Reset

Rooted Health & Wellness LLC

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General Information

Name_____ Age_____ Today's Date _____
Date of Birth_____ Gender_____

Race/Ethnicity: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Mediterranean
☐ Native American ☐ Northern European ☐ Other _____

Home Address _____City _____ State____ Zip_____
Phone_____ Email_____
Emergency Contact Person (number and relationship)

_____
Allergies_____ Height _____ Weight _____
Primary Care Physician and contact number _____

Referred to the practice by:
☐ Clinic website ☐ IFM ☐ Practitioner ☐ Family/Friend ☐ Social Media
☐ Other_____

Major health concerns for today's visit:

_____
_____

What have you done so far about your health concerns (ie medications, supplements, diet):

_____
_____
_____

Past Medical History (check if appropriate)

Constitutional	Yes	No
Fevers	☐	☐
Chills	☐	☐
Night sweats	☐	☐
Fatigue	☐	☐
Insomnia	☐	☐
Weight gain	☐	☐
Weight loss	☐	☐
Other:	☐	☐
Other:	☐	☐
Neurological/Psychological		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
Memory loss	☐	☐
Dementia	☐	☐
Alzheimer's Disease	☐	☐
Stroke	☐	☐
Neuropathy	☐	☐
Poor balance	☐	☐
Frequent falls	☐	☐
Parkinson's Disease	☐	☐
Multiple Sclerosis (MS)	☐	☐
Amyotropic Lateral Sclerosis (ALS)	☐	☐
Attention Deficit Disorder/ Hyperactive Disorder (ADD/ADHD)	☐	☐
Depression	☐	☐
Anxiety	☐	☐
Bipolar Disorder	☐	☐
Schizophrenia	☐	☐
History of abuse	☐	☐
Other:	☐	☐
Other:	☐	☐
Ear/Nose/Throat		
Hearing loss	☐	☐
Vision loss	☐	☐
Cataracts	☐	☐
Macular Degeneration	☐	☐
Glaucoma	☐	☐
Dry eyes	☐	☐
Chronic Sinus Infections	☐	☐
Chronic Post Nasal Drainage	☐	☐
Trouble swallowing	☐	☐
Hoarse voice	☐	☐
Dry mouth	☐	☐

Ear/Nose/Throat (cont)	Yes	No
Gum Disease	☐	☐
Other:	☐	☐
Other:	☐	☐
Cardiovascular		
High blood pressure	☐	☐
Low blood pressure	☐	☐
High cholesterol	☐	☐
Heart attack	☐	☐
Heart failure	☐	☐
Arrhythmia	☐	☐
Mitral Valve Prolapse	☐	☐
Murmur	☐	☐
Rheumatic fever	☐	☐
Aneurysm	☐	☐
Other:	☐	☐
Other:	☐	☐
Pulmonary/Respiratory		
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Pneumonia	☐	☐
Tuberculosis	☐	☐
Chronic cough	☐	☐
Sleep apnea	☐	☐
Other:	☐	☐
Other:	☐	☐
Gastrointestinal (GI)		
Irritable Bowel Syndrome	☐	☐
Crohn's Disease	☐	☐
Ulcerative Colitis	☐	☐
Other Inflammatory Bowel Disease:	☐	☐
Gastritis	☐	☐
Peptic Ulcer Disease	☐	☐
GERD (reflux)	☐	☐
Celiac Disease	☐	☐
Fatty Liver Disease	☐	☐
Hepatitis	☐	☐
Liver Cirrhosis	☐	☐
Gall Bladder Stones	☐	☐
Hernia	☐	☐
Enlarged Spleen	☐	☐
Diverticulosis	☐	☐
Diverticulitis	☐	☐
Constipation	☐	☐

Diarrhea	☐	☐
Hemorrhoids	☐	☐
GI Bleed	☐	☐
Bulimia	☐	☐
Anorexia	☐	☐
Binge eating disorder	☐	☐
Other:	☐	☐
Other:	☐	☐
Genitourinary (GU)		
Kidney Stones	☐	☐
Kidney Disease	☐	☐
Lupus Nephritis	☐	☐
Dialysis	☐	☐
Bladder Stones	☐	☐
Frequent UTI	☐	☐
Painful Bladder Syndrome	☐	☐
Other:	☐	☐
Other:	☐	☐
Musculoskeletal		
Gout	☐	☐
Osteoarthritis	☐	☐
Bone loss	☐	☐
Fractures	☐	☐
Back pain	☐	☐
Neck pain	☐	☐
Fibromyalgia	☐	☐
Chronic Fatigue Syndrome	☐	☐
Rheumatoid Arthritis	☐	☐
Other:	☐	☐
Other:	☐	☐
Integumentary/Skin		
Eczema	☐	☐
Acne	☐	☐
Psoriasis	☐	☐
Systematic Lupus Erythematosus (SLE)	☐	☐
Psoriatic Arthritis	☐	☐
Dry skin	☐	☐
Poor/brittle nails	☐	☐
Fungal nails	☐	☐
Basal Cell Carcinoma	☐	☐
Other:	☐	☐
Other:	☐	☐
Metabolic/Endocrine		
Diabetes Type 1	☐	☐
Diabetes Type 2	☐	☐

Low blood sugars	☐	☐
Metabolic Syndrome	☐	☐
Obesity	☐	☐
Hypothyroidism(underactive thyroid)	☐	☐
Hyperthyroidism(overactive thyroid)	☐	☐
Pituitary Dysfunction	☐	☐
Pituitary Tumors	☐	☐
Addison's Disease	☐	☐
Graves' Disease	☐	☐
Other:	☐	☐
Hematologic/Immune/Blood		
Spontaneous bleeding	☐	☐
Bruise easily	☐	☐
Blood clots	☐	☐
Platelet dysfunction	☐	☐
Idiopathic/Immune Thrombocytopenia (ITP)	☐	☐
Anemia	☐	☐
Iron deficiency	☐	☐
Vitamin B12 deficiency	☐	☐
Frequent infections	☐	☐
HIV/AIDS	☐	☐
Allergic disorders(food/environmental)	☐	☐
Multiple Chemicals Sensitivities	☐	☐
Other Autoimmune:	☐	☐
Other:	☐	☐
Dental History		
Frequent cavities	☐	☐
Root Canal	☐	☐
Crowns	☐	☐
Dentures	☐	☐
Implants	☐	☐
Mercury/Silver fillings	☐	☐
Gold fillings	☐	☐
Gingivitis	☐	☐
Receding gums	☐	☐
Trouble chewing/jaw pain	☐	☐
Brush teeth at least twice a day	☐	☐
Floss teeth daily	☐	☐
Cancer		
Brain	☐	☐
Head/neck	☐	☐
Breast	☐	☐
Lung	☐	☐
Liver	☐	☐

Cancer (cont)		
Pancreatic	☐	☐
Colon	☐	☐
Bladder	☐	☐
Ovarian/Endometrial/Cervical	☐	☐
Prostate	☐	☐
Bone/Muscular	☐	☐
Melanoma	☐	☐
Leukemia	☐	☐
Lymphoma	☐	☐
Multiple Myeloma	☐	☐
Other:	☐	☐

Medical & Surgical History:

Surgeries	Date	Comments
Appendectomy		
Gallbladder		
Hernia		
Hysterectomy		
Tonsillectomy		
Joint Replacement		
Heart Surgery		
Dental		
Other:		
Injuries		
Broken Bone(s)		
Back Injury		
Head Injury		
Other:		
Diagnostic Studies		
Chest X ray		
CT scan		
MRI		
Bone Density		
Colonoscopy		
Upper Endoscopy		
Upper GI series		
Barium Enema		
EKG		
Echocardiogram		

Cardiac stress test		
Other:		
Vaccinations (if known)		
Hospitalizations:		
1.		
2.		
3.		
4.		

Patient Birth History/Childhood Illness

You were born: ☐ Term ☐ Premature ☐ Vaginal birth ☐ Caesarian ☐ Unsure Were there any pregnancy or birth complications ☐ Yes ☐ No If yes, explain: _____
_____

☐ Breast fed/How long_____ ☐ Bottle fed /Type of formula_____ ☐ Unsure

Age of introduction of Solid foods: _____ Dairy:_____ Wheat:_____ As a child, were there any foods avoided due to intolerance or symptoms? Please explain: _____
_____
Diet as a child/favorite foods: _____
Childhood illness: _____

Patient Enviromental/Detoxification History

Do any of these significantly affect you?

