



Date: _____

GENERAL INFORMATION (If more space is needed when filling in certain sections, please feel free to provide separate sheet)

Name: First _____ Middle _____ Last _____

Preferred Name: _____

Date of Birth: ____/____/____ Age: _____ Gender: Male Female

Primary Address: _____ Apt. No.: _____

City: _____ State: _____ Zip: _____

Alternate Address: _____ Apt. No.: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Best Phone and Times to Reach You: _____

Email: _____ Fax: _____

Emergency Contact: Name _____ Phone _____

Relationship to you _____ Address: _____

City: _____ State: _____ Zip: _____

Your Genetic Background: African Asian European Ashkenazi Native American
 Middle Eastern Mediterranean Other _____

Highest Education Level: High School or Equivalent Graduate Post-Graduate

Job Title: _____

Nature of Business: _____

Primary Pharmacy: Name _____ Phone _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Fax: _____

Whom may we thank for referring you? _____

Book Website Media Other _____

Insurance Information

Dr. Bond is not in network with any insurance company. We do not generally bill directly to any insurance carrier for functional Medicine. If you have questions or would like a superbill to submit to insurance please let us know.

Payment Information *Payment is due at time of service, no exceptions. If you would like to submit a claim for payment of services to your insurance company, we will provide you with a statement for a small setup and statement fee. Please see our insurance policy handouts for more information. Knowledge and awareness of insurance coverage is the sole responsibility of the patient.*

Health Concerns & Goals

Please list current and/or ongoing areas of concern you would like to address in order of priority.

Health Concern or Goal #1 *(Please describe as many details as you can)* _____

When did you first notice symptoms appear? _____ Was there a trigger? _____

Is this condition getting: Better Worse About the same

What treatments have you tried? *Please list everything - home remedies to medical interventions:* _____

What makes it better? _____

What makes it worse? _____

If pain is associated with your condition, please check all that apply: *Type of pain*

- Sharp Dull Throbbing Numbness Aching Shooting Burning
- Tingling Cramps Stiffness Swelling Other _____

How often do you experience this condition? _____

Is it constant or does it come and go? _____

Anything else you feel is important about this condition? _____

Health Concern or Goal #2 *(Please describe as many details as you can)* _____

When did you first notice symptoms appear? _____ Was there a trigger? _____

Is this condition getting: Better Worse About the same

What treatments have you tried? *Please list everything - home remedies to medical interventions:* _____

What makes it better? _____

What makes it worse? _____

If pain is associated with your condition, please check all that apply: *Type of pain*

- Sharp Dull Throbbing Numbness Aching Shooting Burning
- Tingling Cramps Stiffness Swelling Other _____

How often do you experience this condition? _____

Is it constant or does it come and go? _____

Anything else you feel is important about this condition? _____

Health Concern or Goal #3 *(Please describe as many details as you can)* _____

When did you first notice symptoms appear? _____ Was there a trigger? _____

Is this condition getting: Better Worse About the same

What treatments have you tried? *Please list everything - home remedies to medical interventions:* _____

What makes it better? _____

What makes it worse? _____

If pain is associated with your condition, please check all that apply: *Type of pain*

- Sharp Dull Throbbing Numbness Aching Shooting Burning
 Tingling Cramps Stiffness Swelling Other _____

How often do you experience this condition? _____

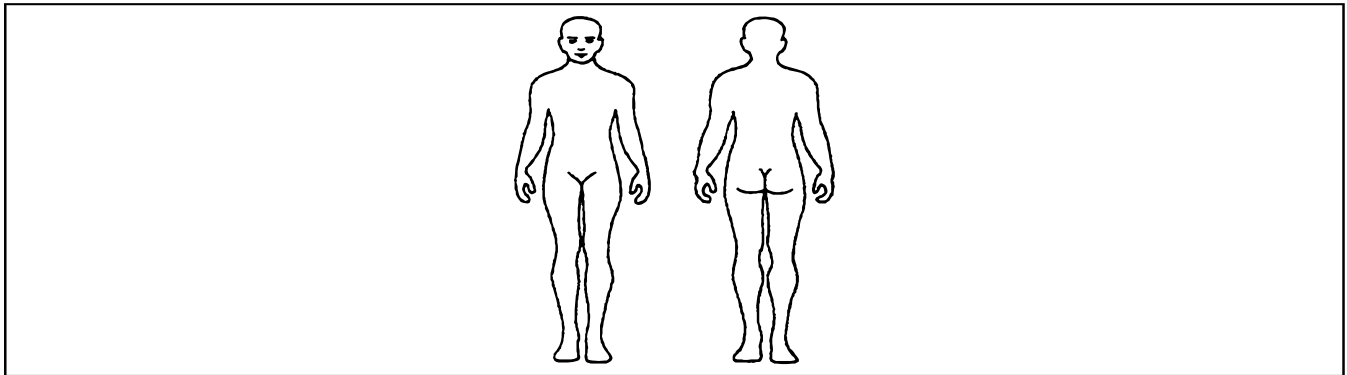
Is it constant or does it come and go? _____

