Client Intake Form (Revised 2/10/25)

Thank you for taking the time to fill out this form and provide us with details of your health, goals and medical history.

Disclaimer: Testing and consultations are not intended to diagnose, treat, cure, or prevent any disease. They are not intended to take the place of medical advice and are for educational purposes only.

Personal Information

Client Information

Legal first name

Last name

Preferred first name

Street

Unit

City

State/Province

Postal code

Home phone

Mobile phone

Email address

Date of birth

Gender

Pronouns

Relationship status

Occupation

Hours per week

Referred by

Age

Height (in inches)

Blood Type (if known)

Current Weight

Birth Weight (if known)

Birth Order (please list ages of biological siblings)

Sibling	Current Age

Family/Living Situation

Children

Health Concerns

What are your main health concerns? (Describe in detail, including the severity of the symptoms).

Here are some ideas of health concerns you may list: Have more energy, Sleep better, Have better digestion, Be able to eat more foods, Get rid of my allergies, Have a better immune system i.e. less colds and coughs, Not be dependent on laxatives or stool softeners, Be able to work out again, Have better muscle tone, Be in less pain, No longer use pain medication, No longer use allergy medication, No longer use sleep medication, To feel less sleepy in the afternoon, Lose weight, Increase my sex drive, Increase my metabolism to burn more fat, I want to reduce my stress, I want to improve my memory, I want to be able to be more focused, I want a better mood, I want to reduce my risk of developing a chronic disease, I want to slow down ageing, I want to detoxify my body, I want to improve my diet, I want to clear up my skin, Management of addiction/substance use disorder (can be anything-i.e. nicotine, caffeine, drugs, food)

When did you first experience these concerns?

How have you dealt with these concerns in the past?

Doctors, Self-Care, Prescriptions, Over-The-Counters, Nutritional or Herbal Supplements, Other

Have you experienced any success with these approaches?

Have any other family members had similar problems (please describe)?

What other health practitioners are you currently seeing? List name, specialty and phone # below.

How much time have you had to take off from work or school in the last year?

- ☐ 0-2 days
- ☐ 3-14 days
- ☐ More than 15 days

Please list the date and description of any surgical procedures you have had (including breast reduction or augmentation).

Surgical Procedure	Date	Description

Childhood History

Infancy

	Yes	No	Don't Know	Comments
Were you a premature baby?	☐	☐	☐	
Were you breast fed?	☐	☐	☐	
Were you bottle fed?	☐	☐	☐	

When pregnant with you did you mother do any of the following?

	Yes	No	Don't Know	Comments
Smoke tobacco	☐	☐	☐	
Use recreational drugs	☐	☐	☐	
Drink alcohol	☐	☐	☐	

	Yes	No	Don't Know	Comments
Use estrogen/birth control	☐	☐	☐	
Other prescription or non prescription medications	☐	☐	☐	

Please indicate if you have been vaccinated against any of the following diseases?

	Yes	No	Don't Know	Comment
Small Pox	☐	☐	☐	
Tetanus	☐	☐	☐	
Diptheria	☐	☐	☐	
Pertussis	☐	☐	☐	
Polio (oral)	☐	☐	☐	
Polio (injection)	☐	☐	☐	
Mumps	☐	☐	☐	
Measles	☐	☐	☐	
Rubella (German Measles	☐	☐	☐	
Typhoid	☐	☐	☐	
Cholera	☐	☐	☐	

Was your childhood diet high in any of the following?

	Yes	No	Don't Known	Comment
Sugar	☐	☐	☐	
Soda	☐	☐	☐	
Fast Food	☐	☐	☐	
Pre packaged foods	☐	☐	☐	
Artificial Sweeteners	☐	☐	☐	
Milk, cheese, or other dairy products	☐	☐	☐	
Meat, vegetables, and potato diet	☐	☐	☐	
Vegetarian diet	☐	☐	☐	
Diet high in white breads	☐	☐	☐	

As a child, were there foods that you had to avoid because they caused a reaction (e.g. milk-diarrhea)?