☐ Cigarette Smoke ☐ Perfumes/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 areas
☐ Carpets/rugs ☐ Old paint ☐ Paints ☐ Stagnant/stuffy air ☐ Smoking ☐ Pesticides ☐ Herbicides
☐ Harsh Chemicals (solvents, gas, acids, etc) ☐ Cleaning chemicals ☐ Heavy metals (lead, mercury)

Have you had significant exposure to any harmful chemicals? ☐ Yes ☐ No If yes please explain (Name, length of exposure, date)_____

How often do you travel via airplane? _____Do you have wifi? ☐ Yes ☐ No
How many hours a day do you spend on: Computer/Tablet_____ Smart cell phone_____ TV_____
Do you have any pets or farm animals? ☐ Yes ☐ No Do they live ☐ Inside ☐ Outside ☐ Both

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 Insomnia? ☐ Yes ☐ No Do you snore? ☐ Yes ☐ No
Do you grind your teeth? ☐ Yes ☐ No Do you feel rested upon awakening? ☐ Yes ☐ No
Do you use sleeping aides? ☐ Yes ☐ No If yes, explain_____
Do you watch TV in the evening? ☐ Yes ☐ No
Are you on your smart phone/tablet/computer within 2 hours before bed? ☐ Yes ☐ No

Exercise

Exercise ☐ Yes ☐ No Times per week _____ Duration _____
Exercise activity type (cardio/lifting/stretching/sports/leisure)_____
Yoga or meditation ☐ Yes ☐ No Times per week _____
Do you feel motivated to exercise? ☐ Yes ☐ No ☐ Sometimes
Limitations to exercise: _____

Nutrition/Gastrointestinal

Do you follow any of the following special diets or nutrition programs? (Check all that apply)
☐ Vegetarian ☐ Vegan ☐ Allergy ☐ Elimination ☐ Low Fat ☐ Low Carb ☐ High Protein ☐ Paleo
☐ Ketogenic ☐ Intermittent Fasting ☐ Blood Type ☐ Low Sodium ☐ Kosher ☐ Halal ☐ No Dairy
☐ No Wheat ☐ Gluten Free ☐ Other_____

Do you have sensitivities to certain foods? ☐ Yes ☐ No If yes, please list food and symptoms:_____
_____
Do you have food aversions? ☐ Yes ☐ No If yes, please 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 foods (wine, dried fruit,etc) ☐ Shellfish ☐ Fish
☐ Eggs ☐ Preservatives ☐ Food colors ☐ Other_____

Are there any foods that you crave or binge on? ☐ Yes ☐ No If yes, which foods? _____
_____
Favorite foods (list):_____
Do you eat 3 meals a day? ☐ Yes ☐ No Do you snack during the day? ☐ Yes ☐ No If yes, how many times per day? _____ Does skipping meals greatly affect you? ☐ Yes ☐ No Do you cook? ☐ Yes ☐ No
How many meals do you eat out per week? ☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ >5

Do you experience any of these symptoms? (Check all that apply)
☐ Bloating after meals ☐ Belching after/during meals ☐ Reflux with certain foods ☐ Nausea
☐ Vomiting ☐ Feel full quickly ☐ Constipation ☐ Diarrhea ☐ Undigested food in stool ☐ Floating stools
Do you move your bowels daily? ☐ Yes ☐ No If not how often ____ Do you pass gas daily? ☐ Yes ☐ No

Any foreign travel and where:_____
Camping and where:_____
History of severe diarrhea after travel and explain:_____

Factors of your current lifestyle and eating habits: (check all that apply)

☐ Fast eater ☐ Eat too much ☐ Late-night eating ☐ Dislike healthy foods ☐ Time constraints
☐ Travel frequently ☐ Eat more than 50% of meals away from home ☐ Healthy foods not readily available
☐ Poor snack choices ☐ Significant other/family members don't like healthy foods ☐ Significant other/ family members with special dietary needs ☐ Love to eat ☐ Eat because I have to ☐ Struggle with eating issues ☐ Negative relationship with food ☐ Emotional eater ☐ Eat under stress
☐ Eat less under stress ☐ Don't care to cook ☐ Confused about nutrition

Diet

Please list the common foods/drinks you eat in a typical week:

Breakfast:_____
Lunch:_____
Dinner:_____
Snacks:_____
Drinks:_____

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

Fruits (not juice) _____ Vegetables (not white potatoes/corn)_____ Nuts/Seeds _____
Legumes (beans, peas)_____ Red meat _____ Fish_____ Dairy/Alternatives_____
Fats/Oil _____ Sweets (candy, cookies, cakes, ice cream, etc)_____

Do you drink caffeinated beverages? ☐ Yes ☐ No If yes, select amount: Coffee (cups per day) ☐ 1 ☐ 2-4 ☐ >4 Tea (cup per day) ☐ 1 ☐ 2-4 ☐ >4
Caffeinated sodas/energy drinks (cans per day) ☐ 1 ☐ 2-4 ☐ >4
Do you have any adverse reactions to caffeine? ☐ Yes ☐ No
If yes, explain_____
When you drink caffeine do you feel ☐ Irritable ☐ Wired ☐ Aches/Pains

Smoking

Do you currently smoke? ☐ Yes ☐ No Packs per day:_____ How many years?:_____
What kind? ☐ Cigarettes ☐ Smokeless ☐ Pipe ☐ Cigar ☐ E-cigarette
Have you attempted to quit? ☐ Yes ☐ No If yes, what methods: _____
If you smoked previously: Packs per day:_____ Number of years:_____
Are you exposed regularly to second-hand smoke? ☐ Yes ☐ No

Alcohol

How many alcoholic beverages do you drink in a week? (1 drink = 5 oz wine, 12 oz beer, 1.5 oz of liquor)
☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ >10 ☐ None
Previous alcohol intake ☐ Yes (☐ Mild ☐ Moderate ☐ High) ☐ None

Have you ever had a problem with alcohol? ☐ Yes ☐ No If yes, when and explain: _____

_____

_____

Have you ever thought about getting help to control or stop drinking? ☐ Yes ☐ No

Other substances

Have you been recommended medical marijuana and are you state registered? ☐ Yes ☐ No
Are you currently using any recreational drugs? ☐ Yes ☐ No If yes, which type:_____

_____

Have you ever used any IV or inhaled recreational drugs? ☐ Yes ☐ No

Stress

Do you feel you have an excessive amount of stress? ☐ Yes ☐ No
Do you feel you can handle stress easily? ☐ Yes ☐ No

Rate on a scale 0-10, 10 being the highest, each of the following on a daily basis:

Work _____ Family _____ Social _____ Finances _____ Health _____ Other _____

Any nervous habits? (Nail biting, picking, teeth clenching, etc)_____
Do certain situations make you nervous or panic? (Heights, closed in spaces, crowds, travel, flying etc) _____

_____

Do you use any relaxation techniques? ☐ Yes ☐ No If yes, how often? _____ Which techniques?
☐ Meditation ☐ Breathing ☐ Tai Chi ☐ Yoga ☐ Prayer ☐ Reiki ☐ Other:_____

Have you ever gone to counseling/therapy? ☐ 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

Please list your hobbies/leisure activities: _____

_____

Relationships

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Long term partner ☐ Widow/er

With who do you live with? (Include children, parents, relatives, friends, pets) _____

_____

Current occupation:_____
Previous occupation (s): _____

Do you have 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 so, what kind_____

How well have things been going for you? (Circle on a scale of 1-10, N/A is not applicable)

	N/A	Poorly					Fine				Great
Overall	☐	1	2	3	4	5	6	7	8	9	10
At your job	☐	1	2	3	4	5	6	7	8	9	10
At school	☐	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 your partner	☐	1	2	3	4	5	6	7	8	9	10
With sex	☐	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 attitude	☐	1	2	3	4	5	6	7	8	9	10
Medication	☐	1	2	3	4	5	6	7	8	9	10

Medications

Current Medications (prescriptive and over the counter), if you more need space, please list under supplements

Medication	Dosage	Start Date (mo/yr)	Reason for use

Current Nutritional Supplements (vitamins, minerals, herbs, etc)

Medication	Dosage	Start Date (mo/yr)	Reason for use

Have you used any of these regularly or for a long time?

