the past for more than 3 months

Medication	Start/end date (month/year)	Reason for use

❒Yes ❒ No Some medications are/were difficult to stop using:_____

_____

Pre- and peri-menopausal women

❒ Yes ❒ No Periods are more frequent and/or irregular	❒ Yes ❒ No Moody or irritable prior to periods
❒ Yes ❒ No Periods are evenly spaced	❒ Yes ❒ No Periods are all about the same length
❒ Yes ❒ No Severe cramping with periods	❒ Yes ❒ No Trouble sleeping due to busy mind/thoughts
❒ Yes ❒ No Breast tenderness around periods	❒ Yes ❒ No Difficultly getting pregnant/miscarriages
❒ Yes ❒ No History of or current uterine fibroids	❒ Yes ❒ No Anxiety or panic attacks
❒ Yes ❒ No Depression or postpartum depression	❒ Yes ❒ No Current or past use of birth control pills
❒ Yes ❒ No Headaches during period	❒ Yes ❒ No History of no period for 3 or more months
❒ Yes ❒ No Cravings for sugar, fat, salt, chocolate	❒ Yes ❒ No Bloating or water retention during period
❒ Yes ❒ No Pain during intercourse	❒ Yes ❒ No Family hist. of breast/uterine/ovarian cancer
❒ Yes ❒ No Endometriosis	❒ Yes ❒ No Current or past use of IUD
Age of first period:	❒ Yes No ❒ Is there any chance you're pregnant?

Post-menopausal women

❒ Yes ❒ No Hot flashes	❒ Yes ❒ No Your last period was >1year ago
❒ Yes ❒ No Night sweats	❒ Yes ❒ No Osteoporosis
❒ Yes ❒ No Vaginal dryness	❒ Yes ❒ No Trouble sleeping due to busy mind/thoughts
❒ Yes ❒ No Reduced libido	❒ Yes ❒ No Anxiety or panic attacks
❒ Yes ❒ No Pain during intercourse	❒ Yes ❒ No Family hist. of breast/uterine/ovarian cancer
❒ Yes ❒ No Hysterectomy	❒ Yes ❒ No Current/past hormone replacement therapy
❒ Yes ❒ No History of birth control pills	❒ Yes ❒ No History of IUD
Age of first period: Age of last period:	Other:

Women only: ❒ Yes ❒ No Do/did you use non-organic tampons?_____

Check all that apply and provide product brand (if known)

❒ Shampoo	❒ Conditioner	❒ Bath soap
❒ Hand soap	❒ Toothpaste	❒ Mouthwash
❒ Deodarant	❒ Shaving cream	❒ Talc/powder
❒ Hair gel	❒ Hairspray	❒ Facial cleanser
❒ Toner	❒ Serum	❒ Moisterizers
❒ Foundation	❒ Lip stick	❒ Mascara

❒ Eye shadow	❒ Eye liner	❒ Facial blush/powder
❒ Parfume/cologne	❒ Body spray	❒ Bath oil
❒ Hair color	❒ Highlights	❒ Nail polish
❒ Hand sanitizer	❒ Products containing Triclosan	❒ Anti-microbial soap
❒ Glass cleaner	❒ Dish soap	❒ Laundry soap
❒ Dishwasher detergent	❒ Fabric softener	❒ Surface cleaner
❒ Bleach	❒ Toilet bowl cleaner	❒ Window cleaner
❒ Pesticides	❒ Fertilizers	❒ Potting soil

Please list pharmaceutical, environmental, pollen, food or supplement allergies, and describe your reaction to them

Vision history and corrective lenses E P T X L B Nc Y

❒ Yes ❒ No 20/20 vision	Visual acuity e.g., 20/40 (if known):
❒ Yes ❒ No Nearsighted (impaired distance vision)	❒ Yes ❒ No Farsighted (can't see up close)
❒ Yes ❒ No Glaucoma or other eye diseases	❒ Yes ❒ No Cataracts
❒ Yes ❒ No Astigmatism	❒ Yes ❒ No Do you use corrective lenses?
❒ Yes ❒ No Do you wear contacts?	❒ Yes ❒ No Surgery to correct vision
Year began using glasses/contacts:	❒ Yes ❒ No Experience eye strain from reading
❒ Yes ❒ No Hard to see at night	Other:

Toxicity/chemical exposure survey

(Yes) 10 9 8 7 6 5 4 3 2 1 (No) Pesticides	(Yes) 10 9 8 7 6 5 4 3 2 1 (No) Mold
(Yes) 10 9 8 7 6 5 4 3 2 1 (No) Pollution	(Yes) 10 9 8 7 6 5 4 3 2 1 (No) Paint
(Yes) 10 9 8 7 6 5 4 3 2 1 (No) Fumes	(Yes) 10 9 8 7 6 5 4 3 2 1 (No) Solvents
(Yes) 10 9 8 7 6 5 4 3 2 1 (No) Cleaning products	(Yes) 10 9 8 7 6 5 4 3 2 1 (No) Chemicals
(Yes) 10 9 8 7 6 5 4 3 2 1 (No) Radiation	(Yes) 10 9 8 7 6 5 4 3 2 1 (No) Chemotherapy

(Yes) 10 9 8 7 6 5 4 3 2 1 (No) Asbestos	(Yes) 10 9 8 7 6 5 4 3 2 1 (No) Exhaust fumes
(Yes) 10 9 8 7 6 5 4 3 2 1 (No) Mercury fillings	(Yes) 10 9 8 7 6 5 4 3 2 1 (No) Lead
(Yes) 10 9 8 7 6 5 4 3 2 1 (No) Welding	(Yes) 10 9 8 7 6 5 4 3 2 1 (No) Dust
(Yes) 10 9 8 7 6 5 4 3 2 1 (No) Pest control service	(Yes) 10 9 8 7 6 5 4 3 2 1 (No) Flea fumigation kits

41. Please use this space to express anything else you feel would be helpful for us to know about you, your life or health: