THE INSTITUTE FOR FUNCTIONAL MEDICINE®

Adult Intake Questionnaire

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Adult Intake Questionnaire

General Information

Name _____ Age _____ Today's Date _____

Date of Birth _____ Email _____

Address _____

City _____ State _____ Zip _____

Phone (Home) _____ (Cell) _____ (Work) _____

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

Sex assigned at birth _____

What is your current gender identity? _____

What are your pronouns? ☐ He/him ☐ She/her ☐ They/them ☐ Other: _____

When, where and from whom did you last receive medical or health care?

_____

Emergency Contact: _____

Relationship _____

Phone (Home) _____ (Cell) _____ (Work) _____

How did you hear about our practice?

☐ Clinic website ☐ IFM website ☐ Referral from doctor
☐ Referral from friend/family member ☐ Social media
☐ Other _____

Current Health Concerns

Please rank current and ongoing health concerns in order of priority

Describe Problem	When Did It Start	Severity	Prior Treatment/Approach	Success
Example: Post Nasal Drip	5 years ago ***or*** age 25	☑ Mild ☐ Moderate ☐ Severe	Elimination Diet	☑ Good ☐ Excellent ☐ Fair ☐ Poor ☐ None
		☐ Mild ☐ Moderate ☐ Severe		☐ Good ☐ Excellent ☐ Fair ☐ Poor ☐ None
		☐ Mild ☐ Moderate ☐ Severe		☐ Good ☐ Excellent ☐ Fair ☐ Poor ☐ None
		☐ Mild ☐ Moderate ☐ Severe		☐ Good ☐ Excellent ☐ Fair ☐ Poor ☐ None
		☐ Mild ☐ Moderate ☐ Severe		☐ Good ☐ Excellent ☐ Fair ☐ Poor ☐ None
		☐ Mild ☐ Moderate ☐ Severe		☐ Good ☐ Excellent ☐ Fair ☐ Poor ☐ None
		☐ Mild ☐ Moderate ☐ Severe		☐ Good ☐ Excellent ☐ Fair ☐ Poor ☐ None
		☐ Mild ☐ Moderate ☐ Severe		☐ Good ☐ Excellent ☐ Fair ☐ Poor ☐ None
		☐ Mild ☐ Moderate ☐ Severe		☐ Good ☐ Excellent ☐ Fair ☐ Poor ☐ None
		☐ Mild ☐ Moderate ☐ Severe		☐ Good ☐ Excellent ☐ Fair ☐ Poor ☐ None
		☐ Mild ☐ Moderate ☐ Severe		☐ Good ☐ Excellent ☐ Fair ☐ Poor ☐ None

Allergies

☐ I have no allergies

Please list all allergies

1. Name of Medication/Supplement/Environmental/Food: ______________________
   Reaction: ______________________
2. Name of Medication/Supplement/Environmental/Food: ______________________
   Reaction: ______________________
3. Name of Medication/Supplement/Environmental/Food: ______________________
   Reaction: ______________________
4. Name of Medication/Supplement/Environmental/Food: ______________________
   Reaction: ______________________
5. Name of Medication/Supplement/Environmental/Food: ______________________
   Reaction: ______________________
6. Name of Medication/Supplement/Environmental/Food: ______________________
   Reaction: ______________________
7. Name of Medication/Supplement/Environmental/Food: ______________________
   Reaction: ______________________

History

Patient's Birth/Childhood History

You were born: ☐ Premature ☐ Term ☐ Postmature ☐ Don't Know

You were born via: ☐ Vaginal birth ☐ C-Section

Were there any pregnancy or birth complications? ☐ Yes ☐ No

If yes, explain: _____

You were: ☐ Breast-fed /How long? _____ ☐ Bottle-fed/Type of formula: _____ ☐ Don't know

Age of introduction of solid food: _____

As a child, were there any foods that were avoided because they gave you symptoms? ☐ Yes ☐ No

If yes, what foods and what symptoms? (Example: milk—gas and diarrhea)

Did you eat a lot of sugar or candy as a child? ☐ Yes ☐ No

Dental History

How many fillings did you have as a kid? _____

Do you brush regularly? ☐ Yes ☐ No Do you floss regularly? ☐ Yes ☐ No

Check if you have any of the following, and provide number if applicable:

☐ Silver mercury fillings _____ ☐ Gold fillings _____ ☐ Root canals _____ ☐ Implants _____
☐ Caps/Crowns _____ ☐ Tooth pain _____ ☐ Bleeding gums ☐ Gingivitis
☐ Problems with chewing ☐ Other dental concerns (explain): _____

Have you had any mercury fillings removed? ☐ Yes ☐ No If yes, when: _____

Environmental/Detoxification History

Do any of these significantly affect you?

☐ Cigarette smoke ☐ Perfume/colognes ☐ Auto exhaust fumes ☐ Other: _____

In your work or home environment are you currently, or have you previously, been exposed to: *(Check all that apply)*

Current and Past Environmental Exposure					
Mold	☐ Current	☐ Past	Hobby chemicals (solvents, glues, gas, acids, etc.)	☐ Current	☐ Past
Water damage (from leaks, broken pipes, etc.):	☐ Current	☐ Past	Cleaning chemicals	☐ Current	☐ Past
Chemicals	☐ Current	☐ Past	Exhaust	☐ Current	☐ Past
Damp/humid spaces	☐ Current	☐ Past	New furniture/upholstery	☐ Current	☐ Past
Carpets or rugs	☐ Current	☐ Past	Heavy metals (lead, mercury, etc.)	☐ Current	☐ Past
Smokers	☐ Current	☐ Past	Paints	☐ Current	☐ Past
Pesticides/herbicides	☐ Current	☐ Past	Airplane travel	☐ Current	☐ Past
Electromagnetic radiation (power lines, cell phone towers, smart meters, wi-fi, etc.)	☐ Current	☐ Past	Other: _____	☐ Current	☐ Past

Have you lived in or remodeled a home built before 1978? ☐ Yes ☐ No

Have you had a significant exposure to any harmful chemicals? ☐ Yes ☐ No

If yes: Chemical name, length of exposure, date: _____

Do you have any pets or farm animals? ☐ Yes ☐ No

If yes, do they live: ☐ Inside ☐ Outside ☐ Both inside and outside

Obstetric History

(Check box and provide number if applicable)

☐ Pregnancies _____ ☐ Miscarriages _____ ☐ Abortions _____ ☐ Living children _____

☐ Vaginal deliveries _____ ☐ Cesarean _____ ☐ Term births _____ ☐ Premature births _____

☐ Still births _____ Birth weight of largest baby _____ Birth weight of smallest baby _____

Did you develop any problems in or after pregnancy?