Please indicate which of the following problems/conditions you experienced as a child (birth to 12 years old) and the approximate age of onset

Feel free to add entries if not listed

	Yes	Age
Attention Deficit Disorder (ADD)	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Chicken pox	☐	☐
Colic	☐	☐
Congenital Problems	☐	☐
Ear infections	☐	☐
Fever Blisters	☐	☐
Frequent Colds or Flu	☐	☐
Frequent Headaches	☐	☐
Hyperactivity	☐	☐
Jaundice	☐	☐
Mumps	☐	☐
Pneumonia	☐	☐
Seasonal Allergies	☐	☐
Skin Disorders (e.g. Dermatitis)	☐	☐
Strep Infections	☐	☐
Tonsilitis	☐	☐
Upset Stomach/Digestive Issues	☐	☐
Whooping Cough	☐	☐
Measles	☐	☐

As a child did you experience any of the following?

	Yes	No	Comments
Have a high absence from school (explain why in comments)	☐	☐	
Experience chronic exposure to second hand smoke in your home?	☐	☐	
Experience abuse	☐	☐	
Have alcoholic parents	☐	☐	

Medication History

List any medications (i.e. prescriptions, over-the-counters, herbal/nutrition/dietary supplements) you are currently taking

Please disregard this section, if you have registered for the Integrative Pharmacist Consultation Service and be sure to complete and upload to the portal the Integrative Pharmacist Medication Management Form instead.

Medication Name	Dosage	Instructions	Purpose	Start/Stop/Increased/Decreased Date	Comments
					☐
					☐
					☐
					☐
					☐
					☐
					☐

How often have you taken antibiotics?

	Less than 10 days/year	More than 10 days/year	Comments
Infancy/Childhood	☐	☐	
Teen	☐	☐	
Adulthood	☐	☐	

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

	Less than 10 days/year	More than 10 days/year	Comments
Infancy/Childhood	☐	☐	
Teen	☐	☐	
Adulthood	☐	☐	

List any allergies

Indicate the agent and the reaction

Signs and Symptoms

To the best of your ability select the option or options that best describe each sign or symptom. If a sign or symptom does not apply select "other" and type N/A. If there are not any descriptions that apply to you select "other" and give your own description. These questions may not seem related to your main complaint but in natural medicine getting a holistic view of the patient allows treatment to be individualized and allows treatment to occur from the root. The goal is to bring the body back to balance and by doing so the body is able to handle whatever ailments it encounters.

Temperature

Check any of the following you experience

"Fever"= feeling hot, not according to a thermometer

- [ ] Cold Hands
- [ ] Hot Hands
- [ ] Fever
- [ ] Dislike for cold conditions
- [ ] Cold Feet
- [ ] Hot Feet
- [ ] Chills
- [ ] Alternating Fever and Chills
- [ ] Feel warm in the afternoon/evening
- [ ] Fever that worsens in the afternoon
- [ ] Feel warm all the time
- [ ] Other areas of cold
- [ ] Other areas of fever
- [ ] Other

If you checked other, please elaborate

Sweat

Check any of the following you experience

- [ ] Sweat Easily
- [ ] Sweat at Night
- [ ] Profuse Sweat
- [ ] Sweaty Hands and Feet
- [ ] Other

If you checked other, please elaborate

Does your sweat have an odor? ◯ Yes ◯ No

Headache

If you are experiencing headaches, please check any that you experience

- [ ] Has been persistently occurring or reoccurring for more than 3 months
- [ ] Dull
- [ ] Distending and/or throbbing
- [ ] Piercing
- [ ] Worse with wind or cold weather
- [ ] Worse with fatigue
- [ ] Feels heavy, like a damp towel wrapped around your head
- [ ] Frontal Headache
- [ ] Temple Region
- [ ] Back of Head
- [ ] Worse during the day
- [ ] Worse During the Evening
- [ ] With sinus problems
- [ ] Other

If you checked other, please elaborate

How would you rate the severity of your headaches?
Refer to the pain chart on the "Pain Scale" handout for a description of each rating (link found below)

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

1 = No Pain, 10 = Debilitating Pain

Pain Scale Handout

Dizziness

Check any of the following you experience

- ☐ With loss of balance
- ☐ With heavy feeling in head
- ☐ Worse with fatigue
- ☐ Sudden onset
- ☐ Gradual onset
- ☐ Other

If you checked other, please elaborate

Chest, Abdomen, Breathing

Check any of the following you experience

- ☐ Shortness of Breath
- ☐ Difficulty Breathing
- ☐ Asthma/Wheezing
- ☐ Difficulty breathing due to sinus problems
- ☐ Chest pain or discomfort
- ☐ Palpitations
- ☐ Chest Tightness
- ☐ Yellow Phlegm
- ☐ Green Phlegm
- ☐ White Phlegm
- ☐ Clear Phlegm
- ☐ Cough

- [ ] Costal Pain (Rib Pain)
- [ ] Upper right abdominal pain
- [ ] Upper left abdominal pain
- [ ] Lower abdominal pain
- [ ] Upper abdominal pain
- [ ] Other

If you checked other, please elaborate

Eyes

Check any of the following you experience

- [ ] Eye pain
- [ ] Swelling
- [ ] Redness
- [ ] Blurred Vision
- [ ] Floaters
- [ ] Dry Eyes
- [ ] Yellow in the whites of eyes
- [ ] Abnormal Eye movement
- [ ] Poor night vision
- [ ] Other

If you checked other, please elaborate

Ears

Check any of the following you experience

- [ ] Sudden onset of ringing in the ears
- [ ] Chronic ringing in the ears
- [ ] Sudden onset of deafness
- [ ] Gradual onset of deafness
- [ ] High pitched ringing
- [ ] Low pitched ringing
- [ ] Ear aches

- [ ] Popping
- [ ] Other

If you checked other, please elaborate

Urination

Check any of the following you experience

- [ ] Incontinence (unable to control when urination occurs)
- [ ] Retention of urine (difficulty/unable to release urine)
- [ ] Incomplete urination (feeling like there is still more to be released but unable to do so)
- [ ] Pain with urination
- [ ] Light yellow colored urine
- [ ] Dark yellow colored urine
- [ ] Excessive amounts of urine at a time
- [ ] Small amounts of urine at a time
- [ ] Blood in urine
- [ ] Clear colored urine
- [ ] My urine output is less than my fluid intake
- [ ] My urine output is more than my fluid intake
- [ ] My urine output is equal to my fluid intake
- [ ] Other

If you checked other, please elaborate

Do you wake up to urinate? ○ Yes ○ No

How often do you urinate throughout the day

Taste

Do you ever have a particular taste in your mouth? Check all that apply.

- [ ] Bitter
- [ ] Sweet
- [ ] Metallic
- [ ] Sour
- [ ] Salty
- [ ] Lack of taste
- [ ] Strong/Sharp Taste
- [ ] Other

If you experience other tastes, please elaborate

Thirst

Check any of the following you experience

- [ ] Lack of thirst
- [ ] Strong desire to drink liquids
- [ ] Dry mouth with desire to sip liquids
- [ ] Thirst without desire to drink
- [ ] Desire for warm liquids
- [ ] Desire for cold liquids
- [ ] Other

If other, please elaborate

Appetite

Check any of the following you experience

- [ ] Lack of appetite
- [ ] Appetite that can't be satisfied
- [ ] Fullness, bloating, and/or distention after eating
- [ ] Preference for warm or hot foods

- [ ] Preference for cold or cool foods
- [ ] Other

If other, please elaborate

Nutritional Status

Are there any foods that you avoid because of the way they make you feel? If yes, please name the food and what you experience after eating.

Do you have symptoms immediately after eating like bloating, gas, sneezing or hives? If so, please explain:

Do you experience bad breath ◯ Yes ◯ No

Are you aware of any delayed symptoms after eating certain foods such as fatigue, muscle aches, sinus congestion, etc? If so, please explain:

Are there foods that you crave? If so please explain:

Describe your diet at the onset of your health concerns:

Do you have any known food allergies or sensitivities?

Which of the following foods do you consume regularly?

- ☐ soda
- ☐ diet soda
- ☐ refined sugar
- ☐ alcohol
- ☐ fast food
- ☐ gluten (wheat, rye, barley)
- ☐ dairy (milk, cheese, yogurt)
- ☐ coffee

Are you currently on a special diet?

- ☐ Autoimmune paleo (AIP)
- ☐ SCD/GAPS
- ☐ dairy restricted or dairy-free
- ☐ vegetarian
- ☐ vegan
- ☐ other (please describe below)
- ☐ paleo
- ☐ blood type
- ☐ raw
- ☐ refined sugar-free
- ☐ gluten-free

If you checked "Other" from the question above, please describe in more detail here.

What percentage of your meals are home-cooked? Please describe.

Is there anything else we should know about your current diet, history or relationship to food?

Intestinal Status

Bowel Movement Frequency

- [ ] 1–3 times per day
- [ ] more than 3 times per day
- [ ] not regularly every day

Bowel Movement Consistency

- [ ] soft & well formed
- [ ] often float
- [ ] difficult to pass
- [ ] chronic diarrhea
- [ ] thin, long or narrow
- [ ] small, round, and hard
- [ ] loose but not watery
- [ ] alternating between hard and loose
- [ ] infrequent but not dry
- [ ] urgent diarrhea that feels hot
- [ ] diarrhea after eating a meal
- [ ] early morning diarrhea (around 5am or 6am)
- [ ] gastrointestinal discomfort improves after bowel movement
- [ ] gastrointestinal discomfort worsens after bowel movement

What stool type best describes your stool?

Please use the "Bristol Stool Chart" handout to help you with your answer (link found below)

Bristol Stool Chart Handout

Bowel Movement Color

- [ ] medium brown
- [ ] very dark or black
- [ ] greenish
- [ ] blood is visible
- [ ] variable
- [ ] yellow, light brown

- ☐ chalky colored
- ☐ greasy, shiny

Do you experience intestinal gas? If so, please explain if it is excessive, occasional, odorous, etc:

Have you ever had food poisoning? If yes, please describe in detail, including 1) Where were you 2) What did you treat it with and 3) If you feel like you fully recovered from it:

Medical Status

Gastrointestinal

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Chosen Treatment(s)	Dates	Past	Now
Irritable Bowel Syndrome				☐	☐
Crohn's				☐	☐
Ulcertative Colitis				☐	☐
Gastritis or Peptic Ulcer Disease				☐	☐
GERD (reflux or heartburn)				☐	☐
Celiac Disease				☐	☐
SIBO				☐	☐
Gut infections				☐	☐
Dysbiosis				☐	☐
Leaky gut				☐	☐
Food allergies, intolerances or reactions				☐	☐
Gallstones				☐	☐
Known absorption or assimilation issues				☐	☐
Other				☐	☐

Cardiovascular

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Chosen Treatment(s)	Dates	Past	Now
Heart attack				☐	☐
Heart Disease				☐	☐

Condition	Symptoms	Chosen Treatment(s)	Dates	Past	Now
Stroke				☐	☐
Elevated cholesterol				☐	☐
Arrhythmia (irregular heartbeat				☐	☐
Hypertension (high blood pressure)				☐	☐
Rheumatic Fever				☐	☐
Mitral Valve Prolapse				☐	☐
Other				☐	☐

Hormones/Metabolic

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Chosen Treatment(s)	Dates	Past	Now
Type 1 Diabetes				☐	☐
Type 2 Diabetes				☐	☐
Metabolic Syndrome				☐	☐
Insulin Resistance or Pre-Diabetes				☐	☐
Hypothyroidism (low thyroid)				☐	☐
Hyperthyroidism (overactive thyroid)				☐	☐
Hashimoto’s (autoimmune hypothyroid)				☐	☐
Grave’s Disease (autoimmune hyperthyroid)				☐	☐
Endocrine problems				☐	☐
Polycystic Ovarian Syndrome (PCOS)				☐	☐
Infertility				☐	☐
Weight gain				☐	☐