NSAIDs (Motrin, Advil, Aleve, Naproxen, Aspirin) ☐ Yes ☐ No

Tylenol (Acetaminophen) ☐ Yes ☐ No

Acid-blocking (Prilosec, Nexium, Protonic, Zantac, Pepcid) ☐ Yes ☐ No

How many times have you taken antibiotics?

	<5	>5	Reason for use
Infancy/childhood			
Teen			
Adulthood			

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

If yes, explain: _____

How often have you taken oral steroids (cortisone, prednisone, etc)?

	<5	>5	Reason for use
Infancy/childhood			
Teen			
Adulthood			

Family History
Check family members that have/had any of the following

	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandfather	Maternal Grandmother	Paternal Grandfather	Paternal Grandmother	Other
Age if still alive										
Age of death (if deceased)										
Cancer										
Heart Disease										
High blood pressure										
Obesity										
Diabetes										
Stroke										
Autoimmune disease										
Arthritis										
Kidney Disease										
Thyroid Problems										
Psychiatric disorders										
Anxiety										
Depression										
Addiction										
Substance abuse										
Asthma										
Allergies										
Eczema										
ADHD										
Autism										
IBS										
Dementia/Alzheimer's										
Genetic disorders										
Other:										
Other:										

Symptom Review

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

General	Mild	Moderate	Severe
Cold intolerance	☐	☐	☐
Daytime sleepiness	☐	☐	☐
Difficulty falling asleep	☐	☐	☐
Don't remember dreams	☐	☐	☐
Fatigue	☐	☐	☐
Flushing	☐	☐	☐
Heat intolerance	☐	☐	☐
Low body temperature	☐	☐	☐
Nightmares	☐	☐	☐
Night sweats	☐	☐	☐
Night walking	☐	☐	☐
Swollen lymph nodes	☐	☐	☐
Head, Eyes, Ears			
Conjunctivitis	☐	☐	☐
Distorted sense of smell	☐	☐	☐
Distorted taste	☐	☐	☐
Ear fullness	☐	☐	☐
Ear ringing/buzzing	☐	☐	☐
Eye crusting	☐	☐	☐
Eye pain	☐	☐	☐
Eyelid pain	☐	☐	☐
Eyelid margin redness	☐	☐	☐
Headache	☐	☐	☐
Hearing loss	☐	☐	☐
Hearing problems	☐	☐	☐
Migraine	☐	☐	☐
Sensitivity to loud noise	☐	☐	☐
Vision problems	☐	☐	☐
Musculoskeletal			
Back muscle spasms	☐	☐	☐
Calf cramps	☐	☐	☐
Chest tightness	☐	☐	☐
Foot cramps	☐	☐	☐
Joint deformity	☐	☐	☐
Joint pain	☐	☐	☐
Joint stiffness	☐	☐	☐
Joint swelling	☐	☐	☐
Muscle pain	☐	☐	☐
Muscle spasms	☐	☐	☐

Musculoskeletal (Cont)	Mild	Moderate	Severe
Muscle twitching:			
Around eyes	☐	☐	☐
Around legs	☐	☐	☐
Muscle stiffness	☐	☐	☐
Muscle weakness	☐	☐	☐
Neck muscle spasm	☐	☐	☐
Tendinitis	☐	☐	☐
Tension headache	☐	☐	☐
TMJ (Jaw) Problems	☐	☐	☐
Mood/Nerves			
Agoraphobia	☐	☐	☐
Anxiety	☐	☐	☐
Auditory hallucinations	☐	☐	☐
Black outs	☐	☐	☐
Depression	☐	☐	☐
Difficulty:			
Concentrating	☐	☐	☐
With balance	☐	☐	☐
With thinking	☐	☐	☐
With judgment	☐	☐	☐
With speech	☐	☐	☐
With memory	☐	☐	☐
Dizziness	☐	☐	☐
Fainting	☐	☐	☐
Fearfulness	☐	☐	☐
Irritability	☐	☐	☐
Light-headedness	☐	☐	☐
Numbness	☐	☐	☐
Other phobias	☐	☐	☐
Panic attacks	☐	☐	☐
Paranoia	☐	☐	☐
Seizures	☐	☐	☐
Suicidal thoughts	☐	☐	☐
Tingling	☐	☐	☐
Tremor/trembling	☐	☐	☐
Visual hallucinations	☐	☐	☐
Cardiovascular			
Angina/chest pain	☐	☐	☐
Breathlessness	☐	☐	☐