Anything else you feel is important about this condition? _____

In general, what do you hope to achieve with your visits here? _____

When was the last time you felt exceptionally well? _____

Please mark any areas of concern with as much detail as you can. Please write anywhere in the box



Other comments you think are important _____

Medical History

Please list all other healthcare providers with whom you have received treatment within the last 10 years:

Doctor of Chiropractic Name: _____ City: _____
Treatment Focus: _____

M.D. / D.O. Name: _____ City: _____
Treatment Focus: _____

Physical Therapist Name: _____ City: _____
Treatment Focus: _____

Acupuncture Name: _____ City: _____
Treatment Focus: _____

Other: _____
Name: _____ City: _____
Treatment Focus: _____

Medical History *continued*

Hospitalizations None

Date _____ - Reason _____
 _____ - _____
 _____ - _____
 _____ - _____

Allergies

Medication/Supplement/Food	Reaction
_____	_____
_____	_____
_____	_____

Diseases/Diagnosis/Conditions: Check appropriate box and provide Month/Year of onset Past Condition Ongoing Condition

Gastrointestinal

- Irritable Bowel Syndrome ___/___
- Inflammatory Bowel Disease ___/___
- Crohn's ___/___
- Ulcerative Colitis ___/___
- Gastritis or Peptic Ulcer Disease ___/___
- GERD (reflux) ___/___
- Celiac Disease ___/___
- Hemorrhoids ___/___
- Other ___/___

- Type 2 Diabetes ___/___
- Hypoglycemia ___/___
- Metabolic Syndrome (Insulin Resistance/ Pre-Diabetes) ___/___
- Hypothyroidism (low thyroid) ___/___
- Hyperthyroidism (overactive thyroid) ___/___
- Endocrine Problems ___/___
- Polycystic Ovarian Syndrome (PCOS) ___/___
- Infertility ___/___
- Weight Gain ___/___
- Weight Loss ___/___
- Frequent Weight Fluctuations ___/___
- Bulimia ___/___
- Anorexia ___/___
- Binge Eating Disorder ___/___
- Night Eating Syndrome ___/___
- Eating Disorder (non-specific) ___/___
- Other ___/___

Cardiovascular

- Heart Attack ___/___
- Other Heart Disease ___/___
- Stroke ___/___
- Elevated Cholesterol ___/___
- Arrhythmia (irregular heart rate) ___/___
- Hypertension (high blood pressure) ___/___
- Rheumatic Fever ___/___
- Mitral Valve Fever ___/___
- Other ___/___

Musculoskeletal/Pain

- Osteoarthritis ___/___
- Fibromyalgia ___/___
- Chronic Pain ___/___
- Tendonitis ___/___
- Tension Headaches ___/___
- TMJ Problems ___/___
- Foot Cramps ___/___
- Joint Deformity ___/___
- Joint Pain ___/___
- Other ___/___

Cancer

- Lung Cancer ___/___
- Breast Cancer ___/___
- Colon Cancer ___/___
- Ovarian Cancer ___/___
- Prostate Cancer ___/___
- Skin Cancer ___/___
- Other ___/___

Genital & Urinary Systems

- Kidney Stones ___/___
- Gout ___/___
- Interstitial Cystitis ___/___
- Frequent Urinary Tract Infections ___/___
- Frequent Yeast Infections ___/___
- Erectile or Sexual Dysfunctions ___/___
- Other ___/___

Metabolic/Endocrine

- Type 1 Diabetes ___/___

Diseases/Diagnosis/Conditions: *continued*

Inflammatory/Autoimmune

- Chronic Fatigue Syndrome ___/___
- Autoimmune Disease ___/___
- Rheumatoid Arthritis ___/___
- Lupus SLE ___/___
- Immune Deficiency Disease ___/___
- Herpes-Genital ___/___
- Cold Sores ___/___
- Severe Infectious Disease ___/___
- Poor Immune Function (*frequent infections*) ___/___
- Food Allergies ___/___
- Environmental Allergies ___/___
- Multiple Chemical Sensitivities ___/___
- Latex Allergy ___/___
- Other ___/___ _____

Respiratory Diseases

- Asthma ___/___
- Chronic Sinusitis ___/___
- Bronchitis ___/___
- Emphysema ___/___
- Pneumonia ___/___
- Tuberculosis ___/___
- Sleep Apnea ___/___
- Other ___/___ _____

Head, Eyes, & Ears

- Conjunctivitis ___/___
- Distorted Sense of Smell ___/___
- Distorted Taste ___/___
- Ear Fullness ___/___
- Ear Pain ___/___
- Hearing Loss ___/___
- Hearing Problems ___/___
- Headache ___/___
- Migraine ___/___
- Sensitivity to Loud Noises ___/___
- Vision Problems (*other than glasses*) ___/___
- Macular Degeneration ___/___
- Vitreous Detachment ___/___
- Retinal Detachment ___/___
- Other ___/___ _____

Nails

- Bitten ___/___
- Brittle ___/___
- Curve Up ___/___
- Frayed ___/___
- Fungus-Fingers ___/___
- Fungus-Toes ___/___
- Pitting ___/___
- Ragged Cuticles ___/___
- Ridges ___/___
- Soft ___/___
- Thickening of Finger Nails ___/___
- Thickening of Toenails ___/___
- White Spots/Lines ___/___
- Other ___/___ _____

Skin Diseases

- Acne on Back ___/___

- Acne on Chest ___/___
- Acne on Face ___/___
- Acne on Shoulders ___/___
- Athlete's Foot ___/___
- Bumps on Back of Upper Arms ___/___
- Cellulite ___/___
- Dark Circles Under Eyes ___/___
- Ears Get Red ___/___
- Easy Bruising ___/___
- Lack of Sweating ___/___
- Hives ___/___
- Jock Itch ___/___
- Lackluster Skin ___/___
- Moles w/ Color/Size Change ___/___
- Oily Skin ___/___
- Pale Skin ___/___
- Patchy Dullness ___/___
- Rash ___/___
- Red Face ___/___
- Sensitive to Poison Ivy/Oak ___/___
- Shingles ___/___
- Skin Darkening ___/___
- Strong Body Odor ___/___
- Hair Loss ___/___
- Vitiligo ___/___
- Eczema ___/___
- Psoriasis ___/___
- Melanoma ___/___
- Skin Cancer ___/___
- Other ___/___ _____

Neurologic/Mood

- Depression ___/___
- Anxiety ___/___
- Bipolar Disorder ___/___
- Schizophrenia ___/___
- Headaches ___/___
- Migraines ___/___
- ADD/ADHD ___/___
- Autism ___/___
- Mild Cognitive Impairment ___/___
- Memory Problems ___/___
- Parkinson's Disease ___/___
- Multiple Sclerosis ___/___
- ALS ___/___
- Seizures ___/___
- Other Neurological Problems _____

Blood Type

- A B AB O Rh+ unknown

Injuries

Check box if yes and provide date/description

- Back Injury ___/___ _____
- Head Injury ___/___ _____
- Neck Injury ___/___ _____
- Broken Bones ___/___ _____
- Other ___/___ _____

Diseases/Diagnosis/Conditions: continued

Female Reproductive

- Breast Cysts ___/___
- Breast Lumps ___/___
- Breast Tenderness ___/___
- Ovarian Cysts ___/___
- Poor Libido ___/___
- Vaginal Discharge ___/___
- Vaginal Odor ___/___
- Vaginal Itch ___/___
- Vaginal Pain with Sex ___/___
- Other ___/___

Surgeries

Check box if yes and provide date of surgery

- None
- Appendectomy ___/___
- Hysterectomy +/- Ovaries ___/___
- Gall Bladder ___/___
- Hernia ___/___
- Tonsillectomy ___/___
- Dental Surgery ___/___
- Joint Replacement: Knee/Hip ___/___
- Heart Surgery: Bypass Valve ___/___
- Angioplasty or Stent ___/___
- Pacemaker ___/___
- Other ___/___