Condition	Symptoms	Chosen Treatment(s)	Dates	Past	Now
Weight loss				☐	☐
Frequent weight fluctuations				☐	☐
Eating disorder				☐	☐
Menopause difficulties				☐	☐
Hair loss				☐	☐
Other				☐	☐

Cancer

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Chosen Treatment(s)	Dates	Past	Now
Lung Cancer				☐	☐
Breast Cancer				☐	☐
Colon Cancer				☐	☐
Ovarian Cancer				☐	☐
Prostate Cancer				☐	☐
Skin Cancer (Melanoma)				☐	☐
Skin Cancer (Squamous, Basal)				☐	☐
Other				☐	☐

Genital & Urinary Systems

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Chosen Treatment(s)	Dates	Past	Now
Kidney Stones				☐	☐
Gout				☐	☐

Condition	Symptoms	Chosen Treatment(s)	Dates	Past	Now
Erectile Dysfunction or Sexual Dysfunction				☐	☐
Interstitial Cystitis				☐	☐
Frequent urinary tract infections				☐	☐
Frequent Yeast Infections				☐	☐
Other				☐	☐

Musculoskeletal/Pain

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Chosen Treatment(s)	Dates	Past	Now
Osteoarthritis				☐	☐
Fibromyalgia				☐	☐
Chronic Pain				☐	☐
Sore muscles or joints, undiagnosed				☐	☐
Other				☐	☐

Immune/Inflammatory

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Chosen Treatment(s)	Dates	Past	Now
Chronic Fatigue Syndrome				☐	☐
Rheumatoid Arthritis				☐	☐
Lupus SLE				☐	☐
Raynaud's				☐	☐
Psoriasis				☐	☐

Condition	Symptoms	Chosen Treatment(s)	Dates	Past	Now
Mixed Connetive Tissue Disease (MCTD)				☐	☐
Poor immune function (frequent infections)				☐	☐
Food allergies				☐	☐
Environmental allergies				☐	☐
Multiple chemical sensitivities				☐	☐
Latex allergy				☐	☐
Hepatitis				☐	☐
Lyme (and co-infections)				☐	☐
Chronic Infections (Epstein-Barr, Cytomegalo-virus, Herpes, etc.)				☐	☐
Other				☐	☐

Respiratory Conditions

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Chosen Treatment(s)	Dates	Past	Now
Asthma				☐	☐
Chronic Sinusitis				☐	☐
Bronchitis				☐	☐
Emphysema				☐	☐
Pneumonia				☐	☐
Sleep Apnea				☐	☐
Frequent or recurrent Colds/Flus				☐	☐
Other				☐	☐

Skin Conditions

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Chosen Treatment(s)	Dates	Past	Now
Eczema				☐	☐
Psoriasis				☐	☐
Dermatitis				☐	☐
Hives				☐	☐
Rash, undiagnosed				☐	☐
Acne				☐	☐
Skin Cancer (Melanoma)				☐	☐
Skin Cancer (Squamous, Basal)				☐	☐
Other				☐	☐

Neurologic/Mood

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Chosen Treatment(s)	Dates	Past	Now
Depression				☐	☐
Anxiety				☐	☐
Bipolar Disorder				☐	☐
Schizophrenia				☐	☐
Headaches				☐	☐
Migraines				☐	☐
ADD/ADHD				☐	☐
Autism				☐	☐
Mild Cognitive Impairment				☐	☐
Memory problems				☐	☐
Memory problems				☐	☐

Condition	Symptoms	Chosen Treatment(s)	Dates	Past	Now
Multiple Sclerosis				☐	☐
ALS				☐	☐
Seizures				☐	☐
Alzheimer's				☐	☐
Other				☐	☐

Miscellaneous

Please list any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates.

