BINGHAM MEMORIAL
INTERNATIONAL AUTOIMMUNE INSTITUTE
AND CENTER FOR FUNCTIONAL MEDICINE

Health Questionnaire

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TABLE OF CONTENTS

New Patient Information
Consent for Treatment, Financial Agreement, and Records Release

PATIENT NAME DOB SOCIAL SECURITY #

My Family Physician/Primary Health Care Practitioner is:

I chose to come to your clinic today because:

I, the undersigned, as a patient (or authorized person), consent to any treatment and/or procedures rendered to me that I may, under the judgment and instruction of the treating provider, be considered advisable or necessary. I understand that if any extensive procedure or surgery is performed, it will be fully explained to me, including the risks and alternatives, and my specific consent will be necessary.

I understand that any ancillary services {x-rays, lab tests, etc.) that may be ordered by the medical provider while I am in the clinic are not included in my clinic bill and that I will be billed separately for these services.

In addition, I authorize Idaho Physicians Clinic Bingham Memorial Hospital, along with any contracted provider services, to furnish all medical and financial information for this visit Medicare, Medicaid, my insurance carrier and/or any agency working on their behalf. I hereby authorize payment of benefits on my behalf to any of the providers performing services related to this encounter. I understand that certain services may not be covered or may be denied by my insurance carrier and I hereby guarantee payment of the charges incurred and agree to pay unpaid balance. I authorize the use of my medical records for performance improvement activities at this facility.

I understand that I may be charged an amount of $35 If i had an established appointment and have failed to cancel or postpone the event 24 hours in advance

I, the undersigned, have read the above authorizations and understand the same and certify that no guarantee or assurances have been made as to the results or outcome of treatment or diagnosis,

___ (Initial) I have been offered a copy of “Your Rights and Responsibilities as a Patient,” and “Notice of Privacy Practices.”

Signature of patient or Legal Guardian Date / Time

Relationship to patient (If Patient unable to sign) Reason Patient unable to sign

Patient Name Birthday M/F Age

Address City State Zipcode Email

Home Phone Cell Phone Preferred Pharmacy

Today's Date Referred By Social Security Number

Race Religion Language Preference

☐ Married ☐ Single ☐ Widowed ☐ Divorced Are you pregnant? ☐ Yes ☐ No

If patient is a minor: Mother's Name _____ Father's Name _____

Employer Occupation Work Phone Number

Employer Address Employer Phone Number

Health Insurance: Medicare Medicaid Other None

Primary Secondary Rx

Policy Holder Name Policy Holder DOB (Please provide copies of all insurance/Rx cards)

Reason for Today's Visit _____ Right / Left _____

When Did This Problem Start? _____ Have You Had The Same Problem Before? Yes ☐ No ☐

Date of Injury? _____ On the Job Accident? Yes ☐ No ☐ Auto Accident? Yes ☐ No ☐

Who is Your Family Physician? _____ Phone Number: _____

List your medical Problems: (Such as High Blood Pressure, Diabetes, Thyroid Problem, Heart Troubles, Ulcers, Cancer, Seizures, Blood Clots, Depressions, or any other)

Have you or anyone in your family had or currently have skin cancer? If yes, who?

☐ Melanoma ☐ Basal Cell Caroma ☐ Squamous Cell Caroma ☐ Other

PLEAE LIST ANY SURGERIES YOU HAVE HAD INCLUDING BLOOD TRANSFUSIONS AND THE APPROXIMATE DATES:

List All Medications You Are Taking: (or attach list) NONE ☐

Current Medications (over the counter and prescription What is it taken for?

Be sure to include any blood thinners (Coumadin, Warfarin, Flavix, Clopidogrel, Lovenox, Asprin, Vitamin Em Ibuprofen, Garlic, Gingko, Ginseng, Ginger, Green Tean, Black Licorice).

Medication Allergies: _____

Any Other Allergies:
Have you had any of these problems in the last month?