Gynecologic History (for women only)

Obstetric History Check box if yes and provide relevant quantity

- Pregnancy _____ Vaginal Delivery _____ Caesarean Delivery _____ Miscarriage _____ Abortion _____
- Living Children _____ Post-Partum Depression _____ Toxemia _____ Gestational Diabetes _____
- Baby over 8 lbs. _____ Premature _____ Low Birth Weight (< 6lbs) _____
- Breast Feeding Your Child *How long?* _____ Oral Contraceptives _____ *How long?* _____

Menstrual History

- Age at first period: _____ Menses Frequency: _____ Length between menses: _____ Pain: Yes No
- Clotting: Yes No Has your period ever skipped? Yes No How long? _____
- Last Menstrual Period: _____
- Do you use contraception? Yes No *If yes:* Condom Diaphragm IUD Partner Vasectomy

Women's Disorders/Hormonal Imbalances

- Fibrocystic Breasts Breast Cancer ___/___ Endometriosis Fibroids Infertility
- Painful Periods Heavy Periods PMS
- Last Mammogram ___/___ Anything Abnormal? _____ Breast Biopsy ___/___
- Thermogram ___/___/___ Last PAP Test ___/___/___ Normal Abnormal
- Date of Last Bone Density: ___/___/___ Results: High Low Within Normal Range
- Are you in menopause? Yes No Age of onset of menopause: _____

Check box if you are experiencing

- Hot Flashes Mood Swings Concentration/Memory Problems Vaginal Dryness
- Decreased Libido Heavy Bleeding Joint Pains Headaches Weight Gain
- Loss of Control of Urine Palpitations Painful Intercourse
- Use of hormone replacement therapy *How Long?* _____ *What hormones and dosage?* _____

Male Reproductive

- Discharge from penis ___/___
- Ejaculation Problem ___/___
- Genital Pain ___/___
- Impotence ___/___
- Prostate or Urinary Infection ___/___
- Lumps in Testicles ___/___
- Poor Libido (*Sex Drive*) ___/___
- Other ___/___

Preventive Tests

Check box if yes and provide date of most recent test

- Blood Tests ___/___
- Full Physical Exam ___/___
- X-Ray ___/___ *Body Part?* _____
- Dental X-Ray ___/___
- Bone Density ___/___
- Colonoscopy ___/___
- Cardiac Stress Test ___/___
- EKG ___/___
- Hemocult Test (stool test for blood) ___/___
- MRI ___/___
- CT Scan ___/___
- Upper Endoscopy ___/___
- Upper GI Series ___/___
- Ultrasound ___/___
- Other ___/___

Men's History *(for men only)*

Have you had a PSA done? Yes No Date of last test? ___/___/___ Highest PSA Level: 0-2 2-4 4-10 >10

Check all that apply:

- Do you regularly have morning erections? Yes No Increased fat accumulation Headaches
- Emotional reactions Prostate enlargement Prostate infection Change in libido Impotence
- Difficulty obtaining an Erection Difficulty maintaining an erection Prostate Cancer
- Nocturia (*urination at night*) How many times a night? _____ Urgency/Hesitancy/Change in Urinary Stream
- Loss of Control of Urine Testicular injury Testosterone replacement More fatigue and/or muscle soreness

Medications

Current Medications *(Both prescription and over-the-counter)*

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

Previous Medications: Last 10 Years

Medication	Dose	Frequency	Start Date (month/year)	End Date (month/year)	Reason For Use

Nutritional Supplements: (Vitamins, Minerals, Herbs, & Homeopathy) *If more space is needed, please write on separate sheet.*

Supplement & Brand	Dose	Frequency	Start Date (month/year)	Reason For Use

Have your medications or supplements ever caused you unusual side effects or problems? Yes No

Describe: _____

Have you had prolonged (3 days or longer) or regular use of NSAIDS (*i.e. Advil, Aleve, Motrin, Aspirin, etc.*)? Yes No

Have you had prolonged or regular use of Tylenol? Yes No

For what reason, and for how long, did you use pain relievers? _____

How much do you use NSAIDS now? Daily _____ Weekly _____ Monthly _____

Have you had prolonged or regular use of Acid Blocking Drugs (*i.e. Tagamet, Zantac, Prilosec, etc.*)? Yes No