Condition	Symptoms	Chosen Treatment(s)	Dates	Past	Now
Anemia				☐	☐
Chicken Pox				☐	☐
German Measles				☐	☐
Measles				☐	☐
Mononucleosis				☐	☐
Mumps				☐	☐
Sleep Apnea				☐	☐
Whooping Cough				☐	☐
Tuberculosis				☐	☐
Known genetic variants (SNPs, polymorphisms, etc)				☐	☐
Other				☐	☐

Please check frequency of the following:

	Yes	No	Sometimes
Short term memory impairment	☐	☐	☐
Shortened focus of attention and ability to concentrate	☐	☐	☐
Coordination and balance problems	☐	☐	☐

	Yes	No	Sometimes
Problems with lack of inhibition	☐	☐	☐
Poor organization abilities	☐	☐	☐
Problems with time management (late or forget appts)	☐	☐	☐
Mood instability	☐	☐	☐
Difficulty understanding speech and word finding	☐	☐	☐
Brain fog, brain fatigue	☐	☐	☐
Lower effectiveness at work, home or school	☐	☐	☐
Judgment problems like leaving the stove on, etc	☐	☐	☐

Pain

Describe your pain

Use "Pain Scale" handout to assist with your answers (link below)
You may use these words to help you describe the nature of your pain: Better with application of heat, Improved with pressure, Aggravated by pressure, aggravated by damp weather, associated with bloating/fullness/distention, sharp or stabbing, moves from location to location, dull pain worse with fatigue

Location	Nature of Pain	How long?	What makes pain better	What makes pain worse?	Activities inhibited by pain	Pain Rating

Pain Scale Handout

Health Hazards/Environment

Have you been exposed to any chemicals or toxic metals (lead, mercury, arsenic, aluminum)?

Do odors affect you?

Are you or have you been exposed to 2nd hand smoke regularly? If yes, explain.

Have you lived or traveled outside of the United States? If so, when and where?

Oral Health History

Check yes or no to the following

	Yes	No	Comments
Problem with sore gums (gingivitis)	☐	☐	☐
Having TMJ (temporal mandibular joint) problems?	☐	☐	☐
Previously or currently wear braces	☐	☐	☐
Problems chewing	☐	☐	☐
Floss Regularly	☐	☐	☐

List your approximate age and type of dental work done from childhood until present

Age	Type of Dental Work	Describe any health problems following dental work

In the past 12 months has a dentist or hygienist talked to you about your oral health, blood sugar or other health concerns? (Explain.)

What is your current oral and dental regimen? (Please note whether this regimen is once or twice daily or occasionally and what kind of toothpaste you use.)

Do you have any mercury amalgams? If yes, how many and when did you receive them? If no, were they removed, when, and how?

Do you have any concerns about your oral or dental health?

Is there anything else about your current oral or dental health or health history that you'd like us to know?

Lifestyle History

Do you exercise regularly? ◯ Yes ◯ No

What does your exercise regimen consist of?
If not listed, feel free to add entries

Type of Exercise	Number of times/week	Length of Session
Jogging/Walking		
Aerobics		
Strength Training		
Pilates		
Yoga		
Tai Qi		
Sports (e.g. tennis, basketball, water sports, etc)		

Have you had periods of eating foods that are not beneficial to your health/wellbeing, binge eating or dieting? List any known diet that you have been on for a significant amount of time

Tobacco History

Have you ever used tobacco ◯ Yes ◯ No

Alcohol Intake

Have you ever used alcohol? ◯ Yes ◯ No

Do you notice a tolerance to alcohol (holding more than other)? ◯ Yes ◯ No

Have you ever had a problem with alcohol? ◯ Yes ◯ No

Other Substances

Do you currently or have you previously abused any drugs or medication (i.e. recreational, prescription, over-the-counter) ◯ Yes ◯ No

Do you currently or have you previously abused caffeine? ◯ Yes ◯ No

Sleep History

Are you satisfied with your sleep?

Do you stay awake all day without dozing?

Are you asleep (or trying to sleep) between 2:00 a.m. and 4:00 a.m.?

How long does it take you to fall asleep?

How many hours of sleep do you receive?

What time do you go to bed?

What time do you wake up?