General	Eyes	Ears	Nose/Mouth/Throat	Cardiovascular
☐ Fever ☐ Chills ☐ Unexplained Weight loss/gain ☐ Fatigue ☐ Night Sweats	☐ Visual changes ☐ Eye pain ☐ Contacts/glasses	☐ Hearing loss ☐ Ear pain	☐ Nasal congestion ☐ Oral lesions ☐ Sore throat	☐ Chest pain ☐ Palpitations ☐ Artificial heart valves ☐ Heart murmer requiring antibiotic prophylaxis

Respiratory	Gastrointestinal	Genitourinary	Integumetary	Neurological
☐ Cough ☐ Shortness of breath ☐ Wheezing	☐ Diarrhea ☐ Constipation ☐ Blood in stool ☐ Heartburn ☐ Abdominal pain ☐ Nausea/Vomiting	☐ Urinary frequency ☐ Blood in urine ☐ Incontinence ☐ Yeast infection with antibiotic use	☐ Rash ☐ Skin lesions ☐ Reactive to bandages or skin tape ☐ Excessive scarring	☐ Headaches ☐ Numbness ☐ Dizziness ☐ Trauma ☐ Weakness ☐ Tremors ☐ Seizures

Psychiatric	Hematologic / Lymphatic	Allergic / Immunologic	Endocrine	Musculoskeletal
☐ Anxiety ☐ Depression ☐ Addiction	☐ Easy bruising ☐ Easy bleeding ☐ Swollen glands	☐ Recurrent infections ☐ Seasonal allergies ☐ Immuno-suppressed	☐ Hair loss ☐ Hot flashes ☐ Swollen lymph node ☐ Excessive thirst	☐ Trauma ☐ Joint Replacement ☐ Arthritis

Musculoskeletal History: (Please list all fractures/injuries, joint pain/swelling, back pain, shoulder pain, leg or ankle pain, other) Please explain: _____

Have you ever been treated with: ☐ Digitalis ☐ Insulin ☐ Steroid Aspirin ☐ Other

Tobacco Use? Yes ☐ No ☐ Vape/Chew/Smoke? How Often: Quit Date:

Do you drink Alcoholic Beverages? Yes ☐ No ☐ How much?

Relative	Living	Deceased at what age?	Medical Problems	Cause of Death
Father				
Mother				
Siblings				
Children				

In Other Blood Relatives, is there any history of:

Yes	No		Yes	No		Yes	No	
☐	☐	Tuberculosis	☐	☐	Heart Trouble	☐	☐	High Blood Pressure
☐	☐	Kidney Trouble	☐	☐	Birth Defects	☐	☐	Diabetes
☐	☐	Bleeding Tendencies	☐	☐	Cancer	☐	☐	Mental or Nervous Disorders
						☐	☐	Malignany Hypothermia

Patient Name _____ Signature _____ Date/Time _____

Emergency Contact _____ Phone Number: _____

ALLERGIES

Medication/Supplement/ Food	Reaction

COMPLAINTS 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 your current and ongoing problems in the order of priority:

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

MEDICAL HISTORY

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

Past 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)
- ☐ ☐ Hypotension (low 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 (POCS)
- ☐ ☐ 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_____

Past Condition *Ongoing Condition*

GENITAL AND URINARY SYSTEM
- ☐ ☐ Kidney Stones
- ☐ ☐ Gout
- ☐ ☐ Interstitial Cystitis
- ☐ ☐ Frequent Urinary Tract Infections
- ☐ ☐ Frequent Yeast Infections
- ☐ ☐ Erectile Dysfunction
- ☐ ☐ Sexual Dysfunction
- ☐ ☐ Other_____

MUSCULOSKELETAL/PAIN
- ☐ ☐ Osteoarthritis
- ☐ ☐ Fibromyalgia
- ☐ ☐ Chromic Pain
- ☐ ☐ Other_____