Have you taken antibiotics **more than 1 x** per year? Yes No

Have you had long-term use of antibiotics? (*More than 10 days.*) Yes No

How many times have you taken antibiotics throughout your lifetime? _____

Have you ever used steroids (*i.e. prednisone, nasal allergy inhalers, skin/joint creams, etc.*)? Yes No

GI History

Foreign travel? Yes No *Where?* _____
Wilderness Camping Yes No *Where?* _____
Have you had severe: Gastroenteritis Diarrhea Crohn's/Ulcerative colitis Parasites
Do you feel like you digest your food well? Yes No Do you feel bloated after meals? Yes No

Patient Birth History

Term Premature *Pregnancy Complications:* _____
Birth Complications: _____
 Breast Fed *How long?* _____ Bottle-fed
Age at introduction of: Solid Foods: _____ Dairy: _____ Wheat: _____
Did you eat candy or sugar as a child? Yes No

Dental History

Dental Surgery? _____
 Silver Mercury Fillings *How many?* _____ Gold Fillings Root Canals Implants Tooth Pain
 Bleeding Gums Gingivitis Problems with Chewing
Do you floss regularly? Yes No Do you brush regularly? Yes No
What toothpaste do you use? _____ Have you had Fluoride treatments? Yes No

Diet

Do you have known adverse food reactions, allergies, or sensitivities? Yes No *If yes, describe symptoms and list all foods:*

Do you have an adverse reaction to caffeine? Yes No
When you drink caffeine do you feel: Irritable or Wired Aches & Pains Headaches
Do you adversely react to: *Check all that apply*
 Monosodium Glutamate (MSG) Aspartame (NutraSweet) Preservatives (ex. sodium benzoate)
 Cheese Citrus foods Chocolate Alcohol Red Wine Caffeine Bananas Garlic Onion
 Sulfite containing foods (wine, dried fruit, salad bars) Other: _____

Environmental & Detoxification Assessment Which of these significantly affect you? *Check all that apply*

Cigarette Smoke Perfumes/Colognes Auto Exhaust Fumes Other: _____
In your home or work environment, are you exposed to: Chemicals Electromagnetic Radiation Mold
How often do you use your cell phone? _____ hrs/day How often do you use your computer? _____ hrs/day _____ hrs/wk
Have you ever turned yellow (*jaundiced*)? Yes No
Have you ever been told you have Gilbert's syndrome or a liver disorder? Yes No

If yes, explain _____

Do you have a known history of significant exposure to any harmful chemicals such as the following:
 Herbicides Insecticides (*frequent visits of exterminator*) Pesticides Organic Solvents
 Heavy Metals Other _____

Chemical Name/Date/Length of Exposure (*if known*) _____

Do you dry clean your clothes frequently? Yes No
Do you or have you lived or worked in a damp or moldy environment or had other mold exposure? Yes No
Do you have any pets or farm animals? Yes No
What detergents/soaps do you use (*Brand names*)? _____
What deodorant? _____
What beauty products do you use (*Lotions, Hair products, Make-up, etc.*)? _____

Family History

<i>Check family members that apply</i>	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age (if still alive)												
Age at Death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis <i>(Rheumatoid, Psoriatic, Ankylosing Spondylitis)</i>												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Diseases <i>(such as Lupus)</i>												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities, or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse <i>(such as Alcoholism)</i>												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar / Mood Disorder												
<i>Other:</i>												

Social History

Weight Stats

Height ____ft. ____in. Current Weight _____ Usual Weight Range (+/- 5lbs) _____
Desired Weight Range (+/- 5lbs) _____ Highest Adult Weight _____ Lowest Adult Weight _____
Have you experienced weight fluctuations greater than 10 lbs? Yes No Body fat % _____
Is your weight, in the recent past, increasing, decreasing, or staying the same? *If changing describe* _____

Nutrition History

Have you ever had a nutrition consultant? Yes No
Have you made any changes in your eating habits because of your health? Yes No *Describe* _____