Do you feel rested when you wake up? ◯ Yes ◯ No

Do you dream? ◯ Yes ◯ No

Do you nap during the day? ◯ Yes ◯ No

For Those Assigned Female at Birth

Obstetric History

Check if yes, and provide the number of occurences

	Yes	Number of Occurences
Pregnancies	☐	
Misscarriages	☐	
Post Partum Depression	☐	
Caesarean	☐	
Abortion	☐	
Toxemia	☐	
Vaginal Deliveries	☐	
Living children	☐	
Gestational diabetes	☐	

Gynecological History

What was the age of your first menses?

What is the length of your menstrual cycle?

How often do you have your menstrual cycle?

What was the date of your last menstrual period?

Check all that apply to your menstrual cycle

- ☐ Early
- ☐ Late
- ☐ Irregular
- ☐ Heavy (Filling a menstrual cup more than 2 times/cycle, having to change tampon or pad after less than 2 hours for several consecutive hours)
- ☐ Bright Red
- ☐ Pale Red
- ☐ Dark Red
- ☐ Brown
- ☐ Clots

Does the amount of blood shed during your menstrual cycle impact your quality of life and explain how? (e.g. Bleeding through clothes, causes stress or anxiety, having to wear a pad or two as back up)

Which of the following symptoms do you experience before your period?

- ☐ Breast Distention
- ☐ Breast Tenderness
- ☐ Food Cravings
- ☐ Irritability
- ☐ Water Retention
- ☐ Headaches
- ☐ Migraines
- ☐ Anxiety
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Alternating Diarrhea
- ☐ Depression

- [ ] Cramps
- [ ] Other

If you checked other, please elaborate

Do you experience cramping? ◯ Yes ◯ No

If you experience cramping, how would you describe the nature of your cramping?
Here are some words to help: Stabbing, aching, better with pressure, worse with pressure, better with heat, better with cold, better with exercise, worse with exercise

Do you currently use hormonal contraception?
Add an entry if it is not listed

	Yes	Duration of use till date?
Birth Control Pills	☐	
Patch	☐	
Nuva Ring	☐	
IUD (e.g. Mirena, Kyleena, Liletta, and Skyla)	☐	

Do you currently use non-hormonal contraception?
Add an entry if it is not listed

	Yes	Duration of use till date?
	☐	
Condom	☐	
Diaphragm	☐	
Copper IUD (e.g. Paragard)	☐	
Partner Vesectemy	☐	

Have you been on hormonal contraception in the past? If so, what king, when, and how long?

Do you experience vaginal discharge ◯ Yes ◯ No

Have you experienced any yeast infections or urinary tract infections? Are they regular?

At what age did you stop experiencing menstruation?

When was your last PAP test and was it normal or abnormal?

When was your last mammogram?

When was your last breast biopsy?

When was your last bone density scan and was it high, low, or within normal range?

Other Symptoms

Check any you are currently experiencing or have experienced in the past and indicate

	Currently Experiencing	Experienced in the Past	Comments
Fibrocystic Breasts	☐	☐	

	Currently Experiencing	Experienced in the Past	Comments
Lumps in breast	☐	☐	
Fibroid tumors/breast	☐	☐	
Fibroid tumors/uterus	☐	☐	
Endometriosis	☐	☐	
Non period bleeding	☐	☐	
Vaginal irritation	☐	☐	
Vaginal itching	☐	☐	
Vaginal Dryness	☐	☐	
Vaginal Pain	☐	☐	
Partial/total hysterectomy	☐	☐	
Hot flashes	☐	☐	
Mood swings	☐	☐	
Concentration or memory problems	☐	☐	
Breast Cancer	☐	☐	
Ovarian cysts	☐	☐	
Infertility	☐	☐	
Decreased libido	☐	☐	
Joint pains	☐	☐	
Headaches	☐	☐	
Weight Gain	☐	☐	
Loss of bladder control	☐	☐	
Palpitations	☐	☐	

For Those Assigned Male at Birth

Have you had a PSA done? If yes what was your PSA level: 0-2, 2-4, 4-10, >10

Check any you are currently experiencing or have experienced in the past and indicate

