Functional Health Questionnaire

ALL OF THE INFORMATION HEREIN WILL BE TREATED IN ACCORDANCE WITH ALL APPLICABLE CONFIDENTIALITY LAWS AND PRACTICES AND IS INTENDED SOLELY FOR DESERT IV THERAPY.

General Information

NAME _____ **AGE** _____ **TODAY'S DATE** _____ **DATE OF BIRTH** _____

SEX AT BIRTH _____ **CURRENT GENDER IDENTITY** _____

ADDRESS _____ **CITY** _____ **STATE** _____

ZIP _____ **PHONE (HOME)** _____ **(CELL)** _____ **(WORK)** _____

GENETIC BACKGROUND

- ☐ African American
- ☐ Hispanic
- ☐ Mediterranean
- ☐ Asian
- ☐ Native American
- ☐ Caucasian
- ☐ Northern European
- ☐ Other _____

WHEN, WHERE AND FROM WHOM DID YOU LAST RECEIVE MEDICAL OR HEALTH CARE?

EMERGENCY CONTACT 1 _____

RELATIONSHIP _____ **PHONE** _____

EMERGENCY CONTACT 2 _____

RELATIONSHIP _____ **PHONE** _____

HOW DID YOU HEAR ABOUT OUR PRACTICE?

☐ Clinic website ☐ I wbsite ☐ Social media ☐ Referral from doctor ☐ Referral from friend/family ☐ Other _____

Current Health Concerns

Please rank current and ongoing health concerns in order of priority.

DESCRIBE THE PROBLEM	SEVERITY (MILD / MODERATE / SEVERE)	PRIOR TREATMENT/APPROACH	SUCCESS (EXCELLENT / GOOD / FAIR)
Example: Post Nasal Drip	● ○ ○	*Elimination Diet*	● ○ ○
1.	○ ○ ○		○ ○ ○
2.	○ ○ ○		○ ○ ○
3.	○ ○ ○		○ ○ ○
4.	○ ○ ○		○ ○ ○
5.	○ ○ ○		○ ○ ○
6.	○ ○ ○		○ ○ ○
7.	○ ○ ○		○ ○ ○
8.	○ ○ ○		○ ○ ○
9.	○ ○ ○		○ ○ ○

Allergies

NAME OF MEDICATION / SUPPLEMENT / FOOD	REACTION
1.	
2.	
3.	
4.	
5.	

Readiness Assessment & 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? _____

Lifestyle Review

Sleep

HOW MANY HOURS OF SLEEP DO YOU GET EACH NIGHT ON AVERAGE? _____

Problems falling asleep? ◯ Yes ◯ No Staying asleep? ◯ Yes ◯ No Do you feel rested upon awakening? ◯ Yes ◯ No

Problems with insomnia? ◯ Yes ◯ No Do you snore? ◯ Yes ◯ No Do you use sleeping aids? ◯ Yes ◯ No

If yes, explain: _____

Exercise

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: _____

Lifestyle Review

Nutrition

DO YOU CURRENTLY FOLLOW ANY OF THE FOLLOWING SPECIAL DIETS OR NUTRITIONAL PROGRAMS? *(CHECK ALL THAT APPLY)*

☐ Vegetarian ☐ Vegan ☐ Allergy ☐ Elimination ☐ Low Fat ☐ Low Carb ☐ High Protein
☐ Blood Type ☐ Low Sodium ☐ No Dairy ☐ No Wheat ☐ Gluten-Free
☐ 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 food substances: _____

ARE THERE ANY FOODS THAT YOU CRAVE OR BINGE ON? ◯ Yes ◯ No

If yes, what foods? _____

DO YOU EAT THREE (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 ◯ >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
☐ Poor snack choices
☐ 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

Lifestyle Review

Nutrition

PLEASE RECORD WHAT YOU EAT IN A TYPICAL DAY:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Fluids _____

DO YOU DRINK CAFFEINATED BEVERAGES? ◯ Yes ◯ No **IF YES, CHECK AMOUNTS:**

Coffee (cups per day) ◯ 1 ◯ 2-4 ◯ >4 Tea (cups per day) ◯ 1 ◯ 2-4 ◯ >4

Caffeinated sodas—regular or diet (cans per day) ◯ 1 ◯ 2-4 ◯ >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

SMOKING

Do you smoke currently? ◯ Yes ◯ No Packs per day _____ Number of Years _____

What type? ☐ Cigarettes ☐ Smokeless ☐ Pipe ☐ Cigar ☐ E-Cigarette

Have you attempted to quit? ◯ Yes ◯ No If yes, what methods? _____

Have you smoked previously? ◯ Yes ◯ No Packs per day _____ Number of Years _____

Are you regularly exposed to second hand smoke? ◯ Yes ◯ No

ALCOHOL

How many alcoholic beverages do you drink a week? ***(1 Drink = 5oz Wine, 12oz Beer, 1.5oz Spirits)***

◯ 1–3 ◯ 4–6 ◯ 7–10 ◯ >10 ◯ None Previous alcohol intake? ◯ None ◯ Mild ◯ Moderate ◯ Heavy

Have you had an alcohol problem? ◯ Yes ◯ No If yes, when? _____

Explain the problem: _____ Have you thought about getting help your drinking? ◯ Yes ◯ No

OTHER SUBSTANCES

Do you currently use recreational drugs? ◯ Yes ◯ No If yes, what type? _____

Have you used IV or inhaled recreational drugs? _____

Lifestyle Review

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

How much stress do each of the following cause on a daily basis? (*Rate on a scale of 1–10, 10 being highest)*

Work _____ Family _____ Social _____ Finance _____ Health _____ Other _____

Do you use relaxation techniques? ◯ Yes ◯ No

If yes, explain: _____

Which techniques do you use? ☐ Meditation ☐ Breathing ☐ Tai Chi ☐ Yoga ☐ Prayer ☐ Other _____

Have you ever sought counseling? ◯ Yes ◯ No Are you currently in therapy? ◯ Yes ◯ No

If yes, explain: _____

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

What are your hobbies or leisure activities? _____

Relationships

☐ Single ☐ Married ☐ Divorced ☐ Long-term Partner ☐ Polyamorous ☐ Widowed

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

Current Occupation: _____ Previous Occupations: _____

Do you have resources for emotional support? ◯ Yes ◯ No

If yes, check what applies: ☐ Partner ☐ Family ☐ Friends ☐ Religion or Spirituality ☐ Pets ☐ Other _____

Do you have a religious or spiritual practice? ◯ Yes ◯ No If ***yes***, what kind? _____

HOW WELL HAVE THINGS BEEN GOING FOR YOU? *Rate on a scale of 1–10, 10 being highest, N/A if not applicable*

	N/A	POOR				FINE					VERY WELL
Overall	◯	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7	◯ 8	◯ 9	◯ 10
At School	◯	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7	◯ 8	◯ 9	◯ 10
In Your Job	◯	◯ 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 Attitude	◯	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7	◯ 8	◯ 9	◯ 10
With Your Partner	◯	◯ 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 Spouse	◯	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7	◯ 8	◯ 9	◯ 10
With Sex	◯	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5	◯ 6	◯ 7	◯ 8	◯ 9	◯ 10

Lifestyle Review

History

PATIENT'S BIRTH/CHILDHOOD HISTORY

You were born: ◯ Term ◯ Premature ◯ Unsure Were there any pregnancy or birth complications? ◯ Yes ◯ No

If yes, explain: _____

You were: ☐ Breast-fed/How long: _____ ☐ Bottle-fed/Formula: _____ ☐ Don't know

Age of introduction of Solid food: _____ Wheat: _____ Dairy: _____

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

If yes, what foods and what symptoms? *(Ex: milk-gas and diarrhea)* _____

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

DENTAL HISTORY

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

☐ Silver Mercury Fillings _____ ☐ Gold Fillings _____ ☐ Root Canals _____ ☐ Implants _____ ☐ Caps/Crowns _____

☐ Tooth Pain _____ ☐ Bleeding Gums _____ ☐ Gingivitis _____ ☐ Problems Chewing Other : _____