Do you currently follow a special diet or nutritional program? Yes No *Check all that apply*
 Low Fat Low Carbohydrate High Protein Low Sodium Diabetic No Dairy No Wheat
 Gluten Restricted Vegetarian Vegan Ultrametabolism Macrobiotic Paleo
 Specific Program for Weight Loss/Maintenance Type: _____ Other _____
How often do you weigh yourself? Daily Weekly Monthly Rarely Never
Have you ever had your metabolism (*resting metabolic rate*) checked? Yes No *If Yes, what was it?* _____
Do you avoid any particular foods? Yes No *If yes, types & reason* _____

If you could only eat a few foods a week, what would they be? _____

Do you grocery shop? Yes No *If no, who does the shopping?* _____

Do you eat organic foods? Yes No

What percentage of your food is organic (pesticide free, non-GMO, etc.)? _____

How many meals do you eat out per week? 0 – 1 1 – 3 3 – 5 >5 meals per week

Check all factors that apply to your current lifestyle and eating habits

- Fast Eater
- Erratic eating pattern
- Eat too much
- Late night eating
- Dislike healthy food
- Time constraints
- Eat more than 50% meals away from home
- Travel frequency
- Non-availability of healthy foods
- Do not plan meals or menus
- Reliance on convenience
- Poor snack choices
- Significant other or family members don't like healthy foods
- Significant other or family members have special dietary needs or food preferences
- Love to eat
- Eat because I have to
- Have a negative relationship to food
- Struggle with eating issues
- Emotional eater (*eat when sad, lonely, depressed, bored*)
- Eat too much under stress
- Eat too little under stress
- Don't care to cook
- Eating in the middle of the night
- Confused about nutrition advice

The most important thing I should change about my diet to improve my health is: _____

What foods would be the hardest to reduce or eliminate? _____

Smoking

Currently smoking? Yes No *How many years?* _____ *Packs per day:* _____ *Attempts to quit:* _____

Previous smoking? *How many years?* _____ *Packs per day:* _____ *Date quit:* _____

Secondhand smoke exposure? _____ *From where?* _____

Social History *continued*

Alcohol Intake

How many drinks currently per week? 1 Drink = 5 oz. wine, 12 oz. beer, or 1 oz. spirit
 None 1-3 4-6 7-10 > 10 If 'None' – Skip to 'Other Substances'

Most common beverage? _____

Have you ever been told you should cut down your alcohol intake? Yes No

Do you get annoyed when people ask you about your drinking? Yes No

Do you ever feel guilty about your alcohol consumption? Yes No

Do you ever take an eye-opener? Yes No

Do you notice a tolerance to alcohol? (Can you 'hold' more than others?) Yes No

Have you ever been unable to remember what you did during a drinking episode? Yes No

Do you get into arguments or physical fights when you have been drinking? Yes No

Have you ever been arrested or hospitalized because of drinking? Yes No

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

Other Substances

Caffeine intake: Yes No Cups/day: Coffee Tea - 1 2-4 > 4 a day

Caffeinated sodas or diet sodas intake: Yes No

12 oz. soda per day: 1 2-4 > 4 a day Favorite soda: _____

Are you currently using any recreational drugs? Yes No Type _____

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

Exercise

Current exercise program

Activity	Type	Frequency Per Week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength			
Other (Yoga, Pilates, Gyrotonics, etc.)			
Sports or Leisure Activities (Golf, Tennis, Rollerblading, etc.)			

Rate your level of motivation for including exercise in your life? Low Medium High

List your problems that limit activity: _____

Do you feel unusually fatigued after exercise? Yes No If yes, please describe: _____

Do you usually sweat when exercising? Yes No

Psychosocial

Do you feel significantly less vital than you did a year ago? Yes No

Are you happy? Yes No Do you feel your life has meaning and purpose? Yes No

Do you believe stress is presently reducing the quality of your life? Yes No

Do you like the work you do? Yes No Have you ever experienced major losses in your life? Yes No

Do you spend the majority of your time and money to fulfill responsibilities and obligations? Yes No

Would you describe your experience as a child in your family as happy and secure? Yes No

Social History *continued*

Stress / Coping

Have you ever sought counseling? Yes No Describe _____

Are you currently in therapy? Yes No Describe _____

Do you feel you have an excessive amount of stress in your life? Yes No

Do you feel you can easily handle the stress in your life? Yes No

How do you deal with stress? _____

Daily Stressors: Rate on a scale of 1 – 10 Work ____ Family ____ Social ____ Finances ____ Health ____ Other ____