	Currently Experiencing	Experienced in the Past	Comments
Swollen Testes	☐	☐	
Impotence	☐	☐	
Testicular/Genital Pain	☐	☐	
Premature Ejaculation	☐	☐	
Feeling of coldness or numbness in external genitalia	☐	☐	
Prostate enlargement	☐	☐	
Change in Libido	☐	☐	
Diminished or poor Libido	☐	☐	
Infertility	☐	☐	
Lumps in testicals	☐	☐	
Sores on penis	☐	☐	
Hernia	☐	☐	
Prostate Cancer	☐	☐	
Low sperm count	☐	☐	
Difficulty obtaining erection	☐	☐	
Difficulty maintaining erection	☐	☐	
Urination at night (indicate how many times per night in comments)	☐	☐	
Urgency/ Hesitancy/Change in urinary stream	☐	☐	
Loss of bladder control	☐	☐	

Check any of the following you experience

☐ Swollen Testes

- [ ] Impotence
- [ ] Testicular Pain
- [ ] Premature Ejaculation
- [ ] Feeling of coldness or numbness in external genitalia
- [ ] Other

If other symptoms, please elaborate

Are you taking any hormone replacement therapy or hormonal supportive herbs? If so, please list again here.

Sexual History

Do you have any concerns or issues with your sexual functioning that you'd like to share with us (pain with intercourse, dryness, libido issues, erectile dysfunction)?

How many sexual partners have you had in the past year?

Mental Health Status

How are your moods in general? Do any of the following feelings occur more frequently: worry, fear, anxiety, depression, anger, frustration, sadness, joy?

Is there an emotion that is more difficult for you to feel? If so, describe the emotion.

How do you handle stress?

Do you feel that stress is presently reducing the quality of your life? If yes, what do you think might be the source of your stress?

How would you describe your outlook on life lately?

At what point in your life did you feel best and why?

Have you or your family recently experienced any major life changes? If so, please comment

Have you or your family recently experienced any major losses? If so, please comment

Have you ever sought help through counseling? If yes, what type (e.g. therapist, spiritual advisor, etc.) and did it help?

Please check yes or no

	Yes	No
Have you ever been involved in an abusive relationship in your life?	☐	
Have you ever been abused, a victim of a crime, or experienced significant trauma?	☐	
Did you feel safe growing up?	☐	
Was alcoholism or substance abuse present in your childhood home?	☐	
Is alcoholism or substance abuse present in your relationship now?	☐	

How well have things been going for you?

	Very Well	Fine	Poorly	Very Poorly	Does Not Apply
At school	☐	☐	☐	☐	☐
In your job	☐	☐	☐	☐	☐
In your social life	☐	☐	☐	☐	☐
With close friends	☐	☐	☐	☐	☐
With sex	☐	☐	☐	☐	☐

	Very Well	Fine	Poorly	Very Poorly	Does Not Apply
With your attitude	☐	☐	☐	☐	☐
With your partner/spouse	☐	☐	☐	☐	☐
With your children	☐	☐	☐	☐	☐
With your parents	☐	☐	☐	☐	☐

Which of the following provide you emotional support?
If other, add an entry

Spouse/Partner	☐
Family	☐
Friends	☐
Religion/Spirituality	☐
Pets	☐

How important is religion/spirituality for you?

- ☐ Not at all important
- ☐ Somewhat important
- ☐ Extremely important

Do you practice meditation or relaxation techniques? If so, what types and how often?

What are your hobbies and leisure activities?

Energy

On a scale of 1-10, one being the worst and 10 being the best, describe your usual level of energy.

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

1 = Worst, 10 = Best

What time of day do you have the most energy?

What time of day do you have the least energy?

Health Goals

Do you think family and friends will be supportive of you making health and lifestyle changes to improve your quality of life? Explain, if no

Who in you family or on your health care team will be most supportive to you?

What are your health goals and aspirations?

Please describe any other information you think would be useful in helping to address your health concern(s):

Though it may seem odd, please consider why you might want to achieve that for yourself

Disclaimer: Testing and consultations are not intended to diagnose, treat, cure, or prevent any disease. They are not intended to take the place of medical advice and are for educational purposes only.