Have you had any mercury fillings removed? ◯ Yes ◯ No If yes, when? _____ Number of fillings as a kid: _____

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

ENVIRONMENTAL/DETOXIFICATION HISTORY

Do any of these significantly affect you? ☐ Cigarette Smoke ☐ Perfume/Cologne ☐ 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 Environments ☐ Carpets or Rugs ☐ Old Paint ☐ Stagnant/Stuffy Air ☐ Smokers

☐ Pesticides ☐ Herbicides ☐ Airplane Travel ☐ Cleaning Chemicals ☐ Harsh Chemicals

☐ Heavy Metals ☐ Other: _____

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

If yes, list 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 & Outside

If yes, how many? _____ Type(s) of animal(s): _____

Women's History (Skip If Male)

OBSTETRIC HISTORY *(Check and provide number to all that apply)*

☐ Pregnancies _____ ☐ Miscarriages _____ ☐ Abortions _____ ☐ Living Children _____

☐ Vaginal Deliveries _____ ☐ Cesarean _____ ☐ Term Births _____ ☐ Premature Birth _____

Largest Baby Birth Weight _____ Smallest Baby Birth Weight _____

Did you develop any problems in or after pregnancy? (Toxemia, Diabetes, Postpartum Depression, Breast-feeding Issues) ◯ Yes ◯ No

If yes, explain: _____

Health History

MENSTRUAL HISTORY (Skip If Male)

Age of First Cycle _____ Date of Last Cycle _____ Length of Cycle _____ Time Between Cycles _____

Cramping? ◯ Yes ◯ No Pain? ◯ Yes ◯ No

Have you had premenstrual problems? ◯ Yes ◯ No If yes, describe: _____

Other problems with your cycle? ◯ Yes ◯ No If yes, describe: _____

Use of hormonal birth control? ☐ Birth Control Pills ☐ Birth Control Patch ☐ Nuva Ring ☐ Other _____

Problems with hormonal birth control? ◯ Yes ◯ No If yes, describe: _____

Other forms of contraception? ◯ Yes ◯ No ☐ Condoms ☐ Diaphragm ☐ IUD ☐ Partner Vasectomy

Are you in menopause? ◯ Yes ◯ No If yes, age of last cycle: _____

Was it surgical menopause? ◯ Yes ◯ No If yes, explain surgery: _____

Do you currently have symptomatic problems with menopause? *(Check all that apply)*

☐ Hot Flashes ☐ Mood Swings ☐ Headaches ☐ Joint Pain ☐ Concentration/Memory Issues

☐ Vaginal Dryness ☐ Weight Gain ☐ Decreased Libido ☐ Palpitations ☐ Urine Control Loss

Are you on hormone therapy? ◯ Yes ◯ No If yes, for how long & for what reason? _____

OTHER GYNECOLOGICAL SYMPTOMS *(Check all that apply)*

☐ Endometriosis ☐ Infertility ☐ Fibrocystic Breasts ☐ Pelvic Inflammatory Disease ☐ Other: _____

☐ Ovarian Cysts ☐ Fibroids ☐ Reproductive Cancer ☐ Sexually Transmitted Disease (describe): _____

GYNECOLOGICAL SCREENING/PROCEDURES *(If applicable, provide date)*

Last Pap Test: _____ ◯ Normal ◯ Abnormal

Last Mammogram: _____ ◯ Normal ◯ Abnormal

Last Bone Density: _____ ◯ High ◯ Low ◯ Normal Range

Other Tests & Procedures _____

Men's History (Skip If Female)

Check if applicable:

☐ Testicular Mass ☐ Testicular Pain ☐ Prostate Infection ☐ Change in Libido ☐ Impotence

☐ Premature Ejaculation ☐ Difficulty Obtaining Erection ☐ Loss of Urine Control ☐ Urinary Stream Issues ☐ Vasectomy

☐ Prostate Enlargement ☐ Difficulty Maintaining Erection ☐ Nocturia (urination at night) # of Times per Night: _____