INFLAMMATORY/AUTOIMMUNE
- ☐ ☐ Chronic Fatigue Syndrome
- ☐ ☐ Autoimmune Disease
- ☐ ☐ Rheumatoid Arthritis
- ☐ ☐ Lupus SLE
- ☐ ☐ Immune Deficiency Disease
- ☐ ☐ Herpes-Genital
- ☐ ☐ Severe Infectious Function
- ☐ ☐ Poor Immune Function (Frequent Infections)
- ☐ ☐ Food Allergies
- ☐ ☐ Environmental Allergies
- ☐ ☐ Multiple Chemical Sensitivities
- ☐ ☐ Latex Allergy
- ☐ ☐ Hashimoto's Thyroiditis
- ☐ ☐ Lyme Disease, Chronic
- ☐ ☐ PANDAS (Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections)
- ☐ ☐ Polymyalgia Rheumatica
- ☐ ☐ Polymyositis
- ☐ ☐ Psoriatic Arthritis
- ☐ ☐ Raynaud's Disease
- ☐ ☐ Sjogren's Syndrome
- ☐ ☐ Vitiligo
- ☐ ☐ Multiple sclerosis
- ☐ ☐ Other_____

RESPIRATORY DISEASES
- ☐ ☐ Asthma
- ☐ ☐ Chronic Sinusitis
- ☐ ☐ Bronchitis
- ☐ ☐ Emphysema
- ☐ ☐ Pneumonia
- ☐ ☐ Tuberculosis

MEDICAL HISTORY *(continued)*

Past Condition	*Ongoing Condition*	**SKIN DISEASES**
☐	☐	Eczema
☐	☐	Psoriasis
☐	☐	Acne
☐	☐	Melanoma
☐	☐	Skin Cancer
☐	☐	Other_____
		NEUROLOGICAL
☐	☐	Depression
☐	☐	Anxiety
☐	☐	Bipolar Disorder
☐	☐	Schizophrenia

Past Condition	*Ongoing Condition*	**NEUROLOGICAL (CONT.)**
☐	☐	Headaches
☐	☐	Migraines
☐	☐	ADD/ADHD
☐	☐	Autism
☐	☐	Mild Cognitive Impairment
☐	☐	Memory Problems
☐	☐	Parkinson's Disease
☐	☐	Multiple Sclerosis
☐	☐	ALS
☐	☐	Seizures
☐	☐	Other_____

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 test for blood_____
- ☐ MRI _____
- ☐ CT Scan _____
- ☐ Upper Endoscopy_____
- ☐ Upper Endoscopy_____
- ☐ Upper GI Series _____
- ☐ Ultrasound _____
- ☐ Other_____

SURGERIES

Check box if yes and provide date of surgery

- ☐ Apendectomy_____
- ☐ Hysterectomy +/- Ovaries _____
- ☐ Gall Bladder_____
- ☐ Hernia _____
- ☐ Tonsillectomy_____
- ☐ Dental Surgery_____
- ☐ Joint Replacement – Knee/Hip _____
- ☐ Heart Surgery - Bypass Valve _____
- ☐ Angioplasty or Stent _____
- ☐ Pacemaker _____
- ☐ Other _____
- ☐ None

INJURIES

Check box if yes and provide date

- ☐ Back Injury
- ☐ Head Injury
- ☐ Neck Injury
- ☐ Broken Bones
- ☐ Other _____

BLOOD TYPE

- ☐ A
- ☐ B
- ☐ AB
- ☐ O
- ☐ RH+
- ☐ Unknown

HOSPITALIZATION ☐ None

Date	*Reason*

COMMENTS

_____

_____

_____

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 ☐ Vaginal Delivery ☐ C-Section
Pregnancy Complications: _____
Birth Complications:
☐ Breast Fed How long?_____ ☐ Bottle Fed ☐ Difficulty Tolerating Formula
Age at introduction of: Solid Foods:_____ Dairy :_____ Wheat:_____
Did you eat a lot of candy or sugar as a child? ☐ Yes ☐ No

CHILDHOOD HISTORY

☐ Asthma ☐ Abdominal Pain ☐ Allergies ☐ ADD/ADHD ☐ Eczema ☐ Psoriasis ☐ Acne
☐ Fatigue ☐Headaches ☐ Constipation ☐ Mononucleosis ☐ Ear Infections - How many?_____
☐ Sinus Infection- How many?_____ ☐ Strep Throat- How many? _____
☐ Age of 1st antibiotic?_____ ☐ Number of times on antibiotics?_____

ADVERSE CHILDHOOD EVENTS (ACE)

☐ Divorce ☐ Separations ☐ Substance Abuse ☐ Incarceration ☐ Death of a Close Family Member
☐ Physical Abuse ☐ Verbal Abuse ☐ Sexual Abuse ☐ Trauma ☐ Other _____

DENTAL HISTORY

☐ Silver Mercury Fillings How many?_____
☐ Gold Fillings ☐ Root Canals ☐ Implants ☐ Tooth Pain ☐ Bleeding Gums
☐ Gingivitis ☐ Problems with Chewing ☐ Other _____
Do you floss regularly? ☐ Yes ☐ No

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 ☐ Prostrate Infection ☐ Change in Libido ☐ Impotence
☐ Difficulty Obtaining an Erection ☐ Difficulty Maintaining and Erection
☐ Nocturia (urination at night) - How many times at night?_____
☐ Urgency/Hesitancy/Change in Urinary Stream ☐ Loss of Control of Urine

GYNECOLOGIC HISTORY (for women only)

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

☐ Pregnancies_____ ☐ 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
Describe menstrual flow: ☐ Heavy ☐ Moderate ☐ Mild ☐ Not present
Color of menstrual flow: ☐ Dark ☐ Bright red ☐ Slightly reddish
Cramping: ☐ Severe ☐ Moderate ☐ Mild ☐ Before period ☐ During period ☐ At end of period
Has your period ever skipped?_____ For how long?_____
When did your last menstrual period start:_____
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
Could you be pregnant now? ☐ Yes ☐ No

WOMEN'S DISORDERS/HORMONAL IMBALANCES

☐ Fibrocystic Breasts ☐ Endometriosis ☐ Fibroids ☐ Infertility ☐ Ovarian Cysts
☐ PMS ☐ Yeast Infection - How many?_____
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?_____ Type?_____

MEDICATIONS

CURRENT MEDICATIONS

Medications	Dose	Frequency	Start Date (month/year)	Reason for Use

PREVIOUS MEDICATIONS *(Last 10 years)*

Medications	Dose	Frequency	Start Date (month/year)	Reason for Use

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

Medications	Dose	Frequency	Start Date (month/year)	Reason for Use

NUTRITIONAL SUPPLEMENTS (Cont.)

Medications	Dose	Frequency	Start Date (month/year)	Reason for Use

Have your medications or supplements ever caused you unusual side effects or problems? ☐ Yes ☐ No
Describe: _____

_____

_____

_____

Have you ever 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 antibiotic ☐ 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	Mother	Father	brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Maternal Grandfather	Aunt	Uncle	Other
Age (if still alive)												
Age at death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Prostate Cancer												
Skin Cancer												
Heart Disease												
Hypertension												
Thyroid Disease												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis(Rheumatiod, Psoriatic, Ankylosing Spondylitis)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Diseases (such as 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												
Genetic Disorders												
Substance Abuse (such as alcoholism)												

FAMILY HISTORY (Cont.)

Check family members that apply	Mother	Father	brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Maternal Grandfather	Aunt	Uncle	Other
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												
Osteoporosis												
Seizures												

SOCIAL HISTORY

NUTRITION HISTORY

Have you ever had a nutrition consultation? ☐ Yes ☐ No
Have you made any changes to your eating habits because of your health? ☐ Yes ☐ No
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 ☐ VegetarianVegan ☐ Ultrametabolism ☐ High Fat ☐ Mediterranean ☐ Paleolithic
☐ Specific Program for Weight Loss/Maintenance Type:_____ ☐ Other_____

Height (Feet/Inches) _____	Current Weight _____
Usual Weight Range +/- 5 lbs_____	Desired Weight Range +/-_____
Highest Adult Weight _____	Lowest Adult Weight _____
Weight Fluctuations (>10 lbs) ☐ Yes ☐ No	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 ☐ 4-5 ☐ >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 do 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?_____

DRINKING

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 that you should cut down on 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 How do you take your coffee? _____
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:_____
Hae 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, 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 in your life? ☐ Yes ☐ No
If yes, please describe: _____
_____
Do you usually sweat when exercising? ☐ Yes ☐ No

PSYCHOSOCIAL

Do you feel significantly less vital that 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 had counseling? ☐ Yes ☐ No

Are you currently in therapy? ☐ Yes ☐ No Describe:_____

Do you feel you have a 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 ☐ Mediation ☐ Imagery ☐ Breathing ☐ Tai Chi ☐ Prayer Other:_____

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

SLEEP/REST

Average number of hours you sleep per night: ☐ >10 ☐ 8-10 ☐ 6-8 ☐ <6

Do you have problems with insomnia? ☐ Yes ☐ No

Do you have trouble falling asleep? ☐ Yes ☐ No

Do you wake in the middle of the night? ☐ Yes How many times?_____ ☐ No

Do you feel rested upon awakening? ☐ 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:_____

TheirEmployment/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 any 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) ☐ Aspertame (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 tof exterminator) ☐ Pesticides ☐ Organic Solvents

☐ Heavy Metals ☐ Other_____

Chemical Name, Date, Length of Exposure:_____

Do you dry clean you 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

Does your home use well water? ☐ Yes ☐ No

SYMPTOM REVIEW

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

HEAD, EYES, EARS, NOSE, THROAT

- ☐ Conjunctivitis
- ☐ Distorted Sense of Smell
- ☐ Distorted Taste
- ☐ Ear Fullness
- ☐ Ear Pain
- ☐ Ear Ringing/Buzzing
- ☐ Post Nasal Drip
- ☐ Nasal Stuffiness
- ☐ Nose Bleeds
- ☐ Eye Pain
- ☐ Hearing Loss
- ☐ Hearing Problems
- ☐ Headache
- ☐ Vision Problems
- ☐ Teeth Grinding
- ☐ Thyroid problems
- ☐ Pain Behind Eyes
- ☐ Migraine
- ☐ Bad odor in Nose
- ☐ Sore Throat
- ☐ Sensitivity to Loud Noises
- ☐ Macular Degeneration
- ☐ Vitreous Detachment
- ☐ Retinal Detachment

CARDIOVASCULAR

- ☐ Angina/chest pain
- ☐ Breathlessness
- ☐ Irregular Heartbeats
- ☐ Purple Nails
- ☐ Heart Murmur
- ☐ Irregular Pulse
- ☐ Palpitations
- ☐ Phlebitis
- ☐ Swollen Ankles/Feet
- ☐ Varicose Veins
- ☐ Leg Cramps when Walking
- ☐ Leg Cramps at Night
- ☐ Low Blood Pressure
- ☐ Anemia
- ☐ Poor Circulation
- ☐ Swollen Hands
- ☐ Swollen Face
- ☐ High Blood Pressure
- ☐ High Choleserol

DIGESTION

- ☐ Anal Spasms
- ☐ Bad Teeth
- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Bloating of Lower Abdomen
- ☐ Bloating of Whole Abdomen
- ☐ Bloating After Meals
- ☐ Blood in Stools
- ☐ Burping
- ☐ Mouth sores
- ☐ Constipation
- ☐ Cracking at the Corner of Lips
- ☐ Cramps
- ☐ Dentures w/ Poor Chewing
- ☐ Diarrhea
- ☐ Alternating Diarrhea and Constipation
- ☐ Difficulty Swallowing
- ☐ Dry Mouth
- ☐ Excess Flatulence/ Gas
- ☐ Fissures
- ☐ Food "Repeating" (Reflux)
- ☐ Gallbladder Problems
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Upper Abdominal Pain
- ☐ Vomiting

Intolerance to:

- ☐ Lactose
- ☐ All Daity Products
- ☐ Wheat
- ☐ Gluten (Wheat, Rye, Barley)
- ☐ Corn
- ☐ Eggs
- ☐ Fatty Foods
- ☐ Yeast
- ☐ Liver Diease/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

BOWEL HABITS

- ☐ Black/Tarry Stools
- ☐ Blood in Stools
- ☐ Constipation
- ☐ Diarrhea/Loose Stools
- ☐ Hemorrhoids
- ☐ Use of Laxatives
- ☐ Mucus in Stools
- ☐ Cramping/ Pain in Intestines
- ☐ Rectal bleeding

My Bowel Movements are:

- ☐ Regular
- ☐ 1-2 per Day
- ☐ Irregular
- ☐ Once per_____Days

RESPIRATORY

- ☐ Asthma
- ☐ Cough- Dry
- ☐ Cough- Productive
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Pneumonia

Hay Fever:

- ☐ Spring
- ☐ Summer
- ☐ Fall Change of Season

- ☐ Emphysema
- ☐ I get cold easily
- ☐ I sigh frequently
- ☐ Sinus Infection
- ☐ Sinus Infection Recurrent
- ☐ Snoring
- ☐ Wheezing

URINARY

- ☐ Bed Wetting
- ☐ Hesitancy (trouble getting started)
- ☐ Blood in Urine
- ☐ Cloudy Urine
- ☐ Frequent Urination
- ☐ Poor Flow
- ☐ Infection
- ☐ Kidney Disease
- ☐ Leaking/ Incontinence
- ☐ Pain/ Burning
- ☐ Prostate Infection
- ☐ Urgency

ANXIETY/WORRY

- ☐ Agoraphobia
- ☐ Anger
- ☐ Auditory Hallucinations
- ☐ Black-out
- ☐ Depression

SYMPTOM REVIEW (Cont.)

Difficulty:
- ☐ Concentrating
- ☐ With Balance
- ☐ With Thinking
- ☐ With Judgment
- ☐ With Speech
- ☐ With Memory

☐ Dizziness (Spinning)
☐ Fainting
☐ Fear
☐ General Sadness
☐ History of Abuse
☐ I Can't Let Go
☐ I Feel Stressed Often
☐ Irritability
☐ Light-headedness
☐ Nervousness
☐ Numbness
☐ Nervousness
☐ Other Phobias
☐ Panic Attacks
☐ Paranoia
☐ Seizures
☐ Suicidal Tendencies
☐ Tingling
☐ Tremor/Trembling
☐ Visual Hallucinations
☐ Worry

SLEEP PATTERNS

☐ Difficulty Falling Asleep
☐ Difficulty Staying Asleep
☐ I take a Sleep Aid
☐ What time do your sleep problems occur most?_____
☐ Excessive Dreaming
☐ Nightmares
☐ Early Waking
☐ No Dream Recall

EATING

☐ Appetite Poor
☐ Appetite Excessive
☐ Binge Eating
☐ Bulimia
☐ Can't Gain Weight
☐ Can't Lose Weight
☐ Can't Maintain Healthy Weight
☐ Frequent Dieting
☐ Salt Cravings
☐ Carbohydrate Craving (breads, pastas)
☐ Sweet Cravings (candy, cookies, cakes)
☐ Chocolate Cravings
☐ Caffeine Dependency
☐ Citrus/Sour Craving
☐ Spicy/Hot Craving

BODY TEMPERATURE

☐ Cold Hands & Feet
☐ Cold Intolerance
☐ Low Body Temperature
☐ Heat Intolerance
☐ Afternoon Feverishness
☐ Alternating Chills & Feverishness
☐ I Sweat Without Exertion
☐ Cold Natured
☐ Cold Hands
☐ Cold Feet
☐ Warm Natured
☐ Fever or Sensation of Feverishness
☐ I have night sweats
☐ Flushing

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
☐ Dry Skin
☐ Ears Get Red
☐ Easy Bruising
☐ Eczema
☐ Hair Loss
☐ Hives
☐ Jock Itch
☐ Lack of Sweating
☐ Lackluster Skin
☐ Mole w/Color/Size Change
☐ Oily Skin
☐ Pale Skin
☐ Patchy Dullness
☐ Psoriasis
☐ Rash
☐ Red Face
☐ Sensitivity to Bites
☐ Sensitivity to Poison Ivy/Oak
☐ Shingles
☐ Skin Darkening
☐ Strong Body Odor
☐ Vitiligo

NAILS

☐ Bitten
☐ Brittle
☐ Don't Grow Well
☐ Fungus- Fingers
☐ Fungus- Toes
☐ Ridges
☐ Soft
☐ Thickening of Fingernails
☐ Thickening of Toenails
☐ White Spots/Lines

MUSCULOSKELETAL

☐ Back Muscle Spasms
☐ Bursitis
☐ Calf Cramps
☐ Chest Tightness
☐ Foot Cramps
☐ Joint Deformity
☐ Joint Pain
☐ Joint Redness
☐ Joint Stiffness
☐ Joint Swelling
☐ Muscle Pain
☐ Muscle Spasms
☐ Muscle Stiffness
☐ Muscle Twitches - around Eyes
☐ Muscle Twitches - Arms or Legs
☐ Muscle Weakness
☐ Tendonitis
☐ Tension Headache
☐ TMJ Problems

FEMALE REPRODUCTIVE

☐ Breast Cysts
☐ Breast Lumps
☐ Breast Tenderness
☐ Ovarian Cyst
☐ Poor Libido (sex drive)
☐ Vaginal Discharge
☐ Vaginal Odor
☐ Vaginal Itch
☐ Vaginal Pain with Sex

Premenstrual:
- ☐ Bloating
- ☐ Breast Tenderness
- ☐ Carbohydrate Cravings
- ☐ Chocolate Cravings

SYMPTOM REVIEW (Cont.)

- ☐ Constipation
- ☐ Decreased Sleep
- ☐ Diarrhea
- ☐ Fatigue
- ☐ Increased Sleep
- ☐ Irritability

Menstrual:

- ☐ Cramps
- ☐ Heavy Periods
- ☐ Irregular Periods
- ☐ No Periods
- ☐ No Periods
- ☐ Scanty Periods
- ☐ Spotting Between

MALE REPRODUCTIVE

- ☐ Discharge From Penis
- ☐ Ejaculation Problem
- ☐ Genital Pain
- ☐ Infertility
- ☐ Impotence
- ☐ Prostate or Urinary Infection
- ☐ Lumps in Testicles
- ☐ Poor Libido (sex drive)
- ☐ Strength of Erection (1-10)_____

Rate these areas on a scale from 0 to 10

Energy Level	**Low**	0	1	2	3	4	5	6	7	8	9	10	**High**
Anxiety/Worry	**Low**	0	1	2	3	4	5	6	7	8	9	10	**High**
Stress Level	**Low**	0	1	2	3	4	5	6	7	8	9	10	**High**
Sleep Quality	**Low**	0	1	2	3	4	5	6	7	8	9	10	**High**
Memory	**Low**	0	1	2	3	4	5	6	7	8	9	10	**High**
Concentration (focus)	**Low**	0	1	2	3	4	5	6	7	8	9	10	**High**
Mood	**Low**	0	1	2	3	4	5	6	7	8	9	10	**High**
Irritability	**Low**	0	1	2	3	4	5	6	7	8	9	10	**High**
Physical Health	**Low**	0	1	2	3	4	5	6	7	8	9	10	**High**
Mental Health	**Low**	0	1	2	3	4	5	6	7	8	9	10	**High**

READINESS ASSESSMENT

Rate on a scale of 5 (very willing) to 1 (not willing):
In order to improve your health, how willing are you to:
Significantly modify your diet .....☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Take several nutritional 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 DIETARY 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 one teaspoon of 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 sweets, 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 Dairy-Day 1

Name: _____ Date:_____

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

_____

Daily Bowel Movements: _____

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Diet Dairy-Day 2

Name: _____ Date:_____

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

_____

Daily Bowel Movements: _____

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Diet Dairy-Day 3

Name: _____ Date:_____

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

_____

Daily Bowel Movements: _____

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

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 or 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 _____

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
_____ Pain or aches in muscles
_____ Feeling of 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*** _____

OTHER COMMENTS / QUESTIONS / CONCERNS: