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Health Questionnaire Form

Welcome to Thrive Optimal Wellness! Please complete the following form and return to our office before your scheduled appointment.

GENERAL INFORMATION

Date:

First Name: MI: Last:

Preferred Name:

Street Address:

City: State: Zip Code:

Cell Phone: Work Phone:

Email:

Age: Date of Birth: Gender: ❑ Female ❑ Male ❑ Non-Binary

Occupation: # of hours per week:

Genetic Background: Please check appropriate box(es):

❑ African American ❑ Native American ❑ Hispanic ❑ Asian

❑ Mediterranean ❑ Caucasian ❑ Northern European ❑ Other

Are you retired? ❑ Yes ❑ No

How did you hear about our office?

❑ Friend ❑ Family member ❑ Website ❑ Social Media ❑ Other

Have any other family members been to our clinic? If yes, who?

Emergency Contact:

Relationship: Phone:

Who is your primary care physician?

PERSONAL INFORMATION

Marital Status:

❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Single ❑ Partnership

Number of children: _____

Child's Name	Age	Gender
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Number of Siblings: Sisters _____ (# deceased: _____) Brothers: _____ (# deceased: _____)

Are you adopted? ❑ Yes ❑ No What is your birth order? _____

Who lives in your home with you? (Include children, parents, relatives, and/or friends.)

_____

_____

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

If yes, where do they live? ❑ Indoors ❑ Outdoors ❑ Both indoors and outdoors

Have you ever lived or travelled outside the United States? ❑ Yes ❑ No

If yes, when and where? _____

_____

_____

If yes, did you get sick during your travel or shortly after returning home? ❑ Yes ❑ No

If yes, describe your symptoms and experience: _____

_____

_____

Have you or your family recently experienced any major life changes or unexpected trauma?

❑ Yes ❑ No If yes, please comment: _____

_____

Have you experienced any major losses in life? ❑ Yes ❑ No

If so, please comment: _____

_____

_____

Have you been unable to work or go to school in the past year because of your health issues?

❑ Yes ❑ No

If yes, how many days have you missed in the past 12 months?

❑ 0-3 days ❑ 4-6 days ❑ 7-14 days ❑ 15 or more days

Where have you previously worked? _____

_____

_____

What is your highest level of education?

❑ High School

❑ College _____ Major: _____ Year: _____

❑ Graduate School _____ Field: _____ Year: _____

❑ Professional School _____ Field: _____ Year: _____

Did you have difficulty learning while in school? ❑ Yes ❑ No

FUNCTIONAL WELLNESS INFORMATION

The following information is designed to help us get to know you better. If you are unsure of the answers to any questions, you may need to reach out to other family members for additional insight. Please be as thoughtful and accurate as possible, noting even the smallest symptoms or incidents as these can often provide additional clues as to what might be going on. And be sure to write your answers as clearly as possible.

Please list **in order of importance** the health problems you are most concerned about. Be sure to note how long each one has been present.

Health Issue	Date of Onset	Frequency (constant, occasionally, infrequently)	Severity (mild, moderate, severe)
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Have you previously received any formal diagnosis of any of these health issues?

_____

_____

Do you have chronic pain? ❑ Yes ❑ No

If yes, please describe: _____

_____

Do you have chronic inflammation? ❑ Yes ❑ No

If yes, please describe: _____

_____

When was the last time you really felt well? _____

_____

YOUR HEALTH GOALS

What do you hope to achieve by working with us? (Please be thoughtful and very honest in your response.)

_____

_____

_____

If you had a magic wand and could erase three problems, what would they be?

1. _____

2. _____

3. _____

List up to 5 things that you have been unable to do as a result of your present symptoms. Please be specific.

_____

_____

_____

_____

_____

List up to 5 things that you plan to do once you are feeling better. Please be specific.

_____

_____

_____

_____

_____

Are there any other health goals you want to achieve?

_____

_____

_____

_____

_____

Was there a specific trigger or occurrence just prior to the change in your health (i.e., illness, personal loss, travel, etc.)?

_____

_____

Are there certain things that make you feel worse? _____

_____

What makes you feel better? _____

_____

When was your last visit to your primary care doctor and what was the reason for the visit?

_____

Please list the healthcare practitioners you've consulted with for your health concerns and what was done or recommended by each:

Name _____

Recommendations or Action: _____

Name _____

Recommendations or Action: _____

Name _____

Recommendations or Action: _____

Name _____

Recommendations or Action: _____

Name _____

Recommendations or Action: _____

Name _____

Recommendations or Action: _____

Place a check mark in the box next to alternative therapies you have already tried:

- ❑ None
- ❑ Chiropractic
- ❑ Acupuncture
- ❑ Iridology
- ❑ Colonics
- ❑ Massage
- ❑ Rolfing
- ❑ Reiki
- ❑ Homeopathy
- ❑ Biofeedback
- ❑ Yoga
- ❑ Hypnosis
- ❑ Ayurveda
- ❑ Light therapy
- ❑ Meditation
- ❑ Environmental medicine
- ❑ Nutritional therapy
- ❑ Biological Dentistry
- ❑ IV (chelation) therapy
- ❑ Naturopathic medicine

ILLNESSES

List any illnesses you've had over the course of your life (i.e., chicken pox, tonsillitis, mononucleosis, anemia, bronchitis, food poisoning, digestive issues, kidney stones, sinus infections, gall bladder, thyroid blood pressure, etc.). Try to be as thorough as possible. Nothing is insignificant. Be sure to note the dates if the illness happened more than once.

Illness	Date	Date	Date	Comments

INJURIES

List any injuries you've had over the course of your life (i.e. auto accident, bicycle fall, head injury, trip and fall, bone break, etc.). Try to be as thorough as possible. Nothing is insignificant.

Injury	Date	Comments

DIAGNOSTIC TESTING

List any advanced testing you've had over the course of your life (i.e., endoscopy, colonoscopy, mammogram, thermogram, chest x-ray, EKG, CAT scan, bone density, MRI, carotid artery ultrasounds, etc.). Try to be as thorough as possible.

Type of Test	Date	Comments

SURGERIES

List any surgeries you've had over the course of your life (i.e., gall bladder removal, tonsillectomy, tubes in your ears, appendectomy, hernia repair, hysterectomy, dental, cosmetic or reconstructive surgery, joint replacement, etc.). Try to be as thorough as possible.

Surgery	Date	Comments

HOSPITALIZATIONS

Note any overnight or long-term hospitalizations you've had over the course of your life. Provide as much information about the reason for the hospitalization as you can.

Where Hospitalized	Date	Reason

BIRTH HISTORY

	Yes	No	Unsure	Comment
Were you carried to full-term?	❑	❑	❑	
Vaginal delivery?	❑	❑	❑	
Cesarean section?	❑	❑	❑	
Epidural used?	❑	❑	❑	
Breast fed? (how long?)	❑	❑	❑	
Bottle fed? (how long?)	❑	❑	❑	
Did your mother smoke tobacco while pregnant with you?	❑	❑	❑	
Did she drink alcohol?	❑	❑	❑	
Did she take any forms of estrogen?	❑	❑	❑	

CHILDHOOD DIETARY HISTORY

Which of the following were part of your regular diet?	Yes	No	Don't Know	Comment
Sugar/candy/sweets	❑	❑	❑	
Regular soda	❑	❑	❑	
Diet soda	❑	❑	❑	
White bread	❑	❑	❑	
Ice cream	❑	❑	❑	
Fruits and vegetables	❑	❑	❑	
High quality meats	❑	❑	❑	
Raw dairy	❑	❑	❑	
Butter or other healthy fats	❑	❑	❑	
Potatoes, rice or pasta	❑	❑	❑	
High amount of grains	❑	❑	❑	
Vegetarian only	❑	❑	❑	
Vegetarian with milk and eggs	❑	❑	❑	

Were there any foods that you avoided because they bothered you?

Food	Symptom	Other Comments

SPECIFIC CHILDHOOD ILLNESSES OR OTHER HEALTH CONSIDERATIONS

Although these may have been mentioned previously, please note the approximate age when any of the following occurred (from birth to age 15). Provide additional information as necessary in the space below.

❑ Frequent colds or flu (age) _____	❑ Tonsillitis (age) _____
❑ Bronchitis or pneumonia (age) _____	❑ Skin disorders (i.e. eczema) (age) _____
❑ Measles (age) _____	❑ Mumps (age) _____
❑ Chicken Pox (age) _____	❑ Whooping Cough (age) _____
❑ Strep throat infections (age) _____	❑ Seasonal allergies (age) _____
❑ Significant dental work (age) _____	❑ Behavior problems (age) _____
❑ ADD or difficulty learning (age) _____	❑ Hyperactivity (age) _____
❑ Abusive or alcoholic parent(s) (age) _____	❑ Frequent headaches (age) _____
❑ High # of absences from school (age) _____	❑ Upset stomach, indigestion (age) _____
❑ Jaundice (age) _____	❑ Colic (age) _____
❑ Ear infections (age) _____	❑ Congenital abnormalities (age) _____
❑ Fever blisters (age) _____	❑ Exposure to 2nd hand smoke (age) _____
❑ Alcoholic parents (age) _____	❑ Physical or emotional abuse (age) _____
❑ Major illness(es) requiring hospitalization (age) _____	❑ Other: _____ (age) _____

Additional information: _____

_____

_____

_____

_____

_____

IMMUNIZATION HISTORY

Please indicate which of the following vaccines you had as a child or adult:

- ❑ Smallpox
- ❑ Tetanus
- ❑ Diphtheria
- ❑ Pertussis
- ❑ Polio (oral)
- ❑ Polio (injection)
- ❑ Mumps
- ❑ Measles
- ❑ Rubella (German measles)
- ❑ Typhoid
- ❑ Cholera

FAMILY HISTORY

Complete the following, noting the age at which your family member experienced any of the following issues.