☐ Sexually Transmitted Diseases (describe): _____

SCREENING/PROCEDURES:

Last PSA Test: _____ PSA Level: ◯ 1-2 ◯ 2-4 ◯ 4-10 ◯ >10

Other tests/procedures (list types and dates): _____

Health History

Family History

Check family members who have had any of the following:

	MOTHER	FATHER	BROTHER(S)	SISTER(S)	CHILD 1	CHILD 2	CHILD 3	CHILD 4	MATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	PATERNAL GRANDFATHER	OTHER
Age if Still Alive													
Age of Death if Deceased													
Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes Type:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Autoimmune Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Seizures/Epilepsy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric Disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
ADHD	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Autism	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Irritable Bowel Syndrome	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Genetic Disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Health History

Personal Medical History

Check if you have had any of the following:

Gastrointestinal

- [ ] Irritable Bowel Syndrome
- [ ] GERD (Reflux)
- [ ] Crohn's Disease / Ulcerative Colitis
- [ ] Peptic Ulcer Disease
- [ ] Celiac Disease
- [ ] Gallstones
- [ ] SIBO
- [ ] Other:

Respiratory

- [ ] Bronchitis
- [ ] Asthma
- [ ] Emphysema
- [ ] Pneumonia
- [ ] Sinusitis
- [ ] Sleep Apnea
- [ ] Other:

Urinary / Genital

- [ ] Kidney Stones
- [ ] Gout
- [ ] Interstitial Cystitis
- [ ] Frequent Yeast Infections
- [ ] Yeast Urinary Tract Infections
- [ ] Sexual Dysfunction
- [ ] Sexual Transmitted Diseases
- [ ] Other:

Musculoskeletal

- [ ] Fibromyalgia
- [ ] Osteoarthritis
- [ ] Chronic Pain
- [ ] Other:

Skin

- [ ] Eczema
- [ ] Psoriasis
- [ ] Acne
- [ ] Skin Cancer
- [ ] Other:

Cardiovascular

- [ ] Angina
- [ ] Heart Attack
- [ ] Heart Failure
- [ ] Hypertension (High Blood Pressure)
- [ ] Stroke
- [ ] High Blood Fats (Cholesterol, Triglycerides)
- [ ] Rheumatic Fever
- [ ] Arrhythmia (Irregular Heart Rate)
- [ ] Murmur
- [ ] Mitral Valve Prolapse
- [ ] Other:

Health History

Personal Medical History

Check if you have had any of the following:

Endocrine / Metabolic

- [ ] Diabetes Type:
- [ ] Hypothyroidism (Low Thyroid)
- [ ] Hyperthyroidism (Overactive Thyroid)
- [ ] Polycystic Ovarian Syndrome
- [ ] Infertility
- [ ] Metabolic Syndrome / Insulin Resistance
- [ ] Eating Disorder
- [ ] Hypoglycemia
- [ ] Other:

Inflammatory / Immune

- [ ] Rheumatoid Arthritis
- [ ] Chronic Fatigue Syndrome
- [ ] Food Allergies
- [ ] Environmental Allergies
- [ ] Multiple Chemical Sensitivities
- [ ] Autoimmune Disease
- [ ] Immune Deficiency
- [ ] Mononucleosis
- [ ] Hepatitis
- [ ] Other:

Neurological / Emotional

- [ ] Epilepsy / Seizures
- [ ] ADD / ADHD
- [ ] Headaches
- [ ] Migraines
- [ ] Depression
- [ ] Anxiety
- [ ] Autism
- [ ] Multiple Sclerosis
- [ ] Parkinson's Disease
- [ ] Dementia
- [ ] Other:

Cancer

- [ ] Lung
- [ ] Breast
- [ ] Colon
- [ ] Ovarian
- [ ] Skin
- [ ] Other:

Health History

Personal Medical History

Check if you have had any of the following:

Diagnostic Studies	Date	Additional Information
Bone Density		
CT Scan		
Colonoscopy		
Cardiac Stress Test		
EKG		
MRI		
Upper Endoscopy		
Chest X-Ray		
Other		
Other		

Injuries	Date	Additional Information
Concussion		
Head Injury		
Other		
Other		

Surgeries (Please List)	Date	Additional Information

Hospitalizations	Date	Additional Information

Health History

Symptom Review

Check if you have had any of the following and write details on the textbox if you'd like to elaborate.