Cardiovascular (cont)	Mild	Moderate	Severe
High blood pressure	☐	☐	☐
Irregular pulse	☐	☐	☐
Low blood pressure	☐	☐	☐
Painful legs	☐	☐	☐
Palpitations	☐	☐	☐
Swollen limbs	☐	☐	☐
Varicose veins	☐	☐	☐
Respiratory			
Bad odor in nose	☐	☐	☐
Cough-dry	☐	☐	☐
Cough-productive	☐	☐	☐
Hoarseness	☐	☐	☐
Nasal stuffiness	☐	☐	☐
Nose bleeds	☐	☐	☐
Post nasal drip	☐	☐	☐
Sinus infections	☐	☐	☐
Snoring	☐	☐	☐
Sore throat	☐	☐	☐
Wheezing	☐	☐	☐
Winter Stuffiness	☐	☐	☐
Hay fever:			
Change of season	☐	☐	☐
Fall	☐	☐	☐
Spring	☐	☐	☐
Summer	☐	☐	☐
Digestion			
Anal itching	☐	☐	☐
Bad breath	☐	☐	☐
Bad teeth	☐	☐	☐
Belching	☐	☐	☐
Bleeding gums	☐	☐	☐
Bloating after meals	☐	☐	☐

Digestion (cont)	Mild	Moderate	Severe
Bloating of:			
Lower abdomen	☐	☐	☐
Entire abdomen	☐	☐	☐
Blood in stools	☐	☐	☐
Canker sores	☐	☐	☐
Cold sores	☐	☐	☐
Constipation	☐	☐	☐
Cracking at corners of lips	☐	☐	☐
Dentures w/ poor chewing	☐	☐	☐
Diarrhea	☐	☐	☐
Difficulty swallowing	☐	☐	☐
Dry mouth	☐	☐	☐
Flatulence	☐	☐	☐
Food reflex	☐	☐	☐
Heartburn	☐	☐	☐
Hemorrhoids	☐	☐	☐
Intolerance to:			
All dairy products	☐	☐	☐
Corn	☐	☐	☐
Eggs	☐	☐	☐
Fatty Foods	☐	☐	☐
Gluten (wheat)	☐	☐	☐
Lactose	☐	☐	☐
Yeast	☐	☐	☐
Liver disease- jaundice	☐	☐	☐
Lower abdominal pain	☐	☐	☐
Mucus in stool	☐	☐	☐
Nausea	☐	☐	☐
Strong stool odor	☐	☐	☐
Undigested food in stool	☐	☐	☐
Upper abdominal pain:	☐	☐	☐
Vomiting	☐	☐	☐

Eating	Mild	Moderate	Severe
Binge eating	☐	☐	☐
Bulimia	☐	☐	☐
Caffeine dependence	☐	☐	☐
Can't gain weight	☐	☐	☐
Can't lose weight	☐	☐	☐
Carb intolerance	☐	☐	☐
Carb cravings	☐	☐	☐
Sweet cravings	☐	☐	☐
Urinary			
Bed wetting	☐	☐	☐
Bladder spasms	☐	☐	☐
Hesitancy	☐	☐	☐
Infections	☐	☐	☐
Leaking/Incontinence	☐	☐	☐
Pain/Burning	☐	☐	☐
Urgency	☐	☐	☐
Nails			
Bitten	☐	☐	☐
Brittle	☐	☐	☐
Curved up	☐	☐	☐
Frayed	☐	☐	☐
Fungal nails	☐	☐	☐
Fungal toenails	☐	☐	☐
Pitting	☐	☐	☐
Ragged cuticles	☐	☐	☐
Ridges	☐	☐	☐
Soft	☐	☐	☐
Thickening of:			
Finger nails	☐	☐	☐
Toes nails	☐	☐	☐
White spots/lines	☐	☐	☐
Discolored nails	☐	☐	☐
Skin			
Acne on back	☐	☐	☐
Acne on chest	☐	☐	☐
Acne on face	☐	☐	☐
Acne on shoulders	☐	☐	☐
Athlete's foot	☐	☐	☐
Bumps on back of arms	☐	☐	☐
Cellulite	☐	☐	☐
Dark circles under eyes	☐	☐	☐
Ears get red	☐	☐	☐
Easy bruising	☐	☐	☐
Eczema	☐	☐	☐

Skin (cont)	Mild	Moderate	Severe
Herpes-genital	☐	☐	☐
Hives	☐	☐	☐
Jock itch	☐	☐	☐
Lackluster skin	☐	☐	☐
Moles-color/size change	☐	☐	☐
Oily skin	☐	☐	☐
Pale skin	☐	☐	☐
Patchy dullness	☐	☐	☐
Psoriasis	☐	☐	☐
Puffy eyes	☐	☐	☐
Rash	☐	☐	☐
Red face	☐	☐	☐
Sensitive to insect bites	☐	☐	☐
Sensitive-poison ivy/oak	☐	☐	☐
Shingles	☐	☐	☐
Skin cancer	☐	☐	☐
Skin darkening	☐	☐	☐
Strong body odor	☐	☐	☐
Thick calluses	☐	☐	☐
Vitiligo	☐	☐	☐
Skin-dryness of:			
Eyes	☐	☐	☐
Feet	☐	☐	☐
Cracking?	☐	☐	☐
Peeling?	☐	☐	☐
Hair	☐	☐	☐
Hands	☐	☐	☐
Cracking?	☐	☐	☐
Peeling?	☐	☐	☐
Mouth/throat	☐	☐	☐
Scalp	☐	☐	☐
Dandruff?	☐	☐	☐
Skin-itching of:			
Arms	☐	☐	☐
Ear Canals	☐	☐	☐
Eyes	☐	☐	☐
Feet	☐	☐	☐
Hands	☐	☐	☐
Legs	☐	☐	☐
Nipples	☐	☐	☐
Nose	☐	☐	☐
Genitals	☐	☐	☐
Skin in general	☐	☐	☐
Throat/Mouth	☐	☐	☐

READINESS ASSESSMENT

Rate on a scale of 5 (very willing) to 1 (not willing)

In order to improve your health, how willing are you to:

Significantly modify your diet	☐5 ☐ 4 ☐3☐ 2 ☐1
Take several nutritional supplements each day	☐5 ☐ 4 ☐3☐ 2 ☐1
Keep a record of everything you eat each day	☐5 ☐ 4 ☐3☐ 2 ☐1
Modify your lifestyle (work demands, sleep habits)	☐5 ☐ 4 ☐3☐ 2 ☐1
Practice relaxation techniques/stress reduction	☐5 ☐ 4 ☐3☐ 2 ☐1
Engage in regular exercise	☐5 ☐ 4 ☐3☐ 2 ☐1

Rate on a scale of 5 (very confident) to 1 (not confident at all):

How confident are you on 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 and your life lead you to question your capacity to follow through? _____

_____

Rate on a scale of 5 (very supportive) to 1 (very unsupportive):

Currently, how supportive do you think the people in your household will be to your implementing the above changes? ☐5 ☐ 4 ☐3☐ 2 ☐1

Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact):

How much ongoing support (telephone calls, emailing) from our professional staff would be helpful to you to implement your personal health program? ☐5 ☐ 4 ☐3☐ 2 ☐1 Comments _____

_____

_____

HEALTH GOALS

What you do you hope to achieve in your visit with us? _____

_____

_____

Do you think something triggered your health to change? _____

_____

_____

When was the last time you remember feeling well? _____
_____
_____

What makes you feel worse? _____
_____
_____

How does your condition affect you? _____
_____
_____

What you think is happening and why? _____
_____
_____

What do you feel needs to happen for you to get better? _____
_____
_____