Do you practice meditation or relaxation technique? Yes No How often? _____

Check all that apply Yoga Meditation Imagery Breathing Tai Chi Prayer

Other: _____

Have you ever been abused, a victim of a crime, or experienced a significant trauma? Yes No

If yes, please explain _____

Do you regularly give gratitude for everything in your life? Yes No

How would you describe your overall attitude towards life? _____

Do you have a spiritual practice? Yes No Describe _____

Sleep / Rest

Average number of hours you sleep per night: > 10 8 -10 6 – 8 < 6

What time do you typically go to sleep? ____:____^{AM}/_{PM} Do you have trouble going to sleep? Yes No

Do you feel rested upon awakening? Yes No Do you have problems with insomnia? Yes No

Do you snore? Yes No Do you use sleeping aids? Yes No Explain: _____

Roles / Relationship

Marital status: Single Married Divorced Gay/Lesbian Long Term Partnership Widow

Spouses name: _____

Child's Name	Age	Gender

Who is living in your Household? Number _____ Names _____

Their Employment/Occupation: _____

Resources for emotional support? Check all that apply

Spouse Family Friends Religious/Spiritual Pets Other: _____

How well have things been going for you?	Very Well	Fine	Poorly	Does Not Apply
Overall				
At School				
In your job				
In your social life				
With close friends				
With sex				
With your attitude				
With your spouse/boyfriend/girlfriend				
With your children				
With your parents				

ASQ – Appraisal and Symptom Questionnaire – (Abbreviated)

Name: _____ Date: _____

The Health Appraisal and Symptom Questionnaire is designed to elucidate symptoms that help to identify the underlying causes of illness, as well as help track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days.

POINT SCALE:

0 = Never or almost never have the symptom
 1 = Occasionally have it, effect is not severe

2 = Occasionally have, effect is significant
 3 = Frequently have it, effect is significant
 4 = Frequently have it, effect is very significant

Digestive Tract

- Nausea or vomiting
- Diarrhea (loose stools or >3x/day)
- Constipation (not going everyday)
- Bloating feeling or abdominal swelling
- Belching or passing gas
- Heartburn of GERD
- Intestinal/stomach pain
- Reactions to foods
- Gallstones or pain after fatty meals
- Bad breath
- Blood or mucous in stool
- Other _____

Total _____

Ears

- Itchy ears
- Earaches, ear infections
- Drainage from ear
- Ringing in ears, hearing loss

Total _____

Emotions

- Mood swings
- Anxiety, irritability
- Anger or emotional outbursts
- Depression

Total _____

Energy/Activity

- Fatigue, sluggishness
- Apathy, lethargy
- Hyperactivity
- Restlessness
- Restless legs
- General feeling of ill health

Total _____

Eyes

- Watery or itchy eyes
- Swollen, reddened or sticky eyelids
- Bags or dark circles under eyes
- Blurred or tunnel vision (does not include near-or-far-sightedness)

Total _____

Head

- Headaches
- Faintness
- Dizziness or vertigo

Total _____

Heart

- Irregular or skipped heartbeat
- Rapid or pounding heartbeat
- Chest pain

Total _____

Joints/Muscles

- Pain or aches in joints
- Arthritis
- Stiffness or limitation of movement
- Pain or aches in muscles
- Feeling of weakness or tiredness
- Muscle cramping

Total _____

Lungs

- Chest congestion
- Asthma, bronchitis
- Shortness of breath
- Difficulty breathing
- Inability to take deep breaths

Total _____

Mind

- Poor memory
- Confusion, poor comprehension
- Poor concentration
- Poor physical coordination
- Difficulty in making decisions
- Stuttering or stammering
- Stuttered speech
- Slurred speech
- Insomnia
- Learning disabilities

Total _____

Nose

- Stuffy nose
- Sinus problems
- Hay fever
- Sneezing attacks
- Excessive mucus formation

Total _____

Skin

- Acne
- Hives
- Hair loss/thinning
- Rash or reddened skin

____ Excessive sweating

____ Edema

____ Dry or oily skin (circle which)

____ Dry, cracked nails

____ Body odor offensive or strong

Total _____

Weight

- Binge eating
- Craving certain foods
- Excessive weight
- Compulsive eating
- Water retention
- Underweight

Total _____

Mouth/Throat

- Chronic coughing
- Gagging, frequent throat clearing
- Sore throat, hoarseness, loss of voice
- Swollen/discolored tongue, gums, lips
- Canker sores
- Sticky coating on tongue
- Dry, cracked lips

Total _____

Immune

- Frequent illness
- Teeth infection/bleeding
- Frequent or urgent urination
- Urinary tract infections
- Genital itch/discharge or STD outbreak

Total _____

Hormones

- Awake feeling un-refreshed/tired
- Craving salty/sweet foods (circle which)
- Low or High Libido (circle)
- Facial or unusual hair growth
- Flushing or hot flashes
- Painful/abnormal periods (females)
- Cold hand/feet
- Frequent thirst
- Dizziness when standing

Total _____

Grand Total _____

Readiness Assessment

In order to improve your health, how willing are you to: *Rate on a scale of: 5 (very willing) to 1 (not willing)*

- Significantly improve your diet _____ 5 4 3 2 1
- Take several nutritional supplements each day _____ 5 4 3 2 1
- Start preparing your own meals _____ 5 4 3 2 1
- Modify your lifestyle _____ 5 4 3 2 1
- Practice a relaxation technique _____ 5 4 3 2 1
- Engage in regular exercise _____ 5 4 3 2 1
- Have periodic lab tests to assess your progress _____ 5 4 3 2 1
- Get regular bodywork such as chiropractic or massage _____ 5 4 3 2 1
- Setting regular appointments _____ 5 4 3 2 1
- Read books or articles to learn about your health and solutions _____ 5 4 3 2 1
- Be fully responsible for your own healing _____ 5 4 3 2 1

Comments: _____

How confident are you of your ability to organize and follow through on the above health related activities?

Rate on a scale of: 5 (very confident) to 1 (not confident at all) 5 4 3 2 1 *If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities?* _____

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? *Rate on a scale of: 5 (very supportive) to 1 (very unsupportive)* 5 4 3 2 1 *Comments:* _____

How much ongoing support and contact (*office visits*) from the Doctor would be helpful to you as you implement your personal health program? *Rate on a scale of: 5 (very frequent) to 1 (very infrequent contact)* 5 4 3 2 1

Please list how often you would be willing to make appointments if needed _____

Comments: _____

4-Day Diet Diary Instructions

There is a 4-day diet diary at the end of this packet. It is important to keep an accurate record of your usual food and beverage intake as a part of your treatment plan. Please complete this Diet Diary for 4 consecutive days including one weekend day. Please feel free to carry it with you as it is often easier to write down what you consume shortly after you consume it, rather than wait until the end of the day.

- **Do not change your eating behavior at this time, as the purpose of this food record is to analyze your present eating habits.**
- Record information as soon as possible after the food has been consumed.
- Describe the food or beverage as accurately as possible e.g., milk – what kind? (whole, 2%, or nonfat); toast – (whole wheat, white, buttered); chicken - (fried, baked, or breaded); coffee – (decaffeinated w/ sugar & ½ ‘n’ ½)
- Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, ½ cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.
- Record all beverages, **including water**, coffee, tea, sports drinks, sodas/diet sodas, etc.
- Include any additional comments about your eating habits in this form (ex. craving sweet, skipped meal and why, when the meal was at a restaurant, etc.)
- Please note all bowel movements and their consistency (regular, loose, firm, etc.)

Diet Diary: Name _____ Date _____

Day 1

Meal	Time	Food / Beverage / Amount	Comments
Breakfast			
Lunch			
Dinner			
Snacks & Other			

Bowel movements (#, form, color) _____
 Stress/Mood/Emotions _____
 Other Comments _____

Day 2

Meal	Time	Food / Beverage / Amount	Comments
Breakfast			
Lunch			
Dinner			
Snacks & Other			

Bowel movements (#, form, color) _____
 Stress/Mood/Emotions _____
 Other Comments _____

Day 3

Meal	Time	Food / Beverage / Amount	Comments
Breakfast			
Lunch			
Dinner			
Snacks & Other			

Bowel movements (#, form, color) _____
 Stress/Mood/Emotions _____
 Other Comments _____

Day 4

Meal	Time	Food / Beverage / Amount	Comments
Breakfast			
Lunch			
Dinner			
Snacks & Other			

Bowel movements (#, form, color) _____
 Stress/Mood/Emotions _____
 Other Comments _____