Center for Functional Medicine

Intake: New Patient Information

Cleveland Clinic – Main Campus
Desk H-18
9500 Euclid Avenue
Cleveland, OH 44195

Phone 216-445-6900
Fax 216-636-3074

Clevelandclinic.org/functionalmedicine
Email: functionalmedicine@ccf.org
Dear Patient,

Welcome to the Cleveland Clinic Center for Functional Medicine. Please review the information below to get an idea of what to expect during your initial appointment.

**WHAT TO EXPECT AT YOUR INITIAL VISIT**

Please arrive **30 minutes** before your appointment time to allow for parking and navigation to desk H-18 and any additional time for any inclement weather conditions.

- **RECEPTION: Office Check-In: (20 minutes)**
  - Update personal and health insurance information and sign consent forms
  - Complete the PROMIS-10 Electronic Questionnaire
  - Meet Medical Assistant for vital signs

- **DOCTOR CONSULTATION: (75 minutes)**
  - Initial Medical Assessment and Treatment Plan

- **LABS – REVIEW OF RECOMMENDED TESTING: (up to 20 minutes)**
  - Review of recommended lab orders
  - Review lab test instructions and pricing

- **NUTRITIONIST CONSULTATION: (60 minutes)**
  - Nutrition Assessment and Initial Nutrition Plan
  - Review of Healthy Living Supplement Online Shop

- **HEALTH COACH WRAP UP AND REVIEW: (15 minutes)**
  - Introduction to Health Coaching and answer any questions

- **RECEPTION: Office Check-Out: (10 minutes)**
  - Schedule follow-up appointment(s)

- **LAB VISIT:**
  - If onsite labs are ordered, you may complete them at the G-10 Lab located in the same building as our office. (Please note that fasting is required if you are traveling from outside the state of Ohio or a patient of Dr. Hyman). We recommend that you drink plenty of plain water the morning of your appointment. This prepares you for any lab tests that may be drawn.
  - If any additional at home lab testing is recommended you will be given those kits and instructions at the initial appointment.
  - All lab results will be reviewed at the follow up visit with your physician. Please note lab results cannot be reviewed or consulted on via phone or MyChart.
**CHECKLIST TO COMPLETE PRIOR TO APPOINTMENT**

<table>
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<tr>
<th>Step</th>
<th>Items to complete</th>
<th>Done</th>
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<tr>
<td></td>
<td>Read and review all the enclosed new patient procedures</td>
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<tr>
<td>1.</td>
<td><strong>PREPARATION FOR APPOINTMENT:</strong> Complete the attached Health Questionnaire and email the completed questionnaire to (<a href="mailto:functionalmedicine@ccf.org">functionalmedicine@ccf.org</a>) or fax (216-636-3074) at LEAST (7) days prior to your scheduled appointment.</td>
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</table>
| 2.   | If you are traveling from outside the state of Ohio OR a patient of Dr. Hyman begin fasting at midnight the evening before your appointment. This ensures that lab testing can be completed the day of your visit.  
   - Drink plenty of plain water the morning of your appointment regardless if fasting or not fasting. This will prepare you for any lab tests you may have drawn. |      |
| 3.   | Obtain previous medical records from other physicians or health care providers who are not affiliated with Cleveland Clinic.  
   - Complete the medical records release form and give it to each of these outside health care providers in order for us to receive these records prior to your appointment.  
   - Instruct outside health care providers to express mail records to: Cleveland Clinic – Center for Functional Medicine, 9500 Euclid Avenue – H-18, Cleveland, OH 44195 or fax to (216-636-3074). |      |
| 4.   | **Arrival:**  
   - Please refer to the Appointment Policies section in this guide for details on late arrivals and cancellation policies.  
   - We request that patients are fragrance free and with no hand nail polish. |      |
| 5.   | If you have not yet registered for an online MyChart account please do so by visiting www.clevelandclinic.org/mychart. MyChart is a secure online tool used to communicate with your physician, nutritionist and health coach and also access test results. |      |
Health Questionnaire:

Our goal at the Center for Functional Medicine is to provide you with the highest level of personalized care. We are committed to helping you achieve optimal health.

It is important to read all the enclosed information carefully. Please complete the Health Questionnaire and email functionalmedicine@ccf.org, or fax 216-636-3074 to our office at least 7 days prior to your appointment.

The health questionnaire MUST BE COMPLETED BEFORE your appointment. If it is incomplete please consider the time it will take to complete it before your appointment. Filling it out while you are at your visit may consume up to 45 minutes of your allotted 75 minute physician consultation. It will also prohibit us from reviewing this important information in advance. This information is vital for the doctor in preparing your treatment plan. By completing this information in advance the clinical team can efficiently enhance the quality of your care.

Fasting for Initial Visits:

Use the following guideline to determine if you need to fast prior to your appointment.

If you are traveling WITHIN the state of Ohio:
- You DO NOT need to fast for your appointment. Our staff will review instructions as not all labs can perform all testing.

If you are traveling from OUTSIDE the state of Ohio or a patient of Dr. Hyman:
- You DO need to fast for your appointment. Please do not eat or drink anything but water starting at 10:30 pm the night before your appointment. If this is not possible for medical reasons, you will be given a requisition to have your fasting labs drawn at a location convenient to you.
- Begin fasting at midnight the evening before your appointment. You can, and should, drink water during this fast and take all prescription medications.

Medical records:

Medical records can only be released with your authorization. You are responsible for obtaining previous medical records from other physicians or health care providers who are not affiliated with Cleveland Clinic. A medical records release form is included for your use. Please contact your physician or other health care provider to obtain these records prior to your appointment. Please ask your outside provider to express mail medical records to Cleveland Clinic – Center for Functional Medicine, 9500 Euclid Avenue – H-18, Cleveland, OH 44195 or fax (216-636-3074).

If your care has been with Cleveland Clinic providers, your records are available to us through our electronic medical record. You do not need to request a release for these records.

How to open a MyChart account:

Cleveland Clinic MyChart is a secure, online tool that connects you to personalized health information from the privacy of your home at any time, day or night. Set up a new user account by visiting www.clevelandclinic.org/mychart or by calling 216-444-1740.
**APPOINTMENT POLICIES**

**Late arrivals:**
Please arrive **30 minutes** before your appointment time to allow for parking and navigation to desk H-18 and any additional time for any inclement weather conditions.

- If you are more than 30 minutes late you will forfeit your appointment time and be rescheduled for the next available opening.
- If you are late the amount of time you are late will be deducted from your allotted visit time.

**Cancellations:**
If you must cancel or re-schedule your appointment, please contact us at least seven (7) days prior to your appointment. To cancel or re-schedule your appointment, please contact our office at 216-445-6900.

**Consultation Times:**
Your initial visit will include a 75-minute medical consultation with your physician, followed by a 60 minute functional nutrition consultation. In addition, you will have an opportunity to meet your health coach whose role is to support you throughout this process.

Laboratory/diagnostic testing are integral components of your treatment plan. Test results are used to design your personal health care program as well as uncover the root causes of your medical condition. Nutritional supplements are often recommended. We will suggest only the highest quality products available on our Healthy Living Online Shop which can be accessed by visiting https://clevelandclinic.healthylivingshop.com/. You will be guided through the interpretation of all lab results at your follow up visit with your physician. **Please note lab results cannot be consulted on via phone or MyChart.**

**INSURANCE AND PAYMENT DETAILS**

**Appointments with Dr. Hyman:**
*All appointments with Dr. Mark Hyman are self-pay. Appointments with Dr. Hyman are not billed through insurance. Dr. Hyman does not accept insurance and we do not file insurance paperwork on your behalf. However, we will provide a detailed receipt for services performed for you to submit to your insurance carriers.*

Dr. Hyman does not participate in the Medicare program. If you are a Medicare Part B beneficiary and wish to become a patient of Dr. Hyman, you are required to accept the terms and conditions set forth in a Private Contract between you and Dr. Hyman. This Private Contract provides that absolutely no Medicare payment will be made to you or to the Cleveland Clinic for the services provided, even if such services are covered by Medicare. Under the Private Contract, you acknowledge that you accept full responsibility for the payment of charges for all services rendered by Dr. Hyman; such payments are due in full at the time of service. This contract will be reviewed with you prior to your appointment. The Cleveland Clinic will not require you to sign the Private Contract if you are experiencing an emergency or urgent issue.
Insurance Information:

Physician visits are covered by most insurance plans. Coverage for visits with the nutritionist, as well as some of the tests, is determined by your insurance plan. Our financial counselor will verify the insurance coverage of new patients, prior to your appointment, if necessary.

Payment Options:

If it is determined that services are not covered by insurance, you will be contacted and offered the option of cash, check or credit card for services rendered.

ADDITIONAL DETAILS

- Office hours are Monday- Friday 8:00 am to 4:30 pm EST.
- To reach the Center for Functional Medicine office, please call 216-445-6900.
- Fax number is 216-636-3074.
- Email address is functionalmedicine@ccf.org
- After your appointment, the best way to ask a question or leave a message for your physician, nutritionist or health coach is through MyChart. MyChart is a secure, online tool that connects you to personalized health information and allows you to message your clinical team through your Physician. If you have not signed up for MyChart, please visit www.clevelandclinic.org/mychart to register. Refer to the sheet you received at check-in for the activation code you will need to register. You will receive a response to MyChart messages within a 72 hour period.
- If you have a medical emergency, call 911 or go directly to the nearest emergency room.

Our Address:

Cleveland Clinic
Center for Functional Medicine
9500 Euclid Avenue, H-18
Cleveland, OH 44195

Website:

Information about the Center for Functional Medicine is available through our website. Please visit us at: clevelandclinic.org/functionalmedicine.

Directions to Cleveland Clinic Center for Functional Medicine:

- The Cleveland Clinic Center for Functional Medicine is located on the main campus of the Cleveland Clinic in the H building. The suite number is H-18.
- Parking is recommended in the Parking 1 Garage (E. 93rd Street) or Valet is available at the Main Entrance (E. 93rd Street).

For a map of main campus, visit ClevelandClinic.org or visit www.clevelandclinic.org/getthere for specific directions for getting to desk H-18. Parking rate information can be found at http://my.clevelandclinic.org/patients-visitisors/parking-lodging-transportation/parking.
Will I see other practitioners at the Center for Functional Medicine?

Nutritional therapy is a vital component of your treatment plan. Following your initial medical consultation with a physician, you meet with one of our nutritionists. They will provide recommendations based on your health concerns and tailor your diet based on medical evaluation and test results. You may schedule future nutrition follow-ups without seeing the doctor AFTER your initial visit.

In addition at your initial appointment you will be introduced to your health coach. The role of the health coach is to support you in making the lifestyle changes that will help move you towards improving your health. The health coach is available to work with you over the phone and at future follow ups. All appointments are scheduled in advance and there is no fee for the coaching services.

Do you take insurance?

Physician visits are covered by most insurance plans. Coverage for visits with the nutritionist as well as some of the lab tests is determined by your insurance plan. New patients will be contacted by our financial counselor to review coverage prior to your appointment.

*Appointments with Dr. Mark Hyman are not billed through insurance. Dr. Hyman does not accept insurance or Medicare and we do not file insurance paperwork on your behalf.

Are the Center for Functional Medicine physicians considered primary care physicians?

The physicians are trained as primary care physicians but they do not provide acute care or primary care services. They will work with you closely as consultants in preventive, nutritional, and functional medicine to help you address the roots of chronic health problems. They can confer with your primary care doctor.

Can all the tests I need be done at the Cleveland Clinic?

Most of the testing can be performed at the Cleveland Clinic (G-10 lab). During your medical consultation, your physician will determine if any additional tests are needed. If tests are recommended then our medical assistant will review instructions and costs, if applicable. Testing is frequently done to assess nutritional status including amino acids, fatty acids, oxidative stress, vitamin levels, mitochondrial function, food allergies, and heavy metals. Many additional tests are available, including genetic testing for a variety of conditions, hormone evaluations, bone health, gastrointestinal health, adrenal function and others.

Some testing can be performed at home with test kits to collect urine, saliva or stool. Our medical assistant will review the instructions for completing these tests at home.

While the testing gives a more complete picture of your status, effective care can be implemented without it, or testing can be done over time. You should not let this prevent you from moving forward and seeing one of our doctors.
## GENERAL INFORMATION

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**ALLERGIES**

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<th>Reaction</th>
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**COMPLAINTS AND CONCERNS**

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

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

1. _______________________________________________________________________________________________________
2. _______________________________________________________________________________________________________
3. _______________________________________________________________________________________________________

When was the last time you felt well?
_______________________________________________________________________________________________________

Did something trigger your change in health? _______________________________________________________________
_______________________________________________________________________________________________________

What makes you feel worse? _____________________________________________________________________________
_______________________________________________________________________________________________________

What makes you feel better? _____________________________________________________________________________
_______________________________________________________________________________________________________

Please list current and ongoing problems in order of priority:

<table>
<thead>
<tr>
<th>Describe Problem</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Prior Treatment/Approach</th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
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<tr>
<td>Example: Post Nasal Drip</td>
<td>X</td>
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<td>Elimination Diet</td>
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# MEDICAL HISTORY

## DISEASES/DIAGNOSIS/CONDITIONS
Check appropriate box and provide date of onset

### GASTROINTESTINAL
- [ ] Irritable Bowel Syndrome
- [ ] Inflammatory Bowel Disease
- [ ] Crohn’s
- [ ] Ulcerative Colitis
- [ ] Gastritis or Peptic Ulcer Disease
- [ ] GERD (reflux)
- [ ] Celiac Disease
- [ ] Other ________________________________

### CARDIOVASCULAR
- [ ] Heart Attack
- [ ] Other Heart Disease
- [ ] Stroke
- [ ] Elevated Cholesterol
- [ ] Arrhythmia (irregular heart rate)
- [ ] Hypertension (high blood pressure)
- [ ] Rheumatic Fever
- [ ] Mitral Valve Prolapse
- [ ] Other _______________________________

### METABOLIC/ENDOCRINE
- [ ] Type 1 Diabetes
- [ ] Type 2 Diabetes
- [ ] Hypoglycemia
- [ ] Metabolic Syndrome
  - (Insulin Resistance or Pre-Diabetes)
- [ ] Hypothyroidism (low thyroid)
- [ ] Hyperthyroidism (overactive thyroid)
- [ ] Endocrine Problems
- [ ] Polycystic Ovarian Syndrome (PCOS)
- [ ] Infertility
- [ ] Weight Gain
- [ ] Weight Loss
- [ ] Frequent Weight Fluctuations
- [ ] Bulimia
- [ ] Anorexia
- [ ] Binge Eating Disorder
- [ ] Night Eating Syndrome
- [ ] Eating Disorder (non-specific)
- [ ] Other _______________________________

### CANCER
- [ ] Lung Cancer
- [ ] Breast Cancer
- [ ] Colon Cancer
- [ ] Ovarian Cancer
- [ ] Prostate Cancer
- [ ] Skin Cancer
- [ ] Other _______________________________

### GENITAL AND URINARY SYSTEM
- [ ] Kidney Stones
- [ ] Gout
- [ ] Interstitial Cystitis
- [ ] Frequent Urinary Tract Infections
- [ ] Frequent Yeast Infections
- [ ] Erectile Dysfunction
  - Or Sexual Dysfunction
- [ ] Other _______________________________

### MUSCULOSKELETAL/PAIN
- [ ] Osteoarthritis
- [ ] Fibromyalgia
- [ ] Chronic Pain
- [ ] Other _______________________________

### INFLAMMATORY/AUTOIMMUNE
- [ ] Chronic Fatigue Syndrome
- [ ] Autoimmune Disease
- [ ] Rheumatoid Arthritis
- [ ] Lupus SLE
- [ ] Immune Deficiency Disease
- [ ] Herpes-Genital
- [ ] Severe Infectious Disease
- [ ] Poor Immune Function
  - (frequent infections)
- [ ] Food Allergies
- [ ] Environmental Allergies
- [ ] Multiple Chemical Sensitivities
- [ ] Latex Allergy
- [ ] Other _______________________________

### RESPIRATORY DISEASES
- [ ] Asthma
- [ ] Chronic Sinusitis
- [ ] Bronchitis
- [ ] Emphysema
- [ ] Pneumonia
- [ ] Tuberculosis
- [ ] Sleep Apnea
- [ ] Other _______________________________

### SKIN DISEASES
- [ ] Eczema
- [ ] Psoriasis
- [ ] Acne
- [ ] Melanoma
- [ ] Skin Cancer
- [ ] Other _______________________________
## MEDICAL HISTORY (continued)

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

### Preventive Tests and Surgeries

**DATE OF LAST TEST**

Check box if yes and provide date of surgery

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

### Injuries
- Back Injury
- Head Injury
- Neck Injury
- Broken Bones
- Other

### Blood Type:
- A
- B
- AB
- O
- Rh+
- Unknown

### Hospitalization

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### Comments

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GYNECOLOGIC HISTORY (for women only)

OBSTETRIC HISTORY  Check box if yes and provide number of
☐ Pregnanacies___________  ☐ Caesarean____________  ☐ Vaginal Deliveries___________
☐ Miscarriage____________  ☐ Abortion______________  ☐ Living Children____________
☐ Post-Partum Depression  ☐ Toxemia  ☐ Gestational Diabetes  ☐ Baby Over 8 Pounds
☐ Breast Feeding for how long?____________

MENSTRUAL HISTORY
Age at First Period:______ Menses Frequency:_____ Length:_____ Pain: ☐ Yes  ☐ No  Clotting:  ☐ Yes  ☐ No
Has you period ever skipped? _____ For how long?___________
Last Menstrual Period:____________
Use of hormonal contraception such as:  ☐ Birth Control Pills  ☐ Patch  ☐ Nuva Ring How long?___________
Do you use contraception? ☐Yes  ☐No  ☐ Condom  ☐ Diaphragm  ☐ IUD  ☐ Partner Vasectomy

WOMEN’S DISORDERS/HORMONAL IMBALANCES
☐ Fibrocystic Breasts  ☐ Endometriosis  ☐ Fibroids  ☐ Infertility
☐ Painful Periods  ☐ Heavy Periods  ☐ PMS
Last Mammmogram:______________  ☐ Breast Biopsy/Date:____________
Last PAP Test:______________  ☐ Normal  ☐ Abnormal
Last Bone Density:______________ Results: ☐ High  ☐ Low  ☐ Within Normal Range
Are you in Menopause? ☐Yes  ☐No
Age at Menopause:______________
☐ Hot Flashes  ☐ Mood Swings  ☐ Concentration/Memory Problems  ☐ Vaginal Dryness  ☐ Decreased Libido
☐ Heavy Bleeding  ☐ Joint Pains  ☐ Headaches  ☐ Weight Gain  ☐ Loss of Control of Urine  ☐ Palpitations
☐ Use of hormone replacement therapy  How long?____________________

MEN’S HISTORY (for men only)
Have you had a PSA done? ☐Yes  ☐No
PSA Level: ☐ 0-2  ☐ 2-4  ☐ 4-10  ☐ > 10
☐ Prostate Enlargement  ☐ Prostate Infection  ☐ Change in Libido  ☐ Impotence
☐ Difficulty Obtaining an Erection  ☐ Difficulty Maintaining an Erection
☐ Nocturia (urination at night). How many times at night?____________
☐ Urgency/Hesitancy/Change in Urinary Stream  ☐ Loss of Control of Urine
GI HISTORY

Foreign Travel ☐ Yes ☐ No Where? __________________________________________________________

Wilderness Camping ☐ Yes ☐ No Where? __________________________________________________________

Have you ever had severe: ☐ Gastroenteritis ☐ Diarrhea

Do you feel like you digest your food well? ☐ Yes ☐ No

Do you feel bloated after meals? ☐ Yes ☐ No

PATIENT BIRTH HISTORY

☐ Term ☐ Premature

Pregnancy Complications: _________________________________________________________________

Birth Complications: _________________________________________________________________


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

DENTAL HISTORY

☐ Silver Mercury Fillings How many? _____________

☐ Gold Fillings ☐ Root Canals ☐ Implants ☐ Tooth Pain ☐ Bleeding Gums

☐ Gingivitis ☐ Problems with Chewing

Do you floss regularly? ☐ Yes ☐ No
# MEDICATIONS

## CURRENT MEDICATIONS
<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
<th>Start Date (month/year)</th>
<th>Reason For Use</th>
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## PREVIOUS MEDICATIONS *(Last 10 years)*
<table>
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<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
<th>Start Date (month/year)</th>
<th>Reason For Use</th>
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</table>

## NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)
<table>
<thead>
<tr>
<th>Supplement &amp; Brand</th>
<th>Dose</th>
<th>Frequency</th>
<th>Start Date (month/year)</th>
<th>Reason For Use</th>
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Have your medications or supplements ever caused you unusual side effects or problems? ☐ Yes ☐ No
Describe:_____________________________________________________________________________________________

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ☐ Yes ☐ No
Have you had prolonged use of Tylenol? ☐ Yes ☐ No
Have you had prolonged or regular use of acid blocking drugs (Tagamet, Zantac, Prilosec, etc.) ☐ Yes ☐ No
Frequent antibiotics ☐ Yes ☐ No
Long term antibiotics ☐ Yes ☐ No
Use of steroids (prednisone, nasal allergy inhalers) in the past ☐ Yes ☐ No
Use of oral contraceptives ☐ Yes ☐ No
**FAMILY HISTORY**

*Check family members that apply*

<table>
<thead>
<tr>
<th></th>
<th>Mother</th>
<th>Father</th>
<th>Brother(s)</th>
<th>Sister(s)</th>
<th>Children</th>
<th>Maternal Grandmother</th>
<th>Maternal Grandfather</th>
<th>Paternal Grandmother</th>
<th>Paternal Grandfather</th>
<th>Aunt</th>
<th>Uncle</th>
<th>Other</th>
</tr>
</thead>
</table>

Age (if still alive)

Age at death (if deceased)

Cancers

Colon Cancer

Breast or Ovarian Cancer

Heart Disease

Hypertension

Obesity

Diabetes

Stroke

Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Spondylitis)

Inflammatory Bowel Disease

Multiple Sclerosis

Auto Immune Diseases (such as Lapus)

Irritable Bowel Syndrome

Celiac Disease

Asthma

Eczema / Psoriasis

Food Allergies, Sensitivities or Intolerances

Environmental Sensitivities

Dementia

Parkinson’s

ALS or other Motor Neuron Diseases

Genetic Disorders

Substance Abuse (such as alcoholism)

Psychiatric Disorders

Depression

Schizophrenia

ADHD

Autism

Bipolar Disease
SOCIAL HISTORY

NUTRITION HISTORY
Have you ever had a nutrition consultation? ☐ Yes ☐ No
Have you made any changes in your eating habits because of your health? ☐ Yes ☐ No Describe:_____________________
Do you currently follow a special diet or nutritional program? ☐ Yes ☐ No
Check all that apply:
☐ Low Fat    ☐ Low Carbohydrate    ☐ High Protein    ☐ Low Sodium    ☐ Diabetic    ☐ No Dairy    ☐ No Wheat
☐ Gluten Restricted    ☐ Vegetarian    ☐ Vegan    ☐ Ultrametabolism
☐ Specific Program for Weight Loss/Maintenance Type:___________________________ ☐ Other

<table>
<thead>
<tr>
<th>Height (feet/inches)</th>
<th>Current Weight</th>
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<tr>
<th>Usual Weight Range +/- 5 lbs</th>
<th>Desired Weight Range +/- 5 lbs</th>
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<tr>
<th>Highest Adult Weight</th>
<th>Lowest Adult Weight</th>
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<table>
<thead>
<tr>
<th>Weight Fluctuations (&gt;10 lbs)</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Body Fat %</td>
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</table>

How often do you weigh yourself? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never
Have you ever had your metabolism (resting metabolic rate) checked? ☐ Yes ☐ No    If yes, what was it?________________
Do you avoid any particular foods? ☐ Yes ☐ No    If yes, types and reason_________________________________________

_______________________________________________________________________________________________________

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

_______________________________________________________________________________________________________

Do you grocery shop? ☐ Yes ☐ No    If no, who does the shopping?_________________________________________________
Do you read food labels? ☐ Yes ☐ No
Do you cook? ☐ Yes ☐ No    If no, who does the cooking?_____________________________________________________  

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

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

☐ Fast eater
☐ Erratic eating pattern
☐ Eat too much
☐ Late night eating
☐ Dislike healthy food
☐ Time constraints
☐ Eat more than 50% meals away from home
☐ Travel 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 or food preferences
☐ Love to eat
☐ Eat because I have to
☐ Have a negative relationship to food
☐ Struggle with eating issues
☐ Emotional eater (eat when sad, lonely, depressed, bored)
☐ Eat too much under stress
☐ Eat too little under stress
☐ Don’t care to cook
☐ Eating in the middle of the night
☐ Confused about nutrition advice

The most important thing I should change about my diet to improve my health is:____________________________________
SMOKING
Currently Smoking?  ☐ Yes  ☐ No  If yes, how many years?_________ Packs per day:_______
Attempts to quit:____________
Previous Smoking: How many years?_________ Packs per day:_________
Second Hand Smoke Exposure?_________________

ALCOHOL INTAKE
How many drinks currently per week?  1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits
☐ None  ☐ 1-3  ☐ 4-6  ☐ 7-10  ☐ > 10  If none, skip to “Other Substances”
Previous alcohol intake?  ☐ Yes (☐ Mild  ☐ Moderate  ☐ High)  ☐ None
Have you ever been told you should cut down your alcohol intake?  ☐ Yes  ☐ No
Do you get annoyed when people ask you about your drinking?  ☐ Yes  ☐ No
Do you ever feel guilty about your alcohol consumption?  ☐ Yes  ☐ No
Do you ever take an eye-opener?  ☐ Yes  ☐ No
Do you notice a tolerance to alcohol (can you “hold” more than others)?  ☐ Yes  ☐ No
Have you ever been unable to remember what you did during a drinking episode?  ☐ Yes  ☐ No
Do you get into arguments or physical fights when you have been drinking?  ☐ Yes  ☐ No
Have you ever thought about getting help to control or stop your drinking?  ☐ Yes  ☐ No

OTHER SUBSTANCES
Caffeine Intake:  ☐ Yes  ☐ No  | Coffee cups/day:  ☐ 1  ☐ 2-4  ☐ > 4  | Tea cups/day:  ☐ 1  ☐ 2-4  ☐ > 4
Caffeinated Sodas or Diet Sodas Intake:  ☐ Yes  ☐ No
  12-ounce can/bottle:  ☐ 1  ☐ 2-4  ☐ > 4
List favorite type (Ex. Diet Coke, Pepsi, etc.):  ______________________________________
Are you currently using any recreational drugs?  ☐ Yes  ☐ No  If yes, type:_____________________
Have you ever used IV or inhaled recreational drugs?  ☐ Yes  ☐ No

EXERCISE
Current Exercise Program:  (List type of activity, number of sessions/week, and duration)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Type</th>
<th>Frequency Per Week</th>
<th>Duration in Minutes</th>
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</thead>
<tbody>
<tr>
<td>Stretching</td>
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<tr>
<td>Cardio/Aerobics</td>
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<tr>
<td>Strength</td>
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<tr>
<td>Other (yoga, pilates, gyrotonics, etc.)</td>
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<tr>
<td>Sports or Leisure Activities (golf, tennis, rollerblading, etc.)</td>
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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
PSYCHOSOCIAL
Do you feel significantly less vital than you did a year ago? ☐ Yes ☐ No
Are you happy? ☐ Yes ☐ No
Do you feel your life has meaning and purpose? ☐ Yes ☐ No
Do you believe stress is presently reducing the quality of your life? ☐ Yes ☐ No
Do you like the work you do? ☐ Yes ☐ No
Have you ever experienced major losses in your life? ☐ Yes ☐ No
Do you spend the majority of your time and money to fulfill responsibilities and obligations? ☐ Yes ☐ No
Would you describe your experience as a child in your family as happy and secure? ☐ Yes ☐ No

STRESS/COPING
Have you ever sought counseling? ☐ Yes ☐ No
Are you currently in therapy? ☐ Yes ☐ No Describe:________________________________________________________________________
Do you feel you have an excessive amount of stress in your life? ☐ Yes ☐ No
Do you feel you can easily handle the stress in your life? ☐ Yes ☐ No
Daily Stressors: Rate on scale of 1-10
Work_____ Family_____ Social_____ Finances_____ Health_____ Other_____
Do you practice meditation or relaxation techniques? ☐ Yes ☐ No How often?____________
Check all that apply: ☐ Yoga ☐ Meditation ☐ Imagery ☐ Breathing ☐ Tai Chi ☐ Prayer ☐ Other:________________________
Have you ever been abused, a victim of a crime, or experienced a significant trauma? ☐ Yes ☐ No

SLEEP/REST
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:____________________________________________________________________________________

ROLES/RELATIONSHIP
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Long term partnership ☐ Widow
List Children: Child’s Full Name Age Gender
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
Who is Living in Household? Number:_______ Names:________________________________________________________________________________
Their Employement/Occupations:________________________________________________________________________________
Resources for emotional support?
Check all that apply: ☐ Spouse ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other:________________________
Are you satisfied with your sex life? ☐ Yes ☐ No
How well have things been going for you? | Very Well | Fine | Poorly | N/A
---|---|---|---|---
- Overall
- 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

**ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT**

Do you have known adverse food reactions or sensitivities? ☐ Yes ☐ No If yes, describe symptoms:

---

Do you have any food allergies or sensitivities? ☐ Yes List all: ___________________________________________ ☐ No

Do you have an adverse reaction to caffeine? ☐ Yes ☐ No

When you drink caffeine do you feel: ☐ Irritable or Wired ☐ Aches and Pains

Do you adversely react to *(Check all that apply)*

☐ Monosodium glutamate (MSG) ☐ Aspartame (NutraSweet) ☐ Caffeine ☐ Bananas ☐ Garlic ☐ Onion

☐ Cheese ☐ Citrus Foods ☐ Chocolate ☐ Alcohol ☐ Red Wine

☐ Sulfite Containing Foods (wine, dried fruit, salad bars) ☐ Preservatives (ex. Sodium Benzoate)

☐ Other:________________________________________

Which of these significantly affect you? *(Check all that apply)*

☐ Cigarette Smoke ☐ Perfumes/Colognes ☐ Auto Exhaust Fumes ☐ Other:________________________________________

In your work or home environment, are you exposed to: ☐ Chemicals ☐ Electromagnetic Radiation ☐ Mold

Have you ever turned yellow (jaundiced)? ☐ Yes ☐ No

Have you ever been told you have Gilbert's Syndrome or a liver disorder? ☐ Yes ☐ No

Explain:__________________________________________________________________________________________

Do you have a known history of significant exposure to any harmful chemicals such as the following:

☐ Herbicides ☐ Insecticides (frequent visits of exterminator) ☐ Pesticides ☐ Organic Solvents

☐ Heavy Metals ☐ Other:________________________________________________________

Chemical Name, Date, Length of Exposure:__________________________________________________________________________________________

Do you dry clean your clothes frequently? ☐ Yes ☐ No

Do you or have you lived or worked in a damp or moldy environment or had other mold exposure? ☐ Yes ☐ No

Do you have pets or farm animals? ☐ Yes ☐ No
Please check all current symptoms occurring or present in the past 6 months

**GENERAL**
- Cold Hands & Feet
- Cold Intolerance
- Low Body Temperature
- Low Blood Pressure
- Daytime Sleepiness
- Difficulty Falling Asleep
- Early Waking
- Fatigue
- Fever
- Flushing
- Heat Intolerance
- Night Waking
- Nightmares
- No Dream Recall

**HEAD, EYES & EARS**
- Conjunctivitis
- Distorted Sense of Smell
- Distorted Taste
- Ear Fullness
- Ear Pain
- Ear Ringing/Buzzing
- Lid Margin Redness
- Eye Crusting
- Eye Pain
- Hearing Loss
- Hearing Problems
- Headache
- Migraine
- Sensitivity to Loud Noises
- Vision Problems (other than glasses)
- Macular Degeneration
- Vitreous Detachment
- Retinal Detachment

**MUSCULOSKELETAL**
- Back Muscle Spasm
- Calf Cramps
- Chest Tightness
- Foot Cramps
- Joint Deformity
- Joint Pain
- Joint Redness
- Joint Stiffness
- Muscle Pain
- Muscle Spasms
- Muscle Stiffness
- Muscle Twitches – around eyes
- Muscle Twitches – Arms or Legs

**DIGESTION**
- Anal Spasms
- Bad Teeth
- Bleeding Gums
- Bloating of Lower Abdomen
- Bloating of Whole Abdomen
- Bloating After Meals
- Blood in Stools
- Burping
- Canker Sores
- Cold Sores
- Constipation
- Cracking at Corner of Lips
- Cramps
- Dentures w/ Poor Chewing
- Diarrhea
- Alternating Diarrhea and Constipation
- Difficulty Swallowing
- Dry Mouth
- Excess Flatulence/Gas
- Fissures
- Food “Repeat” (Reflux)
- Gas
- Heartburn
- Hemorrhoids
- Indigestion
- Nausea
- Upper Abdominal Pain
- Vomiting
- Intolerance to:
  - Lactose
  - All Dairy Products
  - Wheat
  - Gluten (Wheat, Rye, Barley)
  - Corn
  - Eggs
  - Fatty Foods
  - Yeast
  - Liver Disease/Jaundice (yellow eyes/ skin)
  - Abnormal Liver Function Tests
  - Lower Abdominal Pain
  - Mucus in Stools
  - Periodontal Disease
  - Sore Tongue
  - Strong Stool Odor
  - Undigested Food in Stools

**MOOD/NERVES**
- Agoraphobia
- Anxiety
- Auditory Hallucinations
- Black-out
- Depression
- Difficulty
- Concentrating
- With Balance
- With Thinking
- With Judgment
- With Speech
- With Memory
- Dizziness (Spinning)
- Fainting
- Fearfulness
- Irritability
- Light-headedness
- Numbness
- Other Phobias
- Panic Attacks
- Paranoia
- Seizures
- Suicidal Thoughts
- Tingling
- Tremor/Trembling
- Visual Hallucinations

**EATING**
- Binge Eating
- Bulimia
- Can’t Gain Weight
- Can’t Lose Weight
- Can’t Maintain Healthy Weight
- Frequent Dieting
- Poor Appetite
- Salt Cravings
- Carbohydrate Cravings (breads, pasta)
- Sweet Cravings (candy, cookies, cakes)
- Chocolate Cravings
- Caffeine Dependency
SKIN PROBLEMS
- Acne on Back
- Acne on Chest
- Acne on Face
- Acne on Shoulders
- Athlete’s Foot
- Bumps on Back of Upper Arms
- Cellulite
- Dark Circles Under Eyes
- Ears Get Red
- Easy Bruising
- Lack of Sweating
- Eczema
- Hands
- Any Cracking?
- Any Peeling?
- Mouth/Throat
- Scalp
- Any Dandruff?
- Skin in General

LYMPH NODES
- Enlarged/neck
- Tender/neck
- Other Enlarged/Tender
- Lymph Nodes

NAILS
- Bitten
- Brittle
- Curve Up
- Frayed
- Fungus-Fingers
- Fungus-Toes
- Pitting
- Ragged Cuticles
- Ridges
- Soft
- Thickening of fingernails
- Thickening of toenails
- White Spots/Lines

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

CARDIOVASCULAR
- Angina/chest pain
- Breathlessness

ITCHING SKIN
- Skin in General
- Anus
- Arms
- Ear Canals
- Eyes
- Feet
- Hands
- Legs
- Nipples
- Nose
- Penis
- Roof of Mouth
- Scalp
- Throat

SKIN, DRYNESS OF
- Eyes
- Feet
- Any Cracking?
- Any Peeling?
- Hair

URINARY
- Bed Wetting
- Hesitancy (trouble getting started)
- Infection
- Kidney Disease
- Leaking/Incontinence
- Pain/Burning
- Prostate Infection
- Urgency

MALE REPRODUCTIVE
- Discharge From Penis
- Ejaculation Problem
- Genital Pain
- Impotence
- Prostate or Urinary Infection
- Lumps in Testicles
- Poor Libido (Sex Drive)

FEMALE REPRODUCTIVE
- Breast Cysts
- Breast Lumps
- Breast Tenderness
- Ovarian Cyst
- Poor Libido (Sex Drive)
- Vaginal Discharge
- Vaginal Odor
- Vaginal Itch
- Vaginal Pain with Sex
- Menstrual:
  - Bloating Breast Tenderness
  - Carbohydrate Cravings
  - Chocolate Cravings
  - Constipation
  - Decreased Sleep
  - Diarrhea
  - Fatigue
  - Increased Sleep
  - Irritability

  - Menstrual:
  - Cramps
  - Heavy Periods
  - Irregular Periods
  - No Periods
  - Scanty Periods
  - Spotting Between
Rate on a scale of 5 (very willing) to 1 (not willing):

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

Significantly modify your diet………………………………………☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Take several nutrition supplements each day………………………☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Keep a record of everything you eat each day……………………☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Modify your lifestyle (e.g., work demands, sleep habits)………………☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Practice a relaxation technique………………………………………☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Engage in regular exercise……………………………………………☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Have periodic lab tests to assess your progress………………………☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Comments____________________________________________________________________________________________
_______________________________________________________________________________________________________
_______________________________________________________________________________________________________
_______________________________________________________________________________________________________
_______________________________________________________________________________________________________

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?
☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities?
_______________________________________________________________________________________________________
_______________________________________________________________________________________________________
_______________________________________________________________________________________________________
_______________________________________________________________________________________________________

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?
☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Comments____________________________________________________________________________________________
_______________________________________________________________________________________________________
_______________________________________________________________________________________________________
_______________________________________________________________________________________________________
_______________________________________________________________________________________________________

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

How much on-going support and contact (e.g., telephone consults, e-mail correspondence) from our professional staff would be helpful to you as you implement your personal health program? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Comments____________________________________________________________________________________________
_______________________________________________________________________________________________________
_______________________________________________________________________________________________________
_______________________________________________________________________________________________________
_______________________________________________________________________________________________________
3 DAY DIET DIARY INSTRUCTIONS

It is important to keep an accurate record of your usual food and beverage intake as a part of your treatment plan. Please complete this Diet Diary for 3 consecutive days including one weekend day.

- Describe the food or beverage as accurately as possible e.g., milk - what kind? (whole, 2%, nonfat); toast (whole wheat, white, buttered); chicken (fried, baked, breaded); coffee (decaffeinated with sugar and ½ and ½).
- Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, ½ cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.
- Record all beverages, including water, coffee, tea, sports drinks, sodas/diet sodas, etc.
- Include any additional comments about your eating habits on this form (ex. craving sweet, skipped meal and why, when the meal was at a restaurant, etc.).
- Please note all bowel movements and their consistency (regular, loose, firm, etc.)

DIET DIARY – DAY 1

Name:____________________________________________________   Date:_______________________________________

Daily Exercise (Type of Activity / Time of Day / Duration): ____________________________________

Daily Bowel Movements:________________________________________________________________________

<table>
<thead>
<tr>
<th>TIME</th>
<th>FOOD/ BEVERAGE / AMOUNT</th>
<th>COMMENTS</th>
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</tbody>
</table>
**DIET DIARY – DAY 2**

Name:__________________________ Date:_____________________________________

Daily Exercise (Type of Activity / Time of Day / Duration): ______________________________________________________

Daily Bowel Movements:

<table>
<thead>
<tr>
<th>TIME</th>
<th>FOOD/ BEVERAGE / AMOUNT</th>
<th>COMMENTS</th>
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</tbody>
</table>

**DIET DIARY – DAY 3**

Name:__________________________ Date:_____________________________________

Daily Exercise (Type of Activity / Time of Day / Duration): ______________________________________________________

Daily Bowel Movements:

<table>
<thead>
<tr>
<th>TIME</th>
<th>FOOD/ BEVERAGE / AMOUNT</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
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</table>
Medical Symptoms Questionnaire (MSQ)

Name _______________________________ Date ________________

Rate each of the following symptoms based upon your typical health profile for the past 30 days. Add and total the scores.

**Point Scale**

<table>
<thead>
<tr>
<th>Point</th>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Never or almost never have the symptom</td>
<td>0</td>
</tr>
<tr>
<td>1</td>
<td>Occasionally have it, effect is not severe</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Occasionally have it, effect is severe</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>Frequently have it, effect is not severe</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>Frequently have it, effect is severe</td>
<td>4</td>
</tr>
</tbody>
</table>

**HEAD**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headaches</td>
<td></td>
</tr>
<tr>
<td>Faintness</td>
<td></td>
</tr>
<tr>
<td>Dizziness</td>
<td></td>
</tr>
<tr>
<td>Insomnia</td>
<td>Total</td>
</tr>
</tbody>
</table>

**EYES**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Watery or itchy eyes</td>
<td></td>
</tr>
<tr>
<td>Swollen, reddened or sticky eyelids</td>
<td></td>
</tr>
<tr>
<td>Bags or dark circles under eyes</td>
<td></td>
</tr>
<tr>
<td>Blurred or tunnel vision</td>
<td>Total</td>
</tr>
<tr>
<td>(does not include near or far-sightedness)</td>
<td></td>
</tr>
</tbody>
</table>

**EARS**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Itchy ears</td>
<td></td>
</tr>
<tr>
<td>Earaches, ear infections</td>
<td></td>
</tr>
<tr>
<td>Drainage from ear</td>
<td></td>
</tr>
<tr>
<td>Ringing in ears, hearing loss</td>
<td>Total</td>
</tr>
</tbody>
</table>

**NOSE**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stuffy nose</td>
<td></td>
</tr>
<tr>
<td>Sinus problems</td>
<td></td>
</tr>
<tr>
<td>Hay fever</td>
<td></td>
</tr>
<tr>
<td>Sneezing attacks</td>
<td></td>
</tr>
<tr>
<td>Excessive mucus formation</td>
<td>Total</td>
</tr>
</tbody>
</table>

**MOUTH/THROAT**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic coughing</td>
<td></td>
</tr>
<tr>
<td>Gagging, frequent need to clear throat</td>
<td></td>
</tr>
<tr>
<td>Sore throat, hoarseness, loss of voice</td>
<td></td>
</tr>
<tr>
<td>Swollen or discolored tongue, gums, lips</td>
<td></td>
</tr>
<tr>
<td>Canker sores</td>
<td>Total</td>
</tr>
</tbody>
</table>

**SKIN**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acne</td>
<td></td>
</tr>
<tr>
<td>Hives, rashes, dry skin</td>
<td></td>
</tr>
<tr>
<td>Hair loss</td>
<td></td>
</tr>
<tr>
<td>Flushing, hot flashes</td>
<td></td>
</tr>
<tr>
<td>Excessive sweating</td>
<td>Total</td>
</tr>
</tbody>
</table>

**HEART**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irregular or skipped heartbeat</td>
<td></td>
</tr>
<tr>
<td>Rapid or pounding heartbeat</td>
<td></td>
</tr>
<tr>
<td>Chest pain</td>
<td>Total</td>
</tr>
<tr>
<td>LUNGS</td>
<td>Chest congestion</td>
</tr>
<tr>
<td>------</td>
<td>------------------</td>
</tr>
<tr>
<td>DIGESTIVE TRACT</td>
<td>Nausea, vomiting</td>
</tr>
<tr>
<td>JOINTS/MUSCLE</td>
<td>Pain or aches in joints</td>
</tr>
<tr>
<td>WEIGHT</td>
<td>Binge eating/drinking</td>
</tr>
<tr>
<td>ENERGY/ACTIVITY</td>
<td>Fatigue, sluggishness</td>
</tr>
<tr>
<td>MIND</td>
<td>Poor memory</td>
</tr>
<tr>
<td>EMOTIONS</td>
<td>Mood swings</td>
</tr>
<tr>
<td>OTHER</td>
<td>Frequent illness</td>
</tr>
</tbody>
</table>

GRAND TOTAL TOTAL ________