General

- [ ] Cold Hands & Feet
- [ ] Cold Intolerance
- [ ] Daytime Sleepiness
- [ ] Difficulty Falling Asleep
- [ ] Early Waking
- [ ] Fatigue
- [ ] Fever
- [ ] Flushing
- [ ] Nightmares
- [ ] Can't Remember Dreams
- [ ] Low Body Temperature

Head, Eyes, & Ears

- [ ] Conjunctivitis
- [ ] Distorted Sense of Smell
- [ ] Distorted Taste
- [ ] Ear Fullness
- [ ] Ear Ringing/Buzzing
- [ ] Eye Crusting
- [ ] Eye Pain
- [ ] Eyelid Margin Redness
- [ ] Headache
- [ ] Hearing Loss
- [ ] Hearing Problems
- [ ] Migraine
- [ ] Loud Noise Sensitivity
- [ ] Vision Problems

Musculoskeletal

- [ ] Back Muscle Spasms
- [ ] Calf Cramps
- [ ] Chest Tightness
- [ ] Foot Cramps
- [ ] Joint Deformity
- [ ] Joint Pain
- [ ] Joint Redness
- [ ] Joint Stiffness
- [ ] Muscle Pain
- [ ] Muscle Spasms
- [ ] Muscle Twitches:
  - [ ] Around Eyes
  - [ ] Arms or Legs
- [ ] Muscle Weakness
- [ ] Neck Muscle Spasms
- [ ] Tendinitis
- [ ] Tension Headache
- [ ] TMJ Problems

Mood / Nerves

- [ ] Agoraphobia
- [ ] Anxiety
- [ ] Auditory Hallucinations
- [ ] Blackouts
- [ ] Depression
- [ ] Difficulty:
  - [ ] Concentrating
  - [ ] with Balance
  - [ ] with Thinking
  - [ ] with Judgment
  - [ ] with Speech
  - [ ] with Memory

Health History

Symptom Review

Check if you have had any of the following, and write details on the textbox if you'd like to elaborate.

Mood / Nerves (continued)

- [ ] Dizziness (spinning)
- [ ] Fainting
- [ ] Fearfulness
- [ ] Irritability
- [ ] Lightheadedness
- [ ] Numbness
- [ ] Other Phobias
- [ ] Panic Attacks
- [ ] Paranoia
- [ ] Seizures
- [ ] Suicidal Thoughts
- [ ] Tingling
- [ ] Tremor / Trembling
- [ ] Visual Hallucinations

Cardiovascular

- [ ] Angina / Chest Pain
- [ ] Breathlessness
- [ ] Heart Attack
- [ ] Heart Murmur
- [ ] High Blood Pressure
- [ ] Irregular Pulse
- [ ] Vitral Valve Prolapse
- [ ] Palpitations
- [ ] Phlebitis
- [ ] Swollen Ankles / Feet
- [ ] Varicose Veins

Urinary

- [ ] Bed Wetting
- [ ] Hesitancy
- [ ] Infection
- [ ] Kidney Disease
- [ ] Kidney Stone
- [ ] Leaking / Incontinence
- [ ] Pain / Burning
- [ ] Urgency

Digestion

- [ ] Anal Spasms
- [ ] Bad Teeth
- [ ] Bleeding Gums
- [ ] Bloating:
  - [ ] of Lower Abdomen
  - [ ] of Whole Abdomen
  - [ ] After Meals
- [ ] Blood in Stool
- [ ] Burping
- [ ] Canker Sores
- [ ] Cold Sores
- [ ] Constipation
- [ ] Cracking at Corner of Lips
- [ ] Poor Chewing with Dentures
- [ ] Diarrhea
- [ ] Difficulty Swallowing
- [ ] Dry Mouth
- [ ] Flatulence
- [ ] Fissures
- [ ] Foods "Repeat" (Reflux)
- [ ] Heartburn
- [ ] Hemorrhoids

Health History

Symptom Review

Check if you have had any of the following, and write details on the textbox if you'd like to elaborate.

Digestion (continued)

- [ ] Intolerance to:
  - [ ] Lactose
  - [ ] All Dairy Products
  - [ ] Gluten (Wheat)
  - [ ] Corn
  - [ ] Eggs
  - [ ] Fatty Foods
  - [ ] Yeast
- [ ] Liver Disease / Jaundice
- [ ] Lower Abdominal Pain
- [ ] Mucus in Stool
- [ ] Nausea
- [ ] Periodontal Disease
- [ ] Sore Tongue
- [ ] Strong Stool Odor
- [ ] Undigested Food in Stool
- [ ] Upper Abdominal Pain
- [ ] Vomiting

Eating

- [ ] Binge Eating
- [ ] Bulimia
- [ ] Can't Gain Weight
- [ ] Can't Lose Weight
- [ ] Carbohydrate Craving
- [ ] Carbohydrate Intolerance
- [ ] Poor Appetite
- [ ] Salt Cravings
- [ ] Frequent Dieting
- [ ] Sweet Cravings
- [ ] Caffeine Dependency

Respiratory

- [ ] Bad Breath
- [ ] Bad Odor in Nose
- [ ] Dry Cough
- [ ] Productive Cough
- [ ] Hay Fever
  - [ ] Spring
  - [ ] Summer
  - [ ] Fall
  - [ ] Winter
  - [ ] Change of Season
- [ ] Hoarseness
- [ ] Nasal Stuffiness
- [ ] Nose Bleeds
- [ ] Post Nasal Drip
- [ ] Sinus Fullness
- [ ] Sinus Infection
- [ ] Snoring
- [ ] Sore Throat
- [ ] Wheezing
- [ ] Winter Stuffiness

Nails

- [ ] Bitten
- [ ] Brittle
- [ ] Curve Up
- [ ] Frayed
- [ ] Finger Fungus
- [ ] Toe Fungus
- [ ] Pitting
- [ ] Ragged Cuticles
- [ ] Ridges

Health History

Symptom Review

Check if you have had any of the following, and write details on the textbox if you'd like to elaborate.

Nails (continued)

- [ ] Soft
- [ ] Thickening of:
  - [ ] Fingernails
  - [ ] Toenails
- [ ] White Spots / Lines

Lymph Nodes

- [ ] Enlarged / Neck
- [ ] Tender / Neck
- [ ] Other Enlarged or Tender Lymph Nodes

Skin Dryness

- [ ] Eyes
- [ ] Feet
  - [ ] Cracking
  - [ ] Peeling
- [ ] Hair
  - [ ] And Unmanageable?
- [ ] Hands
  - [ ] Cracking
  - [ ] Peeling
- [ ] Mouth / Throat
- [ ] Scalp
  - [ ] Dandruff
- [ ] Skin in General

Skin Problems

- [ ] Acne
  - [ ] On Back
  - [ ] On Chest
  - [ ] On Face
  - [ ] On Shoulders
- [ ] Athlete's Foot
- [ ] Bumps on Back of Upper Arms
- [ ] Cellulite
- [ ] Dark Circles Under Eyes
- [ ] Ears Get Red
- [ ] Easy Bruising
- [ ] Eczema
- [ ] Herpes - Genital
- [ ] Hives
- [ ] Jock Itch
- [ ] Lackluster Skin
- [ ] Moles with Color / Size Change
- [ ] Oily Skin
- [ ] Pale Skin
- [ ] Patchy Dullness
- [ ] Psoriasis
- [ ] Rash
- [ ] Red Face
- [ ] Sensitive to Bites
- [ ] Sensitive to Poison Ivy / Oak
- [ ] Shingles
- [ ] Skin Cancer
- [ ] Skin Darkening
- [ ] Strong Body Odor
- [ ] Thick Calluses
- [ ] Vitiligo

Health History

Symptom Review

Check if you have had any of the following, and write details on the textbox if you'd like to elaborate.