	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Current age												
If deceased, age at death												
Heart Attack												
Stroke												
Uterine cancer												
Colon cancer												
Breast cancer												
Ovarian cancer												
Prostate cancer												
Skin cancer												
Other cancer												
ADD/ADHD												
ALS or other Motor Neuron Diseases												
Alzheimer's												
Anemia												
Anxiety												
Arthritis												
Asthma												
Autism												
Autoimmune Diseases												
Bipolar disease												
Bladder disease												
Blood clotting problems												
Celiac disease												
Dementia												
Depression												
Diabetes												
Eczema												
Emphysema												
Environmental sensitivities												
Epilepsy												
Flu												
Food allergies, sensitivities, or intolerances												
Genetic disorders												
Glaucoma												
Headache												
Heart disease												
High blood pressure												
Elevated cholesterol												
Inflammatory Bowel Disease												
Insomnia												
Irritable Bowel Syndrome												

	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Kidney disease												
Macular degeneration												
Multiple Sclerosis												
Nervous breakdown												
Obesity												
Osteoporosis												
Parkinson's												
Pneumonia/Bronchitis												
Psoriasis												
Psychiatric disorders												
Schizophrenia												
Sleep apnea												
Smoking addiction												
Stroke												
Substance abuse (such as alcoholism)												
Ulcers												

Any other illnesses or conditions not listed here that we should know about? If so, please describe:

_____

_____

FEMALE MEDICAL HISTORY

(For women only)

OBSTETRICS HISTORY

Select all that apply and note number of occurrences.

❑ Pregnancies _____	❑ Post-partum depression _____
❑ Miscarriages _____	❑ Toxemia _____
❑ Vaginal deliveries _____	❑ Gestational diabetes _____
❑ Caesarean sections _____	❑ Living children _____
❑ Abortions _____	❑ Premature deliveries _____

GYNECOLOGICAL HISTORY

Onset of menses (age): _____ Length of bleeding: _____

Date of last menstrual period: _____/_____/_____ ❑ N/A

Painful menstruation: ❑ Yes ❑ No ❑ N/A Clotting: ❑ Yes ❑ No ❑ N/A

Breast tenderness: ❑ Yes ❑ No Water retention around your period: ❑ Yes ❑ No ❑ N/A

PMS: ❑ Yes ❑ No Have you had your uterus removed? ❑ Yes ❑ No

Have you had a complete hysterectomy? ❑ Yes ❑ No

If yes, please explain why: _____

_____

Are you currently using any form of contraception: ❑ Yes ❑ No

If yes, which of the following:

Hormonal Contraception	**Non-Hormonal Contraception**
❑ Birth control pills	❑ Condom
❑ Nuva ring	❑ IUD
❑ Patch	❑ Diaphragm
❑ Other _____	❑ Partner vasectomy
	❑ Other _____

Have you used hormonal birth control in the past, regardless of whether you are using it right now? If so, please indicate the type and how long you used it:

_____

_____

Are you menopausal? ❑ Yes ❑ No If yes, age of menopause: _____

Are you currently on any type of hormone replacement therapy or bioidentical hormones? ❑ Yes ❑ No

❑ Estrogen ❑ Estrace ❑ Estriol ❑ Progesterone ❑ Premarin ❑ Provera

❑ Testosterone ❑ DHEA ❑ Other _____

When was your last PAP test? _____/_____/_____ Normal: ❑ Yes ❑ No Abnormal: ❑ Yes ❑ No

Last mammogram: _____/_____/_____ Last thermogram: _____/_____/_____

Have you had a breast biopsy? ❑ Yes ❑ No Results: ❑ Normal ❑ Abnormal

Last bone density scan: _____/_____/_____ Results: ❑ High ❑ Low ❑ Within normal

DENTAL HISTORY

Have you ever had sore gums (gingivitis) in the past? ❑ Yes ❑ No

Have you experienced ringing in the ears (tinnitus)? ❑ Yes ❑ No

Have you had TMJ (temporal mandibular joint) problems? ❑ Yes ❑ No

Do you ever have a 'metallic' taste in your mouth? ❑ Yes ❑ No

Do you have bad breath (halitosis) or a white tongue (thrush)? ❑ Yes ❑ No

Have you worn or do you presently wear braces? ❑ Yes ❑ No

Do you have problems chewing? ❑ Yes ❑ No

Do you floss regularly? ❑ Yes ❑ No

Have you had any root canals? ❑ Yes ❑ No

If yes, how many? _____

Have you had any dental surgeries? ❑ Yes ❑ No

If yes, place the date, description, reason and outcome of the surgery: _____

_____

_____

Did your mother have dental fillings prior to giving birth to you? ❑ Yes ❑ No

Did she have any fillings removed while pregnant with you? ❑ Yes ❑ No

Did you have mercury dental fillings as a child? ❑ Yes ❑ No

If yes, approximately how many fillings did you have up to 18 years of age? _____