☐ Preeclampsia (high blood pressure) ☐ Gestational diabetes ☐ Post-partum depression

☐ Issues with breast feeding ☐ Bleeding/clotting issues ☐ Placenta previa

☐ Other _____

Menstrual History

Age at first period _____ Date of last menstrual period _____

Length of cycle _____ Length of period _____

Use of hormonal birth control (*check all that apply*): ☐ Birth control pills ☐ Patch ☐ Vaginal ring ☐ Hormonal IUD ☐ Other

How long have you used hormonal birth control: _____

Any problems with hormonal birth control? ☐ Yes ☐ No

If yes, explain _____

Use of other contraception? ☐ Yes ☐ No ☐ Condoms ☐ Diaphragm ☐ Copper IUD ☐ Partner vasectomy ☐ Sponge ☐ Spermacide ☐ Menstrual cycle tracking ☐ Other: _____

Are you in menopause? ☐ Yes ☐ No If yes, age at last period: _____

Was it surgical menopause? ☐ Yes ☐ No

If yes, explain surgery: _____

Sexual History

Are you sexually active? ☐ Yes ☐ No

If Yes, what gender are your current sexual partners (list all that apply): _____

Have you been sexually active in the past? ☐ Yes ☐ No

If Yes, what gender are your past sexual partners (list all that apply): _____

Have you ever been diagnosed with a sexually transmitted disease (STD)? ☐ Yes ☐ No

If Yes, what STD(s) and list any treatments:

Family History

☐ Adopted
☐ Unknown/incomplete family history

Check family members *who are related to you by blood, that have/had any of the following*

Mother

Age (if still alive) _____ Age at death (if deceased) _____

☐ Heart disease	☐ Cancer	☐ Digestive disorder	☐ Mental health disorder	☐ Other:
☐ High blood pressure	☐ Allergies	☐ Skin conditions	☐ Seizures or convulsions	
☐ High cholesterol	☐ Asthma	☐ Thyroid disease	☐ Dementia	
☐ Stroke	☐ Autoimmune disease	☐ Kidney disease	☐ Genetic disorders	
☐ Diabetes	☐ Arthritis	☐ Osteoporosis		
☐ Obesity		☐ Bleeding disorder		

Include known information about condition(s) and age at diagnosis. Ex: Triple negative breast cancer, age 46:

Father

Age (if still alive) _____ Age at death (if deceased) _____

☐ Heart disease	☐ Cancer	☐ Digestive disorder	☐ Mental health disorder	☐ Other:
☐ High blood pressure	☐ Allergies	☐ Skin conditions	☐ Seizures or convulsions	
☐ High cholesterol	☐ Asthma	☐ Thyroid disease	☐ Dementia	
☐ Stroke	☐ Autoimmune disease	☐ Kidney disease	☐ Genetic disorders	
☐ Diabetes	☐ Arthritis	☐ Osteoporosis		
☐ Obesity		☐ Bleeding disorder		

Include known information about condition(s) and age at diagnosis. Ex: Triple negative breast cancer, age 46:

Brother

Age (if still alive) _____ Age at death (if deceased) _____

☐ Heart disease	☐ Cancer	☐ Digestive disorder	☐ Mental health disorder	☐ Other:
☐ High blood pressure	☐ Allergies	☐ Skin conditions	☐ Seizures or convulsions	
☐ High cholesterol	☐ Asthma	☐ Thyroid disease	☐ Dementia	
☐ Stroke	☐ Autoimmune disease	☐ Kidney disease	☐ Genetic disorders	
☐ Diabetes	☐ Arthritis	☐ Osteoporosis		
☐ Obesity		☐ Bleeding disorder		

Include known information about condition(s) and age at diagnosis. Ex: Triple negative breast cancer, age 46:

Sister

Age (if still alive) _____ Age at death (if deceased) _____

- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke
- ☐ Diabetes
- ☐ Obesity
- ☐ Cancer
- ☐ Allergies
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Arthritis
- ☐ Digestive disorder
- ☐ Skin conditions
- ☐ Thyroid disease
- ☐ Kidney disease
- ☐ Osteoporosis
- ☐ Bleeding disorder
- ☐ Mental health disorder
- ☐ Seizures or convulsions
- ☐ Dementia
- ☐ Genetic disorders
- ☐ Other:

Include known information about condition(s) and age at diagnosis. Ex: Triple negative breast cancer, age 46:

Child

Age (if still alive) _____ Age at death (if deceased) _____

- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke
- ☐ Diabetes
- ☐ Obesity
- ☐ Cancer
- ☐ Allergies
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Arthritis
- ☐ Digestive disorder
- ☐ Skin conditions
- ☐ Thyroid disease
- ☐ Kidney disease
- ☐ Osteoporosis
- ☐ Bleeding disorder
- ☐ Mental health disorder
- ☐ Seizures or convulsions
- ☐ Neurodevelop-mental disorder
- ☐ Genetic disorders
- ☐ Other:

Include known information about condition(s) and age at diagnosis. Ex: Triple negative breast cancer, age 46:

Child

Age (if still alive) _____ Age at death (if deceased) _____

- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke
- ☐ Diabetes
- ☐ Obesity
- ☐ Cancer
- ☐ Allergies
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Arthritis
- ☐ Digestive disorder
- ☐ Skin conditions
- ☐ Thyroid disease
- ☐ Kidney disease
- ☐ Osteoporosis
- ☐ Bleeding disorder
- ☐ Mental health disorder
- ☐ Seizures or convulsions
- ☐ Neurodevelop-mental disorder
- ☐ Genetic disorders
- ☐ Other:

Include known information about condition(s) and age at diagnosis. Ex: Triple negative breast cancer, age 46:

Family History *(continued)*

Child

Age (if still alive) ___________ Age at death (if deceased) ___________

- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke
- ☐ Diabetes
- ☐ Obesity
- ☐ Cancer
- ☐ Allergies
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Arthritis
- ☐ Digestive disorder
- ☐ Skin conditions
- ☐ Thyroid disease
- ☐ Kidney disease
- ☐ Osteoporosis
- ☐ Bleeding disorder
- ☐ Mental health disorder
- ☐ Seizures or convulsions
- ☐ Neurodevelop-mental disorder
- ☐ Genetic disorders
- ☐ Other:

Include known information about condition(s) and age at diagnosis. Ex: Triple negative breast cancer, age 46:

Child

Age (if still alive) ___________ Age at death (if deceased) ___________

- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke
- ☐ Diabetes
- ☐ Obesity
- ☐ Cancer
- ☐ Allergies
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Arthritis
- ☐ Digestive disorder
- ☐ Skin conditions
- ☐ Thyroid disease
- ☐ Kidney disease
- ☐ Osteoporosis
- ☐ Bleeding disorder
- ☐ Mental health disorder
- ☐ Seizures or convulsions
- ☐ Neurodevelop-mental disorder
- ☐ Genetic disorders
- ☐ Other:

Include known information about condition(s) and age at diagnosis. Ex: Triple negative breast cancer, age 46:

Child

Age (if still alive) ___________ Age at death (if deceased) ___________

- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke
- ☐ Diabetes
- ☐ Obesity
- ☐ Cancer
- ☐ Allergies
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Arthritis
- ☐ Digestive disorder
- ☐ Skin conditions
- ☐ Thyroid disease
- ☐ Kidney disease
- ☐ Osteoporosis
- ☐ Bleeding disorder
- ☐ Mental health disorder
- ☐ Seizures or convulsions
- ☐ Neurodevelop-mental disorder
- ☐ Genetic disorders
- ☐ Other:

Include known information about condition(s) and age at diagnosis. Ex: Triple negative breast cancer, age 46:

Maternal Grandmother

Age (if still alive) _____ Age at death (if deceased) _____

- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke
- ☐ Diabetes
- ☐ Obesity
- ☐ Cancer
- ☐ Allergies
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Arthritis
- ☐ Digestive disorder
- ☐ Skin conditions
- ☐ Thyroid disease
- ☐ Kidney disease
- ☐ Osteoporosis
- ☐ Bleeding disorder
- ☐ Mental health disorder
- ☐ Seizures or convulsions
- ☐ Dementia
- ☐ Genetic disorders
- ☐ Other:

Include known information about condition(s) and age at diagnosis. Ex: Triple negative breast cancer, age 46:

Maternal Grandfather

Age (if still alive) _____ Age at death (if deceased) _____

- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke
- ☐ Diabetes
- ☐ Obesity
- ☐ Cancer
- ☐ Allergies
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Arthritis
- ☐ Digestive disorder
- ☐ Skin conditions
- ☐ Thyroid disease
- ☐ Kidney disease
- ☐ Osteoporosis
- ☐ Bleeding disorder
- ☐ Mental health disorder
- ☐ Seizures or convulsions
- ☐ Dementia
- ☐ Genetic disorders
- ☐ Other:

Include known information about condition(s) and age at diagnosis. Ex: Triple negative breast cancer, age 46:

Paternal Grandmother

Age (if still alive) _____ Age at death (if deceased) _____

- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke
- ☐ Diabetes
- ☐ Obesity
- ☐ Cancer
- ☐ Allergies
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Arthritis
- ☐ Digestive disorder
- ☐ Skin conditions
- ☐ Thyroid disease
- ☐ Kidney disease
- ☐ Osteoporosis
- ☐ Bleeding disorder
- ☐ Mental health disorder
- ☐ Seizures or convulsions
- ☐ Dementia
- ☐ Genetic disorders
- ☐ Other:

Include known information about condition(s) and age at diagnosis. Ex: Triple negative breast cancer, age 46:

Paternal Grandfather

Age (if still alive) _____ Age at death (if deceased) _____

- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke
- ☐ Diabetes
- ☐ Obesity
- ☐ Cancer
- ☐ Allergies
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Arthritis
- ☐ Digestive disorder
- ☐ Skin conditions
- ☐ Thyroid disease
- ☐ Kidney disease
- ☐ Osteoporosis
- ☐ Bleeding disorder
- ☐ Mental health disorder
- ☐ Seizures or convulsions
- ☐ Dementia
- ☐ Genetic disorders
- ☐ Other:

Include known information about condition(s) and age at diagnosis. Ex: Triple negative breast cancer, age 46:

Other

Age (if still alive) _____ Age at death (if deceased) _____

- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke
- ☐ Diabetes
- ☐ Obesity
- ☐ Cancer
- ☐ Allergies
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Arthritis
- ☐ Digestive disorder
- ☐ Skin conditions
- ☐ Thyroid disease
- ☐ Kidney disease
- ☐ Osteoporosis
- ☐ Bleeding disorder
- ☐ Mental health disorder
- ☐ Seizures or convulsions
- ☐ Dementia
- ☐ Genetic disorders
- ☐ Other:

Include known information about condition(s) and age at diagnosis. Ex: Triple negative breast cancer, age 46:

Medical History: Illnesses/Conditions

Check NO = a condition you have never had, ***Check YES*** = a condition you currently have
Check PAST = a condition you've had in the past, ***Check UNKNOWN*** = you are unsure if you have or had a condition.

Gastrointestinal				
Appendicitis	☐ No	☐ Yes	☐ Past	☐ Unknown
Celiac disease	☐ No	☐ Yes	☐ Past	☐ Unknown
Crohn's disease/ulcerative colitis	☐ No	☐ Yes	☐ Past	☐ Unknown
Gallstones	☐ No	☐ Yes	☐ Past	☐ Unknown
GERD (reflux)	☐ No	☐ Yes	☐ Past	☐ Unknown
Irritable bowel syndrome	☐ No	☐ Yes	☐ Past	☐ Unknown
Peptic ulcer disease	☐ No	☐ Yes	☐ Past	☐ Unknown
Other:	☐ No	☐ Yes	☐ Past	☐ Unknown
Respiratory				
Asthma	☐ No	☐ Yes	☐ Past	☐ Unknown
Bronchitis	☐ No	☐ Yes	☐ Past	☐ Unknown
Chronic sinusitis	☐ No	☐ Yes	☐ Past	☐ Unknown
Emphysema	☐ No	☐ Yes	☐ Past	☐ Unknown
Pneumonia	☐ No	☐ Yes	☐ Past	☐ Unknown
Sleep apnea	☐ No	☐ Yes	☐ Past	☐ Unknown
Other:	☐ No	☐ Yes	☐ Past	☐ Unknown
Urinary/Genital				
Bacterial vaginosis (BV)	☐ No	☐ Yes	☐ Past	☐ Unknown
Frequent urinary tract infections	☐ No	☐ Yes	☐ Past	☐ Unknown
Frequent yeast infections	☐ No	☐ Yes	☐ Past	☐ Unknown
Gout	☐ No	☐ Yes	☐ Past	☐ Unknown
Interstitial cystitis	☐ No	☐ Yes	☐ Past	☐ Unknown
Kidney stones	☐ No	☐ Yes	☐ Past	☐ Unknown
Premature ejaculation	☐ No	☐ Yes	☐ Past	☐ Unknown
Prostate enlargement (BPH)	☐ No	☐ Yes	☐ Past	☐ Unknown
Prostate infection (prostatitis)	☐ No	☐ Yes	☐ Past	☐ Unknown
Sexual dysfunction	☐ No	☐ Yes	☐ Past	☐ Unknown
Sexually transmitted diseases	☐ No	☐ Yes	☐ Past	☐ Unknown
Other:	☐ No	☐ Yes	☐ Past	☐ Unknown
Endocrine/Metabolic				
Diabetes	☐ No	☐ Yes	☐ Past	☐ Unknown
Endometriosis	☐ No	☐ Yes	☐ Past	☐ Unknown
Fibrocystic breasts	☐ No	☐ Yes	☐ Past	☐ Unknown
Fibroids	☐ No	☐ Yes	☐ Past	☐ Unknown
Hyperthyroidism (overactive thyroid)	☐ No	☐ Yes	☐ Past	☐ Unknown
Hypoglycemia	☐ No	☐ Yes	☐ Past	☐ Unknown
Hypothyroidism (low thyroid)	☐ No	☐ Yes	☐ Past	☐ Unknown
Infertility	☐ No	☐ Yes	☐ Past	☐ Unknown

(continued on the next page)

Medical History: Illnesses/Conditions *(continued)*

Check NO = a condition you have never had, ***Check YES*** = a condition you currently have
Check PAST = a condition you've had in the past, ***Check UNKNOWN*** = you are unsure if you have or had a condition.

Endocrine/Metabolic (*continued*)				
Metabolic syndrome/insulin resistance	☐ No	☐ Yes	☐ Past	☐ Unknown
Ovarian cysts	☐ No	☐ Yes	☐ Past	☐ Unknown
Pelvic inflammatory disease	☐ No	☐ Yes	☐ Past	☐ Unknown
Polycystic ovarian syndrome	☐ No	☐ Yes	☐ Past	☐ Unknown
Prediabetes	☐ No	☐ Yes	☐ Past	☐ Unknown
Weight gain	☐ No	☐ Yes	☐ Past	☐ Unknown
Weight loss	☐ No	☐ Yes	☐ Past	☐ Unknown
Weight fluctuations	☐ No	☐ Yes	☐ Past	☐ Unknown
Other:	☐ No	☐ Yes	☐ Past	☐ Unknown
Inflammatory/Immune				
Autoimmune disease	☐ No	☐ Yes	☐ Past	☐ Unknown
Chronic fatigue syndrome	☐ No	☐ Yes	☐ Past	☐ Unknown
Environmental allergies	☐ No	☐ Yes	☐ Past	☐ Unknown
Food allergies	☐ No	☐ Yes	☐ Past	☐ Unknown
Hepatitis	☐ No	☐ Yes	☐ Past	☐ Unknown
Immune deficiency	☐ No	☐ Yes	☐ Past	☐ Unknown
Lyme disease	☐ No	☐ Yes	☐ Past	☐ Unknown
Mononucleosis	☐ No	☐ Yes	☐ Past	☐ Unknown
Multiple chemical sensitivities	☐ No	☐ Yes	☐ Past	☐ Unknown
Rheumatoid arthritis	☐ No	☐ Yes	☐ Past	☐ Unknown
Other:	☐ No	☐ Yes	☐ Past	☐ Unknown
Musculoskeletal				
Chronic pain	☐ No	☐ Yes	☐ Past	☐ Unknown
Fibromyalgia	☐ No	☐ Yes	☐ Past	☐ Unknown
Growth/developmental disorder	☐ No	☐ Yes	☐ Past	☐ Unknown
Osteoarthritis	☐ No	☐ Yes	☐ Past	☐ Unknown
Osteoporosis	☐ No	☐ Yes	☐ Past	☐ Unknown
Other:	☐ No	☐ Yes	☐ Past	☐ Unknown
Skin				
Acne	☐ No	☐ Yes	☐ Past	☐ Unknown
Eczema	☐ No	☐ Yes	☐ Past	☐ Unknown
Psoriasis	☐ No	☐ Yes	☐ Past	☐ Unknown
Rosacea	☐ No	☐ Yes	☐ Past	☐ Unknown
Seborrheic dermatitis	☐ No	☐ Yes	☐ Past	☐ Unknown
Shingles	☐ No	☐ Yes	☐ Past	☐ Unknown
Vitiligo	☐ No	☐ Yes	☐ Past	☐ Unknown
Other:	☐ No	☐ Yes	☐ Past	☐ Unknown

(continued on the next page)

Medical History: Illnesses/Conditions *(continued)*

Check NO = a condition you have never had, ***Check YES*** = a condition you currently have
Check PAST = a condition you've had in the past, ***Check UNKNOWN*** = you are unsure if you have or had a condition.

Cardiovascular				
Angina	☐ No	☐ Yes	☐ Past	☐ Unknown
Arrythmia (irregular heart rate)	☐ No	☐ Yes	☐ Past	☐ Unknown
Heart attack	☐ No	☐ Yes	☐ Past	☐ Unknown
Heart failure	☐ No	☐ Yes	☐ Past	☐ Unknown
High blood fats (cholesterol, triglycerides)	☐ No	☐ Yes	☐ Past	☐ Unknown
Hypertension (high blood pressure)	☐ No	☐ Yes	☐ Past	☐ Unknown
Mitral valve prolapse	☐ No	☐ Yes	☐ Past	☐ Unknown
Murmur	☐ No	☐ Yes	☐ Past	☐ Unknown
Rheumatic fever	☐ No	☐ Yes	☐ Past	☐ Unknown
Stroke	☐ No	☐ Yes	☐ Past	☐ Unknown
Other:	☐ No	☐ Yes	☐ Past	☐ Unknown
Neurologic/Emotional				
Attention-deficit disorder/ attention-deficit/hyperactivity disorder (ADD/ADHD)	☐ No	☐ Yes	☐ Past	☐ Unknown
Anxiety	☐ No	☐ Yes	☐ Past	☐ Unknown
Autism	☐ No	☐ Yes	☐ Past	☐ Unknown
Balance disorder	☐ No	☐ Yes	☐ Past	☐ Unknown
Dementia	☐ No	☐ Yes	☐ Past	☐ Unknown
Depression	☐ No	☐ Yes	☐ Past	☐ Unknown
Eating disorder	☐ No	☐ Yes	☐ Past	☐ Unknown
Epilepsy/Seizures	☐ No	☐ Yes	☐ Past	☐ Unknown
Memory problems	☐ No	☐ Yes	☐ Past	☐ Unknown
Migraines	☐ No	☐ Yes	☐ Past	☐ Unknown
Multiple sclerosis	☐ No	☐ Yes	☐ Past	☐ Unknown
Parkinson's disease	☐ No	☐ Yes	☐ Past	☐ Unknown
Other:	☐ No	☐ Yes	☐ Past	☐ Unknown
Cancer				
Breast	☐ No	☐ Yes	☐ Past	☐ Unknown
Cervical	☐ No	☐ Yes	☐ Past	☐ Unknown
Colon	☐ No	☐ Yes	☐ Past	☐ Unknown
Fallopian tube	☐ No	☐ Yes	☐ Past	☐ Unknown
Lung	☐ No	☐ Yes	☐ Past	☐ Unknown
Ovarian	☐ No	☐ Yes	☐ Past	☐ Unknown
Penile	☐ No	☐ Yes	☐ Past	☐ Unknown
Prostate	☐ No	☐ Yes	☐ Past	☐ Unknown
Skin	☐ No	☐ Yes	☐ Past	☐ Unknown
Testicular	☐ No	☐ Yes	☐ Past	☐ Unknown
Uterine	☐ No	☐ Yes	☐ Past	☐ Unknown

(continued on the next page)

Medical History: Illnesses/Conditions *(continued)*

Check NO = a condition you have never had, ***Check YES*** = a condition you currently have
Check PAST = a condition you've had in the past, ***Check UNKNOWN*** = you are unsure if you have or had a condition.

Cancer (*continued*)				
Vaginal	☐ No	☐ Yes	☐ Past	☐ Unknown
Vulvar	☐ No	☐ Yes	☐ Past	☐ Unknown
Other:	☐ No	☐ Yes	☐ Past	☐ Unknown
General				
Anemia	☐ No	☐ Yes	☐ Past	☐ Unknown
Bleeding disorder	☐ No	☐ Yes	☐ Past	☐ Unknown
Clotting disorder	☐ No	☐ Yes	☐ Past	☐ Unknown
Genetic disorder	☐ No	☐ Yes	☐ Past	☐ Unknown
Eye disease	☐ No	☐ Yes	☐ Past	☐ Unknown
Hearing impaired	☐ No	☐ Yes	☐ Past	☐ Unknown
Sleep disorder	☐ No	☐ Yes	☐ Past	☐ Unknown
Other:	☐ No	☐ Yes	☐ Past	☐ Unknown

Medical History *(continued)*

Screening Procedures		
Blood tests (cholesterol, blood sugar, etc.)	Date: _____	Results: _____
Bone density	Date: _____	Results: _____
Colonoscopy	Date: _____	Results: _____
Mammogram	Date: _____	Results: _____
Pap test	Date: _____	Results: _____
PSA (prostate specific antigen) test	Date: _____	Results: _____
Other:	Date: _____	Results: _____
Diagnostic Studies		
CT scan	Date: _____	Results: _____
Cardiac stress test	Date: _____	Results: _____
EKG	Date: _____	Results: _____
MRI	Date: _____	Results: _____
Upper endoscopy	Date: _____	Results: _____
Upper GI series	Date: _____	Results: _____
Chest X-ray	Date: _____	Results: _____
Other X-rays	Date: _____	Results: _____
Barium enema	Date: _____	Results: _____
Ultrasound	Date: _____	Results: _____
Other:	Date: _____	Results: _____
Injuries		
Broken bone(s)	Date: _____	Comments: _____
Back injury	Date: _____	Comments: _____
Neck injury	Date: _____	Comments: _____
Head injury	Date: _____	Comments: _____
Other:	Date: _____	Comments: _____
Surgeries		
Appendectomy	Date: _____	Comments: _____
Dental	Date: _____	Comments: _____
Gallbladder	Date: _____	Comments: _____
Hernia	Date: _____	Comments: _____
Hysterectomy	Date: _____	Comments: _____
Tonsillectomy	Date: _____	Comments: _____
Joint Replacement	Date: _____	Comments: _____
Heart surgery	Date: _____	Comments: _____
Vasectomy	Date: _____	Comments: _____
Other:	Date: _____	Comments: _____

(continued on the next page)

Medical History *(continued)*

Hospitalizations	
Date: _____	Reason: _____
Date: _____	Reason: _____
Date: _____	Reason: _____
Date: _____	Reason: _____
Date: _____	Reason: _____

Symptom Review

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

General			
Can't remember dreams	☐ Mild	☐ Moderate	☐ Severe
Cold hands and feet	☐ Mild	☐ Moderate	☐ Severe
Cold intolerance	☐ Mild	☐ Moderate	☐ Severe
Daytime sleepiness	☐ Mild	☐ Moderate	☐ Severe
Difficulty falling asleep	☐ Mild	☐ Moderate	☐ Severe
Early waking	☐ Mild	☐ Moderate	☐ Severe
Fatigue	☐ Mild	☐ Moderate	☐ Severe
Fever	☐ Mild	☐ Moderate	☐ Severe
Flushing	☐ Mild	☐ Moderate	☐ Severe
Heat intolerance	☐ Mild	☐ Moderate	☐ Severe
Low body temperature	☐ Mild	☐ Moderate	☐ Severe
Night waking	☐ Mild	☐ Moderate	☐ Severe
Nightmares	☐ Mild	☐ Moderate	☐ Severe
Sleepwalking	☐ Mild	☐ Moderate	☐ Severe
Head, Eyes, and Ears			
Conjunctivitis	☐ Mild	☐ Moderate	☐ Severe
Distorted sense of smell	☐ Mild	☐ Moderate	☐ Severe
Distorted taste	☐ Mild	☐ Moderate	☐ Severe
Dry Eyes	☐ Mild	☐ Moderate	☐ Severe
Ear fullness	☐ Mild	☐ Moderate	☐ Severe
Ear pain	☐ Mild	☐ Moderate	☐ Severe
Ear ringing/buzzing	☐ Mild	☐ Moderate	☐ Severe
Eye crusting	☐ Mild	☐ Moderate	☐ Severe
Eye pain	☐ Mild	☐ Moderate	☐ Severe
Eyelid margin redness	☐ Mild	☐ Moderate	☐ Severe
Headache	☐ Mild	☐ Moderate	☐ Severe
Hearing loss	☐ Mild	☐ Moderate	☐ Severe
Hearing problems	☐ Mild	☐ Moderate	☐ Severe
Jaw pain	☐ Mild	☐ Moderate	☐ Severe
Sensitivity to loud noises	☐ Mild	☐ Moderate	☐ Severe
Vision problems	☐ Mild	☐ Moderate	☐ Severe
Musculoskeletal			
Back muscle spasm	☐ Mild	☐ Moderate	☐ Severe
Back pain	☐ Mild	☐ Moderate	☐ Severe
Calf cramps	☐ Mild	☐ Moderate	☐ Severe
Chest tightness	☐ Mild	☐ Moderate	☐ Severe
Foot cramps	☐ Mild	☐ Moderate	☐ Severe
Joint deformity	☐ Mild	☐ Moderate	☐ Severe

Musculoskeletal *(continued)*			
Joint pain	☐ Mild	☐ Moderate	☐ Severe
Joint redness	☐ Mild	☐ Moderate	☐ Severe
Joint stiffness	☐ Mild	☐ Moderate	☐ Severe
Muscle pain	☐ Mild	☐ Moderate	☐ Severe
Muscle spasms	☐ Mild	☐ Moderate	☐ Severe
Muscle stiffness	☐ Mild	☐ Moderate	☐ Severe
Muscle twitches	☐ Mild	☐ Moderate	☐ Severe
Around eyes	☐ Mild	☐ Moderate	☐ Severe
Arms or legs	☐ Mild	☐ Moderate	☐ Severe
Muscle weakness	☐ Mild	☐ Moderate	☐ Severe
Neck muscle spasm	☐ Mild	☐ Moderate	☐ Severe
Tendonitis	☐ Mild	☐ Moderate	☐ Severe
Tension headache	☐ Mild	☐ Moderate	☐ Severe
TMJ problems	☐ Mild	☐ Moderate	☐ Severe
Mood/Nerves			
Agoraphobia	☐ Mild	☐ Moderate	☐ Severe
Auditory hallucinations	☐ Mild	☐ Moderate	☐ Severe
Blackouts	☐ Mild	☐ Moderate	☐ Severe
Difficulty:			
Concentrating	☐ Mild	☐ Moderate	☐ Severe
With balance	☐ Mild	☐ Moderate	☐ Severe
With thinking	☐ Mild	☐ Moderate	☐ Severe
With judgment	☐ Mild	☐ Moderate	☐ Severe
With speech	☐ Mild	☐ Moderate	☐ Severe
With memory	☐ Mild	☐ Moderate	☐ Severe
Dizziness (spinning)	☐ Mild	☐ Moderate	☐ Severe
Fainting	☐ Mild	☐ Moderate	☐ Severe
Fearfulness	☐ Mild	☐ Moderate	☐ Severe
Irritability	☐ Mild	☐ Moderate	☐ Severe
Light-headedness	☐ Mild	☐ Moderate	☐ Severe
Numbness	☐ Mild	☐ Moderate	☐ Severe
Other phobias	☐ Mild	☐ Moderate	☐ Severe
Panic attacks	☐ Mild	☐ Moderate	☐ Severe
Paranoia	☐ Mild	☐ Moderate	☐ Severe
Suicidal thoughts	☐ Mild	☐ Moderate	☐ Severe
Tremor/trembling	☐ Mild	☐ Moderate	☐ Severe
Visual Hallucinations	☐ Mild	☐ Moderate	☐ Severe

Symptom Review *(continued)*

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

Cardiovascular			
Angina/chest pain	☐ Mild	☐ Moderate	☐ Severe
Breathlessness	☐ Mild	☐ Moderate	☐ Severe
Palpitations	☐ Mild	☐ Moderate	☐ Severe
Phlebitis	☐ Mild	☐ Moderate	☐ Severe
Sense of racing or rapid heart rate	☐ Mild	☐ Moderate	☐ Severe
Swollen ankles/feet	☐ Mild	☐ Moderate	☐ Severe
Varicose veins	☐ Mild	☐ Moderate	☐ Severe
Urinary			
Bed wetting	☐ Mild	☐ Moderate	☐ Severe
Blood in urine	☐ Mild	☐ Moderate	☐ Severe
Change in stream	☐ Mild	☐ Moderate	☐ Severe
Hesitancy	☐ Mild	☐ Moderate	☐ Severe
Infection	☐ Mild	☐ Moderate	☐ Severe
Kidney disease	☐ Mild	☐ Moderate	☐ Severe
Kidney stone	☐ Mild	☐ Moderate	☐ Severe
Leaking/incontinence (loss of control)	☐ Mild	☐ Moderate	☐ Severe
Nocturia (needing to pee at night)	☐ Mild	☐ Moderate	☐ Severe
Pain/burning	☐ Mild	☐ Moderate	☐ Severe
Prostate enlargement	☐ Mild	☐ Moderate	☐ Severe
Prostate infection	☐ Mild	☐ Moderate	☐ Severe
Urgency	☐ Mild	☐ Moderate	☐ Severe
Digestion			
Anal fissures	☐ Mild	☐ Moderate	☐ Severe
Anal spasms	☐ Mild	☐ Moderate	☐ Severe
Bleeding gums	☐ Mild	☐ Moderate	☐ Severe
Bloating of:			
Lower abdomen	☐ Mild	☐ Moderate	☐ Severe
Whole abdomen	☐ Mild	☐ Moderate	☐ Severe
Bloating after meals	☐ Mild	☐ Moderate	☐ Severe
Blood in stools	☐ Mild	☐ Moderate	☐ Severe
Burping	☐ Mild	☐ Moderate	☐ Severe
Canker sores	☐ Mild	☐ Moderate	☐ Severe
Cavities	☐ Mild	☐ Moderate	☐ Severe
Cold sores	☐ Mild	☐ Moderate	☐ Severe
Constipation	☐ Mild	☐ Moderate	☐ Severe
Cracking at corner of lips	☐ Mild	☐ Moderate	☐ Severe
Dentures w/poor chewing	☐ Mild	☐ Moderate	☐ Severe

Digestion *(continued)*			
Diarrhea	☐ Mild	☐ Moderate	☐ Severe
Difficulty swallowing	☐ Mild	☐ Moderate	☐ Severe
Dry mouth	☐ Mild	☐ Moderate	☐ Severe
Foods regurgitate (reflux)	☐ Mild	☐ Moderate	☐ Severe
Heartburn	☐ Mild	☐ Moderate	☐ Severe
Hemorrhoids	☐ Mild	☐ Moderate	☐ Severe
Intolerance to:			
Lactose	☐ Mild	☐ Moderate	☐ Severe
Dairy products	☐ Mild	☐ Moderate	☐ Severe
Gluten (wheat)	☐ Mild	☐ Moderate	☐ Severe
Corn	☐ Mild	☐ Moderate	☐ Severe
Eggs	☐ Mild	☐ Moderate	☐ Severe
Fatty foods	☐ Mild	☐ Moderate	☐ Severe
Yeast	☐ Mild	☐ Moderate	☐ Severe
Histamines	☐ Mild	☐ Moderate	☐ Severe
Sulfites	☐ Mild	☐ Moderate	☐ Severe
Salicylates	☐ Mild	☐ Moderate	☐ Severe
FODMAPs	☐ Mild	☐ Moderate	☐ Severe
Other:	☐ Mild	☐ Moderate	☐ Severe
Liver disease/jaundice (yellow eyes or skin)	☐ Mild	☐ Moderate	☐ Severe
Lower abdominal pain	☐ Mild	☐ Moderate	☐ Severe
Mucus in stools	☐ Mild	☐ Moderate	☐ Severe
Nausea	☐ Mild	☐ Moderate	☐ Severe
Passing gas	☐ Mild	☐ Moderate	☐ Severe
Periodontal disease	☐ Mild	☐ Moderate	☐ Severe
Sore tongue	☐ Mild	☐ Moderate	☐ Severe
Strong stool odor	☐ Mild	☐ Moderate	☐ Severe
Undigested food in stools	☐ Mild	☐ Moderate	☐ Severe
Upper abdominal pain	☐ Mild	☐ Moderate	☐ Severe
Vomiting	☐ Mild	☐ Moderate	☐ Severe
Eating			
Binge eating	☐ Mild	☐ Moderate	☐ Severe
Caffeine dependency	☐ Mild	☐ Moderate	☐ Severe
Can't gain weight	☐ Mild	☐ Moderate	☐ Severe
Can't lose weight	☐ Mild	☐ Moderate	☐ Severe
Carbohydrate cravings	☐ Mild	☐ Moderate	☐ Severe
Frequent dieting	☐ Mild	☐ Moderate	☐ Severe
Poor appetite	☐ Mild	☐ Moderate	☐ Severe

Symptom Review *(continued)*

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

Eating (*continued*)			
Purging behaviors (ex: laxatives & vomiting)	☐ Mild	☐ Moderate	☐ Severe
Salt cravings	☐ Mild	☐ Moderate	☐ Severe
Sweet cravings	☐ Mild	☐ Moderate	☐ Severe
Respiratory			
Bad breath	☐ Mild	☐ Moderate	☐ Severe
Bad odor in nose	☐ Mild	☐ Moderate	☐ Severe
Cough – dry	☐ Mild	☐ Moderate	☐ Severe
Cough – productive	☐ Mild	☐ Moderate	☐ Severe
Hayfever:	☐ Mild	☐ Moderate	☐ Severe
Spring	☐ Mild	☐ Moderate	☐ Severe
Summer	☐ Mild	☐ Moderate	☐ Severe
Fall	☐ Mild	☐ Moderate	☐ Severe
Change of season	☐ Mild	☐ Moderate	☐ Severe
Hoarseness	☐ Mild	☐ Moderate	☐ Severe
Nasal stuffiness	☐ Mild	☐ Moderate	☐ Severe
Nose bleeds	☐ Mild	☐ Moderate	☐ Severe
Post nasal drip	☐ Mild	☐ Moderate	☐ Severe
Sinus fullness	☐ Mild	☐ Moderate	☐ Severe
Sinus infection	☐ Mild	☐ Moderate	☐ Severe
Snoring	☐ Mild	☐ Moderate	☐ Severe
Sore throat	☐ Mild	☐ Moderate	☐ Severe
Wheezing	☐ Mild	☐ Moderate	☐ Severe
Winter stuffiness	☐ Mild	☐ Moderate	☐ Severe
Nails			
Bitten	☐ Mild	☐ Moderate	☐ Severe
Brittle	☐ Mild	☐ Moderate	☐ Severe
Curve Up	☐ Mild	☐ Moderate	☐ Severe
Frayed	☐ Mild	☐ Moderate	☐ Severe
Fungus – fingers	☐ Mild	☐ Moderate	☐ Severe
Fungus – toes	☐ Mild	☐ Moderate	☐ Severe
Pitting	☐ Mild	☐ Moderate	☐ Severe
Ragged cuticles	☐ Mild	☐ Moderate	☐ Severe
Ridges	☐ Mild	☐ Moderate	☐ Severe
Soft	☐ Mild	☐ Moderate	☐ Severe
Thickening of:			
Fingernails	☐ Mild	☐ Moderate	☐ Severe
Toenails	☐ Mild	☐ Moderate	☐ Severe
White spots/lines	☐ Mild	☐ Moderate	☐ Severe

Lymph Nodes			
Enlarged/neck	☐ Mild	☐ Moderate	☐ Severe
Tender/neck	☐ Mild	☐ Moderate	☐ Severe
Other enlarged/tender lymph nodes	☐ Mild	☐ Moderate	☐ Severe
Dryness of Skin			
Dry skin, in general	☐ Mild	☐ Moderate	☐ Severe
Dry hands	☐ Mild	☐ Moderate	☐ Severe
Cracked skin on hands	☐ Mild	☐ Moderate	☐ Severe
Peeling skin on hands	☐ Mild	☐ Moderate	☐ Severe
Dry feet	☐ Mild	☐ Moderate	☐ Severe
Cracked skin on feet	☐ Mild	☐ Moderate	☐ Severe
Peeling skin on feet	☐ Mild	☐ Moderate	☐ Severe
Dry scalp	☐ Mild	☐ Moderate	☐ Severe
Dandruff	☐ Mild	☐ Moderate	☐ Severe
Dry hair	☐ Mild	☐ Moderate	☐ Severe
Skin Problems			
Acne:			
On back	☐ Mild	☐ Moderate	☐ Severe
On chest	☐ Mild	☐ Moderate	☐ Severe
On face	☐ Mild	☐ Moderate	☐ Severe
On shoulders	☐ Mild	☐ Moderate	☐ Severe
Athlete's foot	☐ Mild	☐ Moderate	☐ Severe
Bumps on back of upper arms	☐ Mild	☐ Moderate	☐ Severe
Cellulite	☐ Mild	☐ Moderate	☐ Severe
Dark circles under eyes	☐ Mild	☐ Moderate	☐ Severe
Ears get red	☐ Mild	☐ Moderate	☐ Severe
Easy bruising	☐ Mild	☐ Moderate	☐ Severe
Herpes – genital	☐ Mild	☐ Moderate	☐ Severe
Hives	☐ Mild	☐ Moderate	☐ Severe
Jock itch	☐ Mild	☐ Moderate	☐ Severe
Lackluster skin	☐ Mild	☐ Moderate	☐ Severe
Moles w color/size change	☐ Mild	☐ Moderate	☐ Severe
Oily skin	☐ Mild	☐ Moderate	☐ Severe
Pale skin	☐ Mild	☐ Moderate	☐ Severe
Patchy dullness	☐ Mild	☐ Moderate	☐ Severe
Rash	☐ Mild	☐ Moderate	☐ Severe
Red face	☐ Mild	☐ Moderate	☐ Severe
Sensitive to bites	☐ Mild	☐ Moderate	☐ Severe

Symptom Review *(continued)*

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

Skin Problems *(continued)*			
Sensitive to poison ivy/oak	☐ Mild	☐ Moderate	☐ Severe
Skin darkening	☐ Mild	☐ Moderate	☐ Severe
Strong body odor	☐ Mild	☐ Moderate	☐ Severe
Thick calluses	☐ Mild	☐ Moderate	☐ Severe
Itching Skin			
Anus	☐ Mild	☐ Moderate	☐ Severe
Arms	☐ Mild	☐ Moderate	☐ Severe
Ear canals	☐ Mild	☐ Moderate	☐ Severe
Eyes	☐ Mild	☐ Moderate	☐ Severe
Feet	☐ Mild	☐ Moderate	☐ Severe
Hands	☐ Mild	☐ Moderate	☐ Severe
Legs	☐ Mild	☐ Moderate	☐ Severe
Nipples	☐ Mild	☐ Moderate	☐ Severe
Nose	☐ Mild	☐ Moderate	☐ Severe
Genitals	☐ Mild	☐ Moderate	☐ Severe
Roof of mouth	☐ Mild	☐ Moderate	☐ Severe
Scalp	☐ Mild	☐ Moderate	☐ Severe
Skin in general	☐ Mild	☐ Moderate	☐ Severe
Throat	☐ Mild	☐ Moderate	☐ Severe
Reproductive			
Breast cysts	☐ Mild	☐ Moderate	☐ Severe
Breast lumps	☐ Mild	☐ Moderate	☐ Severe
Breast tenderness	☐ Mild	☐ Moderate	☐ Severe
Change in sex drive	☐ Mild	☐ Moderate	☐ Severe
Difficulty getting or maintaining erections	☐ Mild	☐ Moderate	☐ Severe
Discharge from penis	☐ Mild	☐ Moderate	☐ Severe
Ejaculation problem	☐ Mild	☐ Moderate	☐ Severe
Impotence	☐ Mild	☐ Moderate	☐ Severe
Infections	☐ Mild	☐ Moderate	☐ Severe
Mass/lumps in testicles	☐ Mild	☐ Moderate	☐ Severe
Menopausal:			
Concentration/ memory problems	☐ Mild	☐ Moderate	☐ Severe
Decreased libido	☐ Mild	☐ Moderate	☐ Severe
Headaches	☐ Mild	☐ Moderate	☐ Severe
Hot flashes	☐ Mild	☐ Moderate	☐ Severe

Reproductive (*continued*)			
Menopausal (*continued*):			
Joint pain	☐ Mild	☐ Moderate	☐ Severe
Loss of control of urine	☐ Mild	☐ Moderate	☐ Severe
Mood swings	☐ Mild	☐ Moderate	☐ Severe
Osteopenia/osteoporosis	☐ Mild	☐ Moderate	☐ Severe
Palpitations	☐ Mild	☐ Moderate	☐ Severe
Vaginal dryness	☐ Mild	☐ Moderate	☐ Severe
Weight gain	☐ Mild	☐ Moderate	☐ Severe
Menstrual:			
Cramps	☐ Mild	☐ Moderate	☐ Severe
Heavy periods	☐ Mild	☐ Moderate	☐ Severe
Irregular periods	☐ Mild	☐ Moderate	☐ Severe
No periods	☐ Mild	☐ Moderate	☐ Severe
Pain	☐ Mild	☐ Moderate	☐ Severe
Scanty periods	☐ Mild	☐ Moderate	☐ Severe
Skipping periods	☐ Mild	☐ Moderate	☐ Severe
Spotting between periods	☐ Mild	☐ Moderate	☐ Severe
Ovarian cysts	☐ Mild	☐ Moderate	☐ Severe
Premenstrual:			
Bloating	☐ Mild	☐ Moderate	☐ Severe
Breast tenderness	☐ Mild	☐ Moderate	☐ Severe
Carbohydrate craving	☐ Mild	☐ Moderate	☐ Severe
Chocolate craving	☐ Mild	☐ Moderate	☐ Severe
Constipation	☐ Mild	☐ Moderate	☐ Severe
Decreased sleep	☐ Mild	☐ Moderate	☐ Severe
Diarrhea	☐ Mild	☐ Moderate	☐ Severe
Fatigue	☐ Mild	☐ Moderate	☐ Severe
Headache	☐ Mild	☐ Moderate	☐ Severe
Increased sleep	☐ Mild	☐ Moderate	☐ Severe
Irritability	☐ Mild	☐ Moderate	☐ Severe
Nausea	☐ Mild	☐ Moderate	☐ Severe
Testicular pain	☐ Mild	☐ Moderate	☐ Severe
Vaginal discharge	☐ Mild	☐ Moderate	☐ Severe
Vaginal odor	☐ Mild	☐ Moderate	☐ Severe
Vaginal itch	☐ Mild	☐ Moderate	☐ Severe
Vaginal pain	☐ Mild	☐ Moderate	☐ Severe

Medications/Supplements

Current medications (include prescription and over-the-counter)

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

Nutritional supplements (vitamins/minerals/herbs etc.)

Name and Brand	Dosage	Start Date (mo/yr)	Reason for Use

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

If yes, describe: _____

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

NSAIDs (Advil, Aleve, Aspirin, Motrin, etc.)? ☐ Yes ☐ No Tylenol (acetaminophen)? ☐ Yes ☐ No

Acid-blocking drugs (Zantac, Prilosec, Nexium, etc.)? ☐ Yes ☐ No

How many times have you taken antibiotics?

Infancy/childhood ☐ 0 ☐ 1-5 ☐ 5 or more Reason for use _____

Teen ☐ 0 ☐ 1-5 ☐ 5 or more Reason for use _____

Adulthood ☐ 0 ☐ 1-5 ☐ 5 or more Reason for use _____

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

If yes, explain: _____

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

Infancy/childhood ☐ Less than 5 ☐ 5 or more Reason for use _____

Teen ☐ Less than 5 ☐ 5 or more Reason for use _____

Adulthood ☐ Less than 5 ☐ 5 or more Reason for use _____

Are you on hormone replacement therapy? ☐ Yes ☐ No

If yes, what hormone(s), for how long, and for what reasons? (Example: Estrogen - 4 years - osteoporosis prevention)?

_____

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 problems with insomnia? ☐ Yes ☐ No Do you snore? ☐ Yes ☐ No

Do you feel rested upon awakening? ☐ Yes ☐ No

Do you use sleeping aids? ☐ Yes ☐ No

If yes, explain: _____

Physical Activity

Current Physical Activity Program:

Activity	Type	# of Times Per Week	Time/Duration (Minutes)
Cardio/Aerobic			
Strength/Resistance			
Flexibility/Stretching			
Balance			
Sports/Leisure (e.g., golf)			
Other:			

Do you feel motivated to exercise? ☐ Yes ☐ A little ☐ No

Are there any problems that limit exercise? ☐ Yes ☐ No

If yes, explain: _____

Do you feel unusually fatigued or sore after exercise? ☐ Yes ☐ No

If yes, explain: _____

Nutrition

Do you currently follow any of the following special diets or nutritional programs? (Check all that apply)

☐ Vegetarian ☐ Vegan ☐ Elimination ☐ Low Fat ☐ Low Carb ☐ High Protein
☐ Blood Type ☐ Low sodium ☐ No Dairy ☐ No Wheat ☐ Gluten Free ☐ Paleo
☐ Mediterranean ☐ Other: _____

Do you have sensitivities to certain foods? ☐ Yes ☐ No

If yes, list food and symptoms: _____

Do you have an aversion to certain foods? ☐ Yes ☐ No

If yes, 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–containing foods (wine, dried fruit, salad bars)
☐ Preservatives ☐ Food colorings ☐ Other foods or food substances: _____

Are there any foods that you crave or binge on? ☐ Yes ☐ No

If yes, what foods? _____

Do you eat 3 meals a day? ☐ Yes ☐ No If no, how many _____

Does skipping a meal greatly affect you? ☐ Yes ☐ No

How many meals do you eat out per week? ☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ More than 5 meals per week

Check the factors that apply to your current lifestyle and eating habits:

- ☐ 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
- ☐ Snack between meals
- ☐ Significant other or family members don't like healthy foods
- ☐ Significant other or family members have special dietary needs
- ☐ Love to eat
- ☐ Eat because I have to
- ☐ Have negative relationship to food
- ☐ Struggle with eating issues
- ☐ Emotional eater (eat when sad, lonely, bored, etc.)
- ☐ Eat too much under stress
- ☐ Eat too little under stress
- ☐ Don't care to cook
- ☐ Confused about nutrition advice

Please record what you eat in a typical day:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Fluids _____

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

Fruits (not juice) _____ Vegetables (not including white potatoes) _____

Legumes (beans, peas, etc) _____ Red meat _____ Fish _____

Dairy/Alternatives _____ Nuts & Seeds _____ Fats & Oils _____

Cans of soda (regular or diet) _____ Sweets (candy, cookies, cake, ice cream, etc.) _____

Do you drink caffeinated beverages? ☐ Yes ☐ No If yes, check amounts:

Coffee (cups per day) ☐ 1 ☐ 2-4 ☐ More than 4

Tea (cups per day) ☐ 1 ☐ 2-4 ☐ More than 4

Caffeinated sodas—regular or diet (cans per day) ☐ 1 ☐ 2-4 ☐ More than 4

Energy drinks (per day) ☐ 1 ☐ 2-4 ☐ More than 4

Do you have adverse reactions to caffeine? ☐ Yes ☐ No

If yes, explain: _____

When you drink caffeine do you feel: ☐ Irritable or wired ☐ Aches or pains

Tobacco

Do you smoke tobacco currently? ☐ Yes ☐ No Packs per day: _____ Number of years _____

What type? ☐ Cigarettes ☐ Smokeless ☐ Pipe ☐ Cigar ☐ E-Cig ☐ Hookah

Have you attempted to quit? ☐ Yes ☐ No

If yes, using what methods: _____

If you smoked previously: Packs per day: _____ Number of years _____

Are you regularly exposed to second-hand smoke? ☐ Yes ☐ No

Do you use any of the following tobacco or nicotine products?

☐ Smokeless tobacco (ex: snuff, dip, chew, snus) ☐ Nicotine (gum, pouches, or dissolvables)

☐ Other _____

Alcohol

How many alcoholic beverages do you drink in a week? *(1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits)*
☐None ☐1-3 ☐4-6 ☐7-10 ☐More than 10

In the past year, how often have you had 4 or more drinks a day? _____

Has drinking ever interfered with your responsibilities or relationships?
☐Yes ☐No ☐Past ☐Unsure

Have you ever wanted to cut back or stop drinking alcohol? ☐Yes ☐No

Other Substances

Are you currently using or have you used any drugs in the past that have not been prescribed to you? ☐No ☐Yes
If yes, which drugs: _____
How many times in the past year have you used these drugs? _____

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

Stress

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 ☐Sometimes

How much stress do each of the following cause on a daily basis *(Rate on scale of 1-10, 10 being highest)*
Work _____ Family _____ Social _____ Finances _____ Health _____ Other _____

Do you use relaxation techniques? ☐Yes ☐No
If yes, how often? _____

Which techniques do you use? *(Check all that apply)*
☐Meditation ☐Breathing ☐Tai Chi ☐Yoga ☐Prayer ☐Other: _____

What are your hobbies or leisure activities? _____

Have you ever sought counseling? ☐Yes ☐No

Are you currently in therapy? ☐Yes ☐No
If yes, describe: _____

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

Relationships

Current relationship status (check all that apply):
☐Not currently in a relationship ☐In a relationship with one person ☐In relationships with multiple partners
☐Married or in civil union ☐Separated ☐Divorced
☐Widowed ☐Choose not to disclose ☐Other: _____

With whom do you live? (Include children, parents, relatives, partners, friends, pets)

_____

Current occupation: _____

Previous occupations: _____

Do you have resources for emotional support? ☐Yes ☐No *(Check all that apply)*
☐Spouse/Partner ☐Family ☐Friends ☐Religious/Spiritual ☐Pets
☐Other: _____

Do you have a religious practice, spiritual practice, or have a sense of connection to something greater than yourself?
☐Yes ☐No
If yes, what kind? _____

Meaning and Purpose

How well have things been going for you?

*(Enter score on scale of 1–10, with 1 being **poorly**, 5 being **fine**, and 10 being **very well**; choose **N/A** if not applicable)*

How Well Have Things Been Going for You?		
Overall	**Score** _____	☐ **N/A**
At school	**Score** _____	☐ **N/A**
In your job	**Score** _____	☐ **N/A**
In your social life	**Score** _____	☐ **N/A**
With close friends	**Score** _____	☐ **N/A**
With sex	**Score** _____	☐ **N/A**
With your attitude	**Score** _____	☐ **N/A**
With your significant other	**Score** _____	☐ **N/A**
With your children	**Score** _____	☐ **N/A**
With your parents	**Score** _____	☐ **N/A**

What matters most to you in your life right now? (this can include mission, aspirations, or purpose)

What brings you a sense of joy and happiness

Readiness Assessment and Health Goals

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 _____
- Take several nutritional supplements each day _____
- Keep a record of everything you eat each day _____
- Modify your lifestyle (e.g., work demands, sleep habits) _____
- Practice a relaxation technique _____
- Engage in regular exercise _____

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

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

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to follow through?

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

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 frequent contact) to 1 (very infrequent contact):

How much ongoing support (e.g., telephone consults, email correspondence) from our professional staff would be helpful to you as you implement your personal health program? _____

Health Goals

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

When was the last time you felt well?

Did something trigger your change in health?

What makes you feel better?

What makes you feel worse?

How does your condition affect you?

What do you think is happening and why?

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