Itching Skin

- [ ] Anus
- [ ] Arms
- [ ] Ear Canals
- [ ] Eyes
- [ ] Feet
- [ ] Hands
- [ ] Legs
- [ ] Nipples
- [ ] Nose
- [ ] Genitals
- [ ] Roof of Mouth
- [ ] Scalp
- [ ] Skin in General
- [ ] Throat

Male Reproductive *(Skip If Female)*

- [ ] Discharge From Penis
- [ ] Ejaculation Problem
- [ ] Genital Pain
- [ ] Impotence
- [ ] Infection
- [ ] Lumps in Testicles
- [ ] Poor Libido (Low Sex Drive)

Female Reproductive *(Skip If Male)*

- [ ] Breast Cysts
- [ ] Breast Lumps
- [ ] Breast Tenderness
- [ ] Ovarian Cyst
- [ ] Poor Libido (Sex Drive)
- [ ] Endometriosis
- [ ] Fibroids
- [ ] Infertility
- [ ] Vaginal Discharge
- [ ] Vaginal Odor
- [ ] Vaginal Itch
- [ ] Vaginal Pain
- [ ] Premenstrual:
  - [ ] Bloating
  - [ ] Breast Tenderness
  - [ ] Carbohydrate Craving
  - [ ] Chocolate Craving
  - [ ] Constipation
  - [ ] Decreased Sleep
  - [ ] Diarrhea
  - [ ] Fatigue
  - [ ] Increased Sleep
  - [ ] Irritability
- [ ] Menstrual:
  - [ ] Cramps
  - [ ] Heavy Periods
  - [ ] Irregular Periods
  - [ ] No Periods
  - [ ] Scanty Periods
  - [ ] Spotting Between

Health History

Current Medications

Medication	Dosage	Start Date	Reason for Use

Health History

Current Supplements

Supplement	Dosage	Start Date	Reason for Use

Health History

Current Supplements

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 time?

Tylenol (Acetaminophen)? ◯ Yes ◯ No

NSAIDs (Advil, Aleve, etc.), Motrin, Aspirin? ◯ Yes ◯ No

Acid-Blocking Drugs (Zantac, Prilosec, Nexium, etc.)? ◯ Yes ◯ No

HOW MANY TIMES HAVE YOU TAKEN ANTIBIOTICS?

Childhood: ◯ <5 ◯ >5 Reason for Use: _____

Teen: ◯ <5 ◯ >5 Reason for Use: _____

Adult: ◯ <5 ◯ >5 Reason for Use: _____

Have you ever taken long-term antibiotics? ◯ Yes ◯ No If yes, explain: _____

HOW OFTEN HAVE YOU TAKEN ORAL STEROIDS (CORTISONE, PREDNISONE, ETC.)?

Childhood: ◯ <5 ◯ >5 Reason for Use: _____

Teen: ◯ <5 ◯ >5 Reason for Use: _____

Adult: ◯ <5 ◯ >5 Reason for Use: _____

Health History

Readiness Assessment & Health Goals

RATE ON A SCALE OF 1 (NOT WILLING) TO 5 (VERY WILLING):

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

Significantly modify your diet	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Take several nutritional supplements each day	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Keep a record of everything you eat each day	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Modify your lifestyle (e.g., work demands, sleep habits)	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Practice a relaxation technique	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5
Engage in regular exercise	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5

RATE ON A SCALE OF 5 (VERY CONFIDENT) TO 1 (NOT CONFIDENT AT ALL):

How confident are you to organize & follow through on the above activities?	◯ 1	◯ 2	◯ 3	◯ 4	◯ 5

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 1 (VERY UNSUPPORTIVE) TO 5 (VERY SUPPORTIVE):

At the present time, how supportive do you think the people in your household will be to your implementing the above changes?

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

RATE ON A SCALE OF 5 (VERY) FREQUENT CONTACT TO 1 (VERY INFREQUENT CONTACT):

How much ongoing support from our professional staff would be helpful to you as you implement your personal health program?

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Comments:

Any additional information you would like to share: