Health Questionnaires

We want to hear your story!

Mulberry Clinics
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Spring Hill, TN 37174

Phone: 615-614-2500
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GENERAL INFORMATION

Your story is important to us. Please fill out this form carefully. Incomplete form may delay your appointment.

First *Middle* *Last*

Name : _____

Preferred Name: _____

Date of Birth: _____

Age: _____

Gender: ▢ Male ▢ Female

Genetic Background: ▢ African ▢ European ▢ Native American ▢ Mediterranean

▢ Asian ▢ Ashkenazi ▢ Middle Eastern ▢ _____

Highest Education Level: ▢ High School ▢ Under-Graduate ▢ Post-Graduate

---

Job Title: _____

Nature of Business:

Number, Street

Primary Address: _____

City *State* *Zip*

Alternate Address: *Number, Street*

City *State* *Zip*

Phone: *Cell* *Work* *Fax*

Email:

Emergency Contact: *Name* *Phone Number*

Relationship: *Cell Phone*

Address *Work Phone*

City *State* *Zip*

Primary Care Physician: *Name* *Phone* *Fax*

Referred By: ▢ Book ▢Website ▢ Media ▢ Family or Friend

▢ PCP ▢ Other

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ALLERGIES

Medication/ Supplement / Food	Reaction

COMPLAINTS/CONCERNS

What do you hope to achieve with 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? _____

_____

Describe Problem	Mild	Moderate	Severe	Prior Treatment/Approach	Excellent	Good	Fair
Example: Post Nasal Drip		*X*		*Elimination Diet*	*X*		

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MEDICAL HISTORY

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

Poor Condition	Ongoing Condition	
		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)
☐	☐	Hyperthyroidism (overactive thyroid)_____
☐	☐	Hypothyroidism (low 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_____

Poor Condition	Ongoing Condition	
		GENITAL AND URINARY SYSTEM
☐	☐	Kidney Stones_____
☐	☐	Gout_____
☐	☐	Interstitial Cystitis_____
☐	☐	Frequent Urinary Tract Infection_____
☐	☐	Frequent Yeast Infection_____
☐	☐	Erectile Dysfunction_____ Or Sexual Dysfunction
☐	☐	Other_____
		MUSCULOSKELETAL/PAIN
☐	☐	Ostearthritis_____
☐	☐	Fibromyaliga_____
☐	☐	Chronic Pain_____
☐	☐	Other _____
		INFLAMMATORY/AUTOIMMUNE
☐	☐	Chronic Fatigue Syndrome_____
☐	☐	Autoimmune Disease_____
☐	☐	RheumatoidArthritis_____
☐	☐	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_____

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MEDICAL HISTORY (continued)_____

NEUROLOGICAL

Past Condition	Ongoing Condition		Past Condition	Ongoing Condition	
▢	▢	Depression_____	▢	▢	Mild Cognitive Impairment_____
▢	▢	Anxiety_____	▢	▢	Memory Problems_____
▢	▢	Bipolar Disorder_____	▢	▢	Parkinson's Disease_____
▢	▢	Schizophrenia_____	▢	▢	Multiple Sclerosis_____
▢	▢	Headaches_____	▢	▢	ALS_____
▢	▢	Migraines_____	▢	▢	Seizures_____
▢	▢	ADD/ADHD_____	▢	▢	Other Neurological Problems_____
▢	▢	Autism_____			

PREVENTATIVE TESTS AND DATE OF LAST TEST

Check box if yes and provide date

- ▢ Full Physical Exam_____
- ▢ Bone Density_____
- ▢ Colonoscopy_____
- ▢ Cardiac Stress Test_____
- ▢ EBT Heart Scan_____
- ▢ EKG_____
- ▢ Hemoccult Test-stool for blood_____
- ▢ MRI_____
- ▢ CT Scan_____
- ▢ Upper Endoscopy_____
- ▢ Upper GI Series_____
- ▢ Ultrasound_____

SURGERIES

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 ▢ **None**

Date	*Reason*

COMMENTS

_____
_____
_____
_____

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GYNECOLOGIC HISTORY (for women only)

OBSTETRIC HISTORY *Check box if yes and provide number of*

▢ Pregnancies_____ ▢ Caesarean_____ ▢ Vaginal Deliveries_____

▢ Miscarriage_____ ▢ Abortion_____ ▢ Living Deliveries_____

▢ Postpartum Depression ▢ Toxemia ▢ Gestational Diabetes ▢ Baby over 8 pounds

▢ Breastfeeding for how long?_____

MENSTRUAL HISTORY

Age first period:_____ Menses Frequency:_____ Length:_____ Pain: ▢ Yes ▢ No Clotting: ▢ Yes ▢ No

Has your 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 Mammogram: _____ 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 ▢ Greater than 10

▢ Prostate Enlargement ▢ Prostate Infection ▢ Change in Libido ▢ Impotence

▢ Difficulty Obtaining an Erection ▢ Difficulty Maintaining an Erection

▢ Nocturia (urination at night) How Many times a night? _____

▢ Urgency/Hesitancy/Change in urinary stream ▢ Loss of control of urine

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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: _____

▢ Breast Fed How long?_____ ▢ Bottle Fed

Age at introduction of: Solid foods: _____ Dairy: _____ Wheat: _____

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

ANY OTHER MEDICAL HISTORY TO TELL US

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MEDICATIONS

CURRENT MEDICATIONS

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

PREVIOUS MEDICATION *(Last 10 years)*

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

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

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

Have your medicine 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

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FAMILY HISTORY_____

Check family members that apply	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandfather	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunt	Uncle	Other
Age (if still alive)												
Age at death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian cancer												
Heart disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic, etc.)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Autoimmune Diseases (ex. Lupus)												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema/Psoriasis												
Food Allergies, Sensitivities, or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Substance Abuse												
Genetic Disorders												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												

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SOCIAL HISTORY

NUTRITION HISTORY

Have you ever had a nutrition consultation? ▢ Yes ▢ No

Have you ever made changes to your eating habits because of your health? ▢ Yes ▢ No Describe: _____

Do you currently follow a special diet or nutritional plan? ▢ 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_____

Height (feet/inches) _____	Current Weight _____
Usual Weight Range +/- 5 lbs _____	Designated Weight Range +/- 5 lbs _____
Highest Adult Weight _____	Lowest Adult Weight _____
Weight Fluctuations (> 10 lbs) ▢ Yes ▢ No	Lowest Body fat % _____

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 ▢ More than 5

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

▢ Fast eater
▢ Erratic eating problem
▢ 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 restrictions or food preferences
▢ Love to eat
▢ Eat because I have to
▢ Have a negative relationship with 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 advice

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

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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 ▢ More than 10 *If none, skip to "Other Substances"*

Previous alcohol intake ▢ Yes (▢ Mild ▢ Moderate ▢ High) ▢ None

Have you ever been told that you need to 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 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)*

Activity	**Type**	**Frequency Per Week**	**Duration in Minutes**
Stretching			
Cardio/Aerobics			
Strength			
Other (yoga, pilates, gyrotonics, etc.)			
Sports or Leisure Activities (golf, tennis, etc.)			

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

List your problems that limit activity:_____

_____

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

_____

Do you usually sweat while exercising? ▢ Yes ▢ No

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PSYCHOLOGICAL

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 feel 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 a scale of 1-10

Work:_____ Family:_____ Social:_____ Finances:_____ Health:_____ Other:_____

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

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

SLEEP/REST

Average number of hours you sleep per night: ▢ Greater than 10 ▢ 8-10 ▢ 6-8 ▢ Less than 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 the household? Number:_____ Names:_____

Their Employment/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 any adverse food reactions or sensitivities? ▢ Yes ▢ No If yes, describe symptoms:

_____

Do you have any food allergies or sensitivities? ▢ Yes ▢ No List all: _____

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, and salad bars) ▢ Preservatives (ex. Sodium Benzoate)

▢ Other:_____

Which of the following 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 jaundiced (yellow)? ▢ 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 ▢ Pesticides ▢ Organic Solvents ▢ Heavy Metals ▢ Other:_____

Chemical Name, Date, and Length of Exposure:_____

Do you dry clean your clothes frequently? ▢ Yes ▢ No | Do you have pets or farm animals? ▢ Yes ▢ No

Have you ever lived or worked in a damp or moldy environment or had other mold exposure? ▢ Yes ▢ No

Have you ever had a concerning tick bite? ▢ Yes ▢ No

Could you have Lyme Disease or a similar disease? ▢ Yes ▢ No

READINESS ASSESSMENT

Rate on a scale of 5 (very willing) to 1 (not willing):

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

Practice a brain retraining exercise . . . . . ▢ 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?

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 (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_____

_____

_____

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PTOM REVIEW

Please check all current symptoms occurring or present in the past 6 months.

GENERAL

- ▢ Cold hands and 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
- ▢ Muscle Weakness
- ▢ Tendonitis
- ▢ Tension Headache
- ▢ TMJ Problems

MOOD/NERVES

- ▢ Agoraphobia
- ▢ Anxiety
- ▢ Auditory Hallucinations
- ▢ Black-out
- ▢ Depression

DIFFICULTY

- ▢ Concentrating
- ▢ With balance
- ▢ With thinking
- ▢ With judgement
- ▢ 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 a healthy weight
- ▢ Frequent dieting
- ▢ Poor appetite
- ▢ Salt cravings
- ▢ Carbohydrate cravings
- ▢ Sweet cravings
- ▢ Chocolate cravings
- ▢ Caffeine dependency

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
- ▢ Mucus in stools
- ▢ Periodontal disease
- ▢ Sore tongue
- ▢ Strong stool odor
- ▢ Undigested food in stools
- ▢ Lower abdominal pain

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SKIN ISSUES

- ▢ 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
- ▢ Hives
- ▢ Jock itch
- ▢ Lackluster skin
- ▢ Moles w/ color/size/change
- ▢ Oily skin
- ▢ Pale skin
- ▢ Patchy dullness
- ▢ Rash
- ▢ Red face
- ▢ Sensitivity to bites
- ▢ Sensitivity to Poison Ivy/Oak
- ▢ Shingles
- ▢ Skin darkening
- ▢ Strong body odor
- ▢ Hair loss
- ▢ Vitiligo

ITCHING SKIN

- ▢ Skin in general
- ▢ Anus
- ▢ Arms
- ▢ Ear canals
- ▢ Eyes
- ▢ Feet
- ▢ Hands
- ▢ Legs
- ▢ Nipples
- ▢ Nose
- ▢ Penis
- ▢ Roof of mouth
- ▢ Scalp
- ▢ Sinus infection

SKIN, DRYNESS OF

- ▢ Eyes
- ▢ Feet
- ▢ Cracking-Feet
- ▢ Peeling-Feet
- ▢ Hair
- ▢ Hair unmanageable?
- ▢ Hands
- ▢ Cracking-Hands
- ▢ Peeling-Hands
- ▢ 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 stuffiness
- ▢ Nose bleeds
- ▢ Post nasal drip
- ▢ Sinus fullness

MENSTRUAL

- ▢ Snoring
- ▢ Wheezing
- ▢ Winter stuffiness
- ▢ Heart Murmur
- ▢ Irregular Pulse
- ▢ Palpitations
- ▢ Phlebitis
- ▢ Swollen ankles/feet
- ▢ Varicose veins

URINARY

- ▢ Bed wetting
- ▢ Hesitancy
- ▢ Infection
- ▢ Kidney disease
- ▢ Leaking/incontinence
- ▢ Pain/burning
- ▢ Prostate infection
- ▢ Urgency

MALE REPRODUCTIVE

- ▢ Discharge from penis
- ▢ Ejaculation problem
- ▢ Genital pain
- ▢ Impotence
- ▢ Prostate infection or UTI
- ▢ Lumps in testicles
- ▢ Poor libido (sex drive)

FEMALE REPRODUCTIVE

- ▢ Breast cysts
- ▢ Breast lumps
- ▢ Indigestion
- ▢ Ovarian cyst
- ▢ Poor libido (sex drive)
- ▢ Vaginal discharge
- ▢ Vaginal odor
- ▢ Vaginal itch
- ▢ Vaginal pain with sex

PREMENSTRUAL

- ▢ Bloating/Breast tenderness
- ▢ Carbohydrate cravings
- ▢ Chocolate cravings
- ▢ Constipation
- ▢ Decreased sleep
- ▢ Diarrhea
- ▢ Fatigue
- ▢ Increased sleep
- ▢ Irritability
- ▢ Throat
- ▢ Cramps
- ▢ Heavy periods
- ▢ Irregular periods
- ▢ No periods
- ▢ Scanty periods
- ▢ Spotting between

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3-DAY DIET INSTRUCTIONS

It is important to keep an accurate record of your usual food and beverage intake as 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 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:_____

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

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DIET DIARY - DAY 2

Name:_____ Date:_____

Daily Exercise (Type of Activity / Time of day / Duration):_____

_____

Daily Bowel Movements:_____

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

DIET DIARY - DAY 3

Name:_____ Date:_____

Daily Exercise (Type of Activity / Time of day / Duration):_____

_____

Daily Bowel Movements:_____

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

OTHER COMMENTS / QUESTIONS / CONCERNS:_____

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Medical Symptoms Questionnaire

Name _____ **Date**_____

Rate each of the following symptoms based upon your typical health profile for the ***past 30 days***

Point Scale *0 - Never or almost never have the symptom*
1 - Occasionally have it, effect is not severe
2 - Occasionally have it, effect is severe
3 - Frequently have it, effect is not severe
4 - Frequently have it, effect is severe

HEAD

_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia Total:_____

EYES

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

EARS

_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss Total:_____

NOSE

_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation Total:_____

MOUTH/THROAT

_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, lips
_____ Canker sores Total:_____

SKIN

_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating Total:_____

HEART

_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain Total:_____

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LUNGS

_____	Chest congestion	
_____	Asthma, bronchitis	
_____	Shortness of breath	
_____	Difficulty breathing	Total:_____

DIGESTIVE TRACT

_____	Nausea, vomiting	
_____	Diarrhea	
_____	Constipation	
_____	Bloated feeling	
_____	Belching, passing gas	
_____	Heartburn	
_____	Intestinal/Stomach pain	Total:_____

JOINTS/MUSCLE

_____	Pain or aches in joints	
_____	Arthritis	
_____	Stiffness or limitation of movement	
_____	Feeling weakness or tiredness	Total:_____

WEIGHT

_____	Binge eating/drinking	
_____	Craving certain foods	
_____	Excessive weight	
_____	Compulsive eating	
_____	Water retention	
_____	Underweight	Total:_____

ENERGY/ACTIVITY

_____	Fatigue, sluggishness	
_____	Apathy, lethargy	
_____	Hyperactivity	
_____	Restlessness	Total:_____

MIND

_____	Poor memory	
_____	Confusion, poor comprehension	
_____	Poor concentration	
_____	Poor physical coordination	
_____	Difficulty in making decisions	
_____	Stuttering or stammering	
_____	Slurred speech	
_____	Learning disabilities	Total:_____

EMOTIONS

_____	Mood swings	
_____	Anxiety, fear, nervousness	
_____	Anger, irritability, aggressiveness	
_____	Depression	Total:_____

OTHER

_____	Frequent illness	
_____	Frequent or urgent urination	
_____	Genital itch or discharge	Total:_____

GRAND TOTAL ***TOTAL***:_____