Have you had dental fillings as an adult? ❑ Yes ❑ No

If yes, about how many fillings did you have after 18 years of age? _____

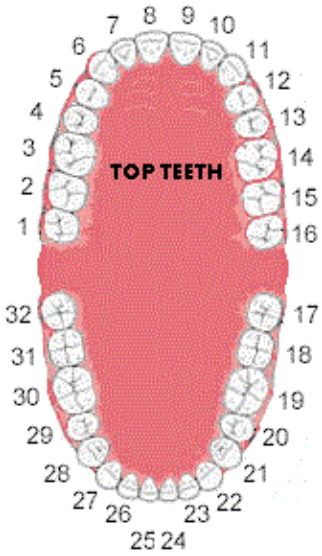
If yes, were any of them mercury? ❑ Yes ❑ No

How many mercury fillings do you have now? _____

Did you play with mercury as a child or adult? ❑ Yes ❑ No

Have you consumed a significant amount of fish in your life? ❑ Yes ❑ No

Please circle the tooth or teeth you have had or still have problems with. Please state what type of problem you have had, for example: root canal, crown, abscessed tooth, partials, etc., and indicate which teeth have fillings.



LEFT SIDE / RIGHT SIDE

RECORD ANSWERS:

_____

_____

_____

_____

_____

_____

_____

_____

ANTIBIOTIC AND STEROID HISTORY

Antibiotics: How often have you taken antibiotics?

	< 5 times	**> 5 times**
Infancy/Childhood		
Teen		
Adulthood		

Oral Steroids: How often have you taken oral steroids (e.g., Prednisone, Cortisone, etc.)?

	< 5 times	**> 5 times**
Infancy/Childhood		
Teen		
Adulthood		

MEDICATION HISTORY

Indicate any medications you're currently taking or have taken in the last month:

❑ Acid Blocking Drugs	❑ Anti-anxiety medications
❑ Antibiotics	❑ Anticonvulsants
❑ Antidepressants	❑ Antifungals
❑ Aspirin/Ibuprofen	❑ Asthma inhalers
❑ Beta blockers	❑ Birth control pills/implant contraceptives
❑ Chemotherapy	❑ Cholesterol lowering medications
❑ Cortisone/steroids	❑ Diabetic medications/insulin
❑ Diuretics	❑ Estrogen or progesterone (pharmaceutical, prescription)
❑ Estrogen or progesterone (natural)	❑ Heart medications
❑ High blood pressure medications	❑ Laxatives
❑ Relaxants/Sleeping pills	❑ Testosterone (natural or prescription)
❑ Thyroid medication	❑ Acetaminophen (Tylenol)
❑ Ulcer medications	❑ Sildenafil citrate (Viagra or similar)

CURRENT MEDICATION LOG

Please indicate the type of medications you are currently taking, ones you've taken in the past and any non-prescription drugs you are currently using.

Medication Name	Date Started	Dated Stopped	Dosage	# per day

CURRENT SUPPLEMENT LOG

Please list all vitamins, minerals, herbs or other nutritional supplements you are currently taking.

Supplement Name/Brand	Dose	Frequency	Dated Started	Reason for Use

Are there any supplement ingredients (animal or otherwise) that you are particularly averse to?

❑ Yes ❑ No

If yes, please describe: _____

_____

Have your medications or supplements ever caused you unusual side effects or problems?

❑ Yes ❑ No

If yes, please describe: _____

_____

ALLERGY HISTORY

Please list any allergies, sensitivities or intolerances you currently have or have had in the past.

Medication, Supplement or Food	Reaction

NUTRITION AND LIFESTYLE HISTORY

Have you made any changes to your diet because of your health? ❑ Yes ❑ No

Do you currently follow a special diet or nutritional program? ❑ Yes ❑ No

If yes, check all that apply:

❑ Low fat
❑ Mixed food diet (animal and vegetable sources)
❑ High protein
❑ Vegetarian
❑ Vegan
❑ Gluten restricted
❑ Low sodium
❑ Fat restriction
❑ Low starch/carbohydrate
❑ The Blood Type Diet
❑ The Metabolic Typing Diet
❑ Paleo Diet
❑ Total calorie restriction
❑ Ovo-lacto diet
❑ Diabetic dietary guidelines
❑ No dairy
❑ No wheat

❑ Specific Program for Weight Loss/Maintenance Type: _____

❑ Other: _____

Please check any specific food restrictions or sensitivities you currently have:

❑ Dairy
❑ Soy
❑ Wheat
❑ Corn
❑ Eggs
❑ All gluten
❑ Other: _____

Is there anything special about your diet that I should know? _____

_____

_____

Height (feet/inches): _____

Current weight: _____

Usual weight range +/- 5 lbs: _____

Desired weight range +/- 5 lbs: _____

Highest adult weight: _____

Lowest adult weight: _____

Do you currently experience weight fluctuations (>10 lbs.)? ❑ Yes ❑ No

How often do you weigh yourself? ❑ Daily ❑ Weekly ❑ Monthly ❑ Rarely ❑ Never

Are there any foods that you avoid because they cause you digestive discomfort or unpleasant symptoms?

❑ Yes ❑ No

If yes, please list the food and the symptom(s) you experience (e.g., wheat—causes gas and bloating).

Food	Symptom	Other Comments

Do you do your own grocery shopping? ❑ Yes ❑ No

If no, who does the shopping? _____

When you shop do you purchase the following?

❑ Organic foods ❑ High-quality fats ❑ Hormone free and antibiotic free meat

❑ Preservative-free foods

Do you read food labels? ❑ Yes ❑ No

Do you cook? ❑ Yes ❑ No

If no, who does the cooking? _____

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

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

- ❑ Fast eater
- ❑ Erratic eating habits
- ❑ Eat too much
- ❑ Late night eater
- ❑ Dislike health food
- ❑ Time constraints
- ❑ Eat more than 50% of meals away from home
- ❑ Travel frequently
- ❑ Non-availability of healthy foods
- ❑ Do not plan meals or menus
- ❑ Reliance on convenience items
- ❑ Poor snack choices
- ❑ Significant other or family members don't like healthy foods
- ❑ Significant other or family members have special dietary needs of 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 nutritional advise
- ❑ Diet often for weight control

CHILDHOOD EATING HISTORY

Which of the following foods were regularly consumed during your childhood?

- ❑ Sugary foods
- ❑ Ice cream
- ❑ Candy
- ❑ Cookies
- ❑ Bread
- ❑ Fast food
- ❑ Processed cheese
- ❑ Meat
- ❑ Vegetables
- ❑ Starches (rice, potatoes, etc.)
- ❑ Vegetarian diet
- ❑ Boxed or packaged foods (Top Ramen, macaroni & cheese, etc.)
- ❑ Artificial colors or sweeteners

Were there foods you avoided because of the way they made you feel? ❑ Yes ❑ No

If so, please explain: _____

_____

_____

FOOD DIARY

Place a check mark next to the food or drink items that are part of your current diet.

Breakfast	Lunch	Usual Dinner
❑ None / don't eat breakfast ❑ Bacon/Sausage ❑ Bagel ❑ Butter ❑ Cereal ❑ Coffee ❑ Donut ❑ Eggs ❑ Granola ❑ Fruit ❑ Juice ❑ Margarine ❑ Milk ❑ Oat bran ❑ Sugar ❑ Sweet roll ❑ Sweetener ❑ Tea ❑ Toast ❑ Water ❑ Wheat bran ❑ Yogurt ❑ Oatmeal ❑ Milk protein shake ❑ Slim fast ❑ Smoothie ❑ Soy protein ❑ Whey protein ❑ Rice protein ❑ Other:	❑ None / don't eat lunch ❑ Butter ❑ Coffee ❑ Eat in a cafeteria ❑ Eat in restaurant ❑ Fish sandwich ❑ Fried foods ❑ Hamburger ❑ Hot dogs ❑ Juice ❑ Leftovers ❑ Lettuce ❑ Margarine ❑ Mayo ❑ Meat sandwich ❑ Milk ❑ Pizza ❑ Potato chips ❑ Salad ❑ Salad dressing ❑ Soda ❑ Soup ❑ Sugar ❑ Sweetener ❑ Tea ❑ Tomato ❑ Vegetables ❑ Quinoa ❑ Fish or chicken ❑ Water ❑ Yogurt ❑ Protein shake ❑ Other:	❑ None / don't eat dinner ❑ Beans (legumes) ❑ Brown rice ❑ Butter ❑ Carrots ❑ Coffee ❑ Fish ❑ Green vegetables ❑ Juice ❑ Margarine ❑ Milk ❑ Pasta ❑ Potato ❑ Poultry ❑ Red meat ❑ Rice ❑ Salad ❑ Salad dressing ❑ Soda ❑ Sugar ❑ Sweetener ❑ Tea ❑ Vinegar ❑ Water ❑ White rice ❑ Yellow vegetables ❑ Other:

Check items that you consume a minimum of 3 days or more each week.

- ❑ Almonds
- ❑ Almond butter
- ❑ Alcohol
- ❑ Apples
- ❑ Avocado
- ❑ Asparagus
- ❑ Bagels
- ❑ Barley
- ❑ Banana
- ❑ Burger King
- ❑ Bacon
- ❑ Bean, lima
- ❑ Bread, white
- ❑ Bread, wheat
- ❑ Bread, rye
- ❑ Bagels
- ❑ Biscuits
- ❑ Bean, pinto
- ❑ Bean, string
- ❑ Broccoli
- ❑ Brazil nuts
- ❑ Brussels Sprouts
- ❑ Blueberries
- ❑ Butter
- ❑ Cabbage
- ❑ Cereal, Special K
- ❑ Cereal, Bran Flakes
- ❑ Cereal, cornflakes
- ❑ Cereal, _____
- ❑ Cereal, _____
- ❑ Celery
- ❑ Cantaloupe
- ❑ Candy
- ❑ Chinese food
- ❑ Cream cheese
- ❑ Carrot
- ❑ Chicken
- ❑ Chili pepper
- ❑ Cinnamon
- ❑ Clam
- ❑ Cloves
- ❑ Cocoa-Chocolate
- ❑ Carnation drink
- ❑ Chewing gum, sweetened
- ❑ Chewing gum, sugar free
- ❑ Coconut
- ❑ Cod
- ❑ Coffee
- ❑ Corn
- ❑ Crab
- ❑ Cranberry
- ❑ Cashew
- ❑ Cheese
- ❑ Cucumber
- ❑ Deli meats
- ❑ Desserts
- ❑ Deli sandwich
- ❑ Eggplant
- ❑ Ensure
- ❑ Flounder
- ❑ Fried foods
- ❑ French fries
- ❑ French toast
- ❑ Garlic
- ❑ Ginger
- ❑ Grape
- ❑ Grits
- ❑ Greek food
- ❑ Grapefruit
- ❑ Grape Nuts
- ❑ Haddock
- ❑ Ham
- ❑ Halibut
- ❑ Herring
- ❑ Hot dogs, pork
- ❑ Hot dogs, beef
- ❑ Hamburgers
- ❑ Hardee's food
- ❑ Honey
- ❑ Italian food
- ❑ Ice cream
- ❑ Indian food
- ❑ Jack in the Box food
- ❑ Japanese food
- ❑ Jelly
- ❑ Ketchup
- ❑ Lamb
- ❑ Lemon
- ❑ Lentil
- ❑ Lettuce
- ❑ Lime
- ❑ Lobster
- ❑ Mackerel
- ❑ Margarine
- ❑ McDonalds food
- ❑ Millet
- ❑ Mung bean
- ❑ Mushroom
- ❑ Mustard
- ❑ Milk, cow
- ❑ Milk, goat
- ❑ Milk, rice
- ❑ Milk, almond
- ❑ Milk, soy
- ❑ Mexican food
- ❑ Malt
- ❑ Nutmeg
- ❑ NutriSweet
- ❑ Oatmeal, regular
- ❑ Oatmeal, instant
- ❑ Olive
- ❑ Onion
- ❑ Orange juice
- ❑ Oregano
- ❑ Oyster
- ❑ Orange
- ❑ Papaya
- ❑ Parsley
- ❑ PopTarts
- ❑ Peanuts
- ❑ Peanut butter
- ❑ Peas
- ❑ Peach
- ❑ Pecan
- ❑ Pepper
- ❑ Pepper, green
- ❑ Perch
- ❑ Pineapple
- ❑ Pancakes
- ❑ Protein shakes, soy
- ❑ Protein shakes, milk
- ❑ Protein shakes, whey
- ❑ Protein shakes, _____
- ❑ Protein shakes, _____
- ❑ Plum
- ❑ Pork
- ❑ Peanut
- ❑ Potato, sweet
- ❑ Potato, white
- ❑ Pumpkin
- ❑ Quinoa
- ❑ Radish
- ❑ Rye
- ❑ Safflower
- ❑ Sage
- ❑ Salt
- ❑ Salmon
- ❑ Scallops
- ❑ Sausage
- ❑ Slim Fast
- ❑ Sweet & Low
- ❑ Sesame
- ❑ Shrimp
- ❑ Snapper
- ❑ Soft drinks
- ❑ Sole
- ❑ Sour cream
- ❑ Soybean
- ❑ Spinach
- ❑ Strawberry
- ❑ Sucralose
- ❑ Sugar
- ❑ Sunflower
- ❑ Salad bar
- ❑ Sardines
- ❑ Squash
- ❑ Taco Bell food
- ❑ Tea, black
- ❑ Tea, decaffeinated
- ❑ Thai food
- ❑ Tomato
- ❑ Trout
- ❑ Tuna
- ❑ Turkey
- ❑ Tangerine
- ❑ Vinegar
- ❑ Walnut
- ❑ Waffles
- ❑ Whitefish
- ❑ Wheat
- ❑ Wendy's food
- ❑ Yeast, Bakers
- ❑ Yeast, Brewers
- ❑ Yogurt
- ❑ Yam
- ❑ Zucchini

Do you snack between meals: ❑ Yes ❑ No If yes, what kinds of snacks do you eat?

Between breakfast & lunch: _____

Between lunch & dinner: _____

After dinner: _____

Which of the following do you consume each day/week?

Item	Daily	Weekly	Favorite Type
Candy	❑	❑	
Cheese	❑	❑	
Chocolate	❑	❑	
Cups of caffeine containing coffee	❑	❑	
Cups of decaffeinated coffee or tea	❑	❑	
Cups of hot chocolate	❑	❑	
Cups of caffeine containing tea	❑	❑	
Diet sodas (12-oz. can/bottle)	❑	❑	
Sodas with caffeine (12-oz. can/bottle)	❑	❑	
Sodas without caffeine (12-oz. can/bottle)	❑	❑	
Energy drinks (12-oz. can/bottle)	❑	❑	
Ice cream	❑	❑	
Salty foods	❑	❑	
Slices of white bread (rolls/bagels)	❑	❑	

How much water do you drink every day (# of 8-oz. glasses)? _____

What type of water do you most often drink?

❑ Tap
❑ Distilled
❑ Spring
❑ Well
❑ Reverse osmosis
❑ Bottled (soft, squishy plastic)
❑ Bottled (firm plastic)
❑ pH water (above 7.0)
❑ Sparkling water
❑ Flavored water
❑ Other _____

Do you experience digestive symptoms immediately after eating or drinking such as belching, bloating, sneezing, etc.?

❑ Yes ❑ No If yes, please explain: _____

_____

Do you experience intestinal gas? ❑ Never ❑ Depends on what I eat ❑ Daily ❑ Occasionally

❑ Excessive ❑ Painful ❑ Foul smelling ❑ Little or no odor

BOWEL HABITS

Frequency	Yes	No	Visible Signs	Yes	No
More than 3x/day	❑	❑	Often floats	❑	❑
1-3x per day	❑	❑	Contains small pieces of food	❑	❑
4-6x per week	❑	❑	Breaks apart easily in the water	❑	❑
2-3x per week	❑	❑	Light or sandy colored	❑	❑
1x per week	❑	❑	Fluorescent green	❑	❑
Less than 1x per week	❑	❑	Black or extremely dark	❑	❑
	❑	❑	Blood in the water	❑	❑

Which of the following type(s) best describes your stool?

❑ Type 1

❑ Type 2

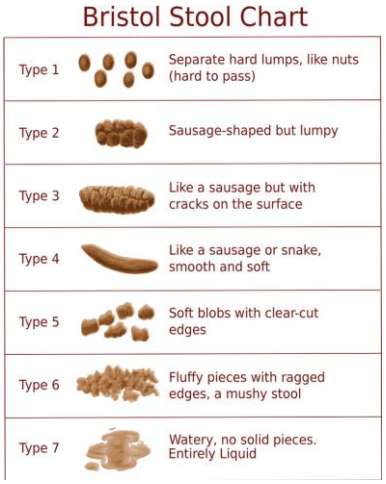
❑ Type 3

❑ Type 4

❑ Type 5

❑ Type 6

❑ Type 7



Do you feel you have **delayed** symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.?

❑ Yes ❑ No

Do you feel **worse** when you eat too much of the following? (Check which ones apply)

❑ Fatty foods
❑ Protein
❑ High carbohydrate foods (breads, pasta, potatoes)
❑ Refined sugar (junk food)
❑ Fried foods
❑ 1 or 2 alcoholic drinks
❑ Other: _____

Do you feel **better** when you eat more of the following? (Check which ones apply)

❑ Fatty foods
❑ High protein foods
❑ High carbohydrate foods (breads, pasta, potatoes)
❑ Refined sugar (junk food)
❑ Fried foods
❑ 1 or 2 alcoholic drinks
❑ Other: _____

Do you experience blood sugar lows or feel 'hangry' if you skip meals? ❑ Yes ❑ No

Has there ever been a food that you've really craved or "pigged out" on over a period of time?

❑ Yes ❑ No If yes, what food(s)? _____

_____

_____

Are there certain foods that you avoid eating or you know they don't make your feel well? ❑ Yes ❑ No

If yes, what food(s)? _____

_____

The worst food I currently eat is: _____

_____

TOBACCO HISTORY

Are you currently using tobacco? ❑ Yes ❑ No

How many years? _____ # of packs per day: _____

If yes, what type? ❑ Cigarette ❑ Smokeless ❑ Cigar ❑ Pipe ❑ Patch/Gum ❑ Vaping

Have you attempted to quit? ❑ Yes ❑ No If so, how many attempts have you made? _____

If you smoked previously, how many years? _____ # of packs per day: _____

Are you currently exposed to 2nd hand smoke? ❑ Yes ❑ No

If yes, please explain: _____

_____

Were you exposed to 2nd hand smoke as a child? ❑ Yes ❑ No

ALCOHOL INTAKE

How many drinks currently per week? *1 drink = 5 ounces wine, 12 oz. beer, 1.5 ounces spirits*

❑ None ❑ 1–3 ❑ 4–6 ❑ 7–10 ❑ >10 If none skip to "Other Substances"

Have you previously had high alcohol intake? ❑ Yes (❑ Mild ❑ Moderate ❑ High) ❑ No

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

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

Do you notice that you can tolerate more alcohol than others? ❑ Yes ❑ No

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

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

Was your mother an alcoholic? ❑ Father? ❑ Other family member? _____

OTHER SUBSTANCES

Are you currently using recreational drugs? ❑ Yes ❑ No

If yes, what types? _____

Are you currently using CBD, THC or other legal marijuana? ❑ Yes ❑ No

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

If yes, what types? _____

EXERCISE

Current exercise program: Activity (list type, number of sessions per week, and duration of activity)

Activity	Type	Frequency per Week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength training			
Other (Pilates, yoga, etc.)			
Sports or leisure activities (golf, tennis, rollerblading etc.)			

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

List 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

SOCIAL AND PSYCHOSOCIAL HISTORY

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

Are you currently happy? ❑ Yes ❑ No

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

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

Do you like the work you do? ❑ Yes ❑ No

Have you 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

STRESS/COPING HISTORY

Please do your best to answer the following questions:

Did you feel safe growing up? ❑ Yes ❑ No

Have you ever been involved in abusive relationships in your life? ❑ Yes ❑ No

Were alcoholism or substance abuse present in your childhood home? ❑ Yes ❑ No

Is alcoholism or substance abuse present in your relationships now? ❑ Yes ❑ No

Have you ever sought counseling? ❑ Yes ❑ No

Currently? ❑ Yes ❑ No Previously? ❑ Yes ❑ No

What kind? _____

Comments: _____

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

Daily stressors (*Rate on a scale of 1–10; 1=not stressful, 10=very stressful)*:

Work _____ Social _____ Health _____

Family _____ Finances _____ Other _____

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

Check all that apply:

❑ Yoga ❑ Meditation ❑ Imagery ❑ Breathing ❑ Tai Chi ❑ Prayer ❑ Other: _____

Hobbies and leisure activities: _____

_____

How important is religion (or spirituality) for you and your family's life?

❑ Not at all important ❑ Somewhat important ❑ Extremely important

How well are things going in your life in the following areas?

	Very Well	**Fine**	**Poorly**	**Very Poorly**	**Does Not Apply**
At school	❑	❑	❑	❑	❑
In your job	❑	❑	❑	❑	❑
In your social life	❑	❑	❑	❑	❑
With close friends	❑	❑	❑	❑	❑
With sex	❑	❑	❑	❑	❑
With your attitude	❑	❑	❑	❑	❑
With your boyfriend/girlfriend	❑	❑	❑	❑	❑
With your children	❑	❑	❑	❑	❑
With your parents	❑	❑	❑	❑	❑
With your spouse	❑	❑	❑	❑	❑

Which of the following provide you with emotional support? *(Check all that apply.)*

❑ Spouse ❑ Family ❑ Friends ❑ Religious/Spiritual ❑ Pets ❑ Other: _____

SOCIAL READJUSTMENT RATING SCALE

Place a check mark in the corresponding box for any of the following that have occurred during the last 12 months.

Life Event	Answer	
Death of spouse	❑ Yes	❑ No
Divorce	❑ Yes	❑ No
Marital separation	❑ Yes	❑ No
Jail term	❑ Yes	❑ No
Death of close family member	❑ Yes	❑ No
Personal injury or illness	❑ Yes	❑ No
Got married	❑ Yes	❑ No
Fired from work	❑ Yes	❑ No
Marital reconciliation	❑ Yes	❑ No
Retirement	❑ Yes	❑ No
Change in family members health	❑ Yes	❑ No
Pregnancy	❑ Yes	❑ No
Sex difficulties	❑ Yes	❑ No
Addition to family	❑ Yes	❑ No
Business readjustment	❑ Yes	❑ No
Change in financial status	❑ Yes	❑ No
Death of close friend	❑ Yes	❑ No
Change in line of work	❑ Yes	❑ No
Change in # of marital arguments	❑ Yes	❑ No
Mortgage or loan over $10,000	❑ Yes	❑ No
Foreclosure of mortgage or loan	❑ Yes	❑ No
Change in work responsibilities	❑ Yes	❑ No
Son or daughter leaving home	❑ Yes	❑ No
Trouble with in-laws	❑ Yes	❑ No
Outstanding personal achievement	❑ Yes	❑ No
Spouse begins or stops work	❑ Yes	❑ No
Starting or finishing school	❑ Yes	❑ No
Change in living conditions	❑ Yes	❑ No

Revision of personal habits	❑ Yes	❑ No
Trouble with boss	❑ Yes	❑ No
Change in work hours, conditions	❑ Yes	❑ No
Change in residence	❑ Yes	❑ No
Change in schools	❑ Yes	❑ No
Change in recreational habits	❑ Yes	❑ No
Mortgage or loan under $10,000	❑ Yes	❑ No
Change in sleeping habits	❑ Yes	❑ No
Change in eating habits	❑ Yes	❑ No
Vacation	❑ Yes	❑ No

STRESS TRIGGERS

Check any of the following that you believe are contributing to your overall stress load over the course of your lifetime.

- ❑ Childhood traumas
- ❑ Need for perfection
- ❑ Divorce or change in a relationship
- ❑ Caregiving or taking care of a sick family member
- ❑ Job or career challenges
- ❑ Illness, either short-term or chronic
- ❑ Dieting or concerns about weight
- ❑ Menopause

Do you worry about any of the following? (Check all that apply)

- ❑ Home life
- ❑ Marriage
- ❑ Children
- ❑ Job
- ❑ Income
- ❑ Other _____

SLEEP/REST HISTORY

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

Do you have trouble falling asleep? ❑ 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: _____

_____