Dr. Hughes's Holistic Wellness Center

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Today's date _____/_____/_____
Month / Day / Year

Name (First, MI, Last)			Social Security No.(last 4 digits only) XXX-XX-_____	Date of Birth _____/_____/_____ Month / Day / Year
Age	Sex ◯ M ◯ F	Marital Status ◯ S ◯ M ◯ D ◯ W	Email Address	Home Phone (_____) _____ - _____
Home Address (street, city, state and zip code) _____ _____ _____				Work Phone (_____) _____ - _____ Cell Phone (_____) _____ - _____
Employer			Job Title /Occupation	Fax (_____) _____ - _____
Emergency Contact (Name)			Contact (Phone) (_____) _____ - _____	Who referred you?

Personal Physician (Name and Address)	Preferred Pharmacy Name/Phone
_____ _____ _____ Office phone number: (_____) _____ - _____	_____ _____ _____ Pharmacy phone number: (_____) _____ - _____

Best way to contact you (Choose One): ☐Home Phone ☐Work Phone ☐Cell Phone

Do we have permission to leave the following information on an answering machine or voice mail?

Appointment Information: ◯NO ◯YES, these #'s: ☐Home ☐Work ☐Cell ☐Other _____
Medical Information: ◯NO ◯YES, these #'s: ☐Home ☐Work ☐Cell ☐Other _____
Billing/Payment Information: ◯NO ◯YES, these #'s: ☐Home ☐Work ☐Cell ☐Other _____

If someone answers the phone when we call, who can we leave this information with?

☐ No One
☐ Spouse _____ ☐ Child(ren) _____
☐ Friend _____ ☐ Other _____

Minor Patient Section

If the patient is a minor, is he/she accompanied by a legal guardian?
◯ If **Yes**: Must bring a valid photo ID
◯ If **No**: Each adult to accompany the minor must bring
1) a completed Permission to Accompany Minor Form
2) copies of their own and the guardian's valid photo IDs

_____ _____ _____/_____/_____
Legal Guardian's Signature: Print Legal Guardian's Name: Date:

_____ _____ _____/_____/_____
Patient's Signature: Print Patient's Name: Date:

Complaints/Concerns

Please list ***in order of importance,*** **the five (5) main concerns you have (starting with the most important one**).
Please note how long each symptoms has been present.

Problem	Onset	Frequency	Mild	Moderate	Severe	Previous Treatments / Approach	Results? Excellent	Good	Fair
0. e.g. Headaches	6 / 2007	4 times / week							
1.			☐	☐	☐		☐	☐	☐
2.			☐	☐	☐		☐	☐	☐
3.			☐	☐	☐		☐	☐	☐
4.			☐	☐	☐		☐	☐	☐
5.			☐	☐	☐		☐	☐	☐

What do you hope to achieve in your visits with us?

_____
_____
_____

If you had a magic wand and could erase three health problems or symptoms, which would they be, and why?

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 all physicians you have seen for the above health conditions:

1.	4.
2.	5.
3.	6.

Please check all the Alternative Treatments you have tried for your condition(s)

☐ None	☐ Massage	☐ Yoga	☐ Environmental medicine
☐ Chiropractic	☐ Rolfing	☐ Hypnosis	☐ Dietary Therapy
☐ Acupuncture	☐ Reiki	☐ Ayurveda	☐ Biological Dentistry
☐ Supplements	☐ Homeopathy	☐ Light therapy	☐ IV (intravenous) therapy
☐ Colonics	☐ Biofeedback	☐ Meditation	☐ Naturopathic medicine
☐ _____	☐ _____	☐ _____	☐ _____

Past Medical History

Current	Past	Disease/Diagnosis/Condition (Check appropriate box and give date of onset)	Date	Current	Past	Disease/Diagnosis/Condition (Check appropriate box and give date of onset)	Date
		Gastrointestinal				**Heent / respiratory**	
☐	☐	Irritable Bowel Syndrome		☐	☐	Asthma	
☐	☐	Crohn's or Ulcerative Colitis		☐	☐	Bronchitis – Chronic or Recurrent	
☐	☐	Constipation / Diarrhea – Recurrent (Circle one)		☐	☐	Emphysema	
☐	☐	Gastritis or Ulcer Disease		☐	☐	Pneumonia - Recurrent	
☐	☐	GERD or Reflux Disease		☐	☐	Sleep Apnea	
☐	☐	Colon Polyps		☐	☐	Sinusitis – Chronic or Recurrent	
☐	☐	Hepatitis / Liver Disease		☐	☐	Recurrent Ear Infections	
☐	☐	Gallstones / Gall Bladder Problems		☐	☐	Macular Degeneration / Eye Disorder_____	
☐	☐	Other:				**Genital and urinary**	
		Cardiovascular		☐	☐	Kidney Disease / Stones / Infection (Pyelonephritis)	
☐	☐	Heart Attack or Stent Placement		☐	☐	Interstitial Cystitis	
☐	☐	Valvular Disease (Mitral Valve Prolapse etc.)		☐	☐	Urinary Incontinence	
☐	☐	Stroke or TIA (Transient Ischemic Attack)		☐	☐	Frequent Urinary Tract (Bladder) Infections	
☐	☐	High Cholesterol (Hyperlipidemia)		☐	☐	Sexually Transmitted infection (Herpes etc.)	
☐	☐	Irregular Heart Rhythm (Palpitations)		☐	☐	Sexual / Reproductive Problems	
☐	☐	High Blood Pressure (Hypertension)		☐	☐	Recurrent Yeast Infections	
☐	☐	Chest Pain / Angina		☐	☐	Uterine Fibroids / Ovarian Cysts (Women)	
☐	☐	Other:		☐	☐	Menstrual Disorders	
		Metabolic / endocrine		☐	☐	BPH / Prostate Problems (Men)	
☐	☐	Diabetes		☐	☐	Other:	
☐	☐	Hypoglycemia				**Inflammatory / autoimmune**	
☐	☐	Pre-Diabetes (Metabolic Syndrome)		☐	☐	Chronic Fatigue Syndrome	
☐	☐	Hypothyroidism (Low Thyroid)		☐	☐	Fibromyalgia	
☐	☐	Hyperthyroidism (Overactive Thyroid)		☐	☐	SLE (Systemic Lupus Erythematosis)	
☐	☐	Polycystic Ovaries (PCOS)		☐	☐	Rheumatoid Arthritis	
☐	☐	Eating Disorder (Anorexia/Bulimia)		☐	☐	Hashimoto's Thyroiditis	
☐	☐	Obesity / Overweight		☐	☐	Immune Dysfunction (Frequent Infections)	
☐	☐	Other:		☐	☐	Food Allergies	
		Skin & nails		☐	☐	Environmental Allergies	
☐	☐	Acne		☐	☐	Multiple Chemical Sensitivities	
☐	☐	Eczema / Psoriasis (Circle one)				**Neurologic / mood**	
☐	☐	Rosacae/ Hives (Circle one)		☐	☐	Headaches - Migraines / Tension (Circle one)	
☐	☐	Fungal Nails		☐	☐	Seizure Disorder	
☐	☐	Other:		☐	☐	ADD / ADHD (Attention Deficit Disorder)	
		Musculoskeletal / pain		☐	☐	Memory Problems	
☐	☐	Osteoarthritis – Where?		☐	☐	Mild Cognitive Impairment	
☐	☐	Osteoporosis / Osteopenia (Circle one)		☐	☐	Parkinson's	
☐	☐	Gout		☐	☐	ALS / Multiple Sclerosis (Circle One)	
☐	☐	Neck Pain – Why?		☐	☐	Depression	
☐	☐	Back Pain – Why?		☐	☐	Anxiety Disorder	
☐	☐	Herniated Disc – Where?		☐	☐	Bipolar Disorder	
☐	☐	Carpal Tunnel Syndrome		☐	☐	Schizophrenia	
☐	☐	Tendinitis – Where?		☐	☐	Other:	
☐	☐	Other:				**Cancer**	
		Hematological		☐	☐	Breast Cancer / Prostate Cancer (Circle one)	
☐	☐	Anemia		☐	☐	Colon Cancer / Lung Cancer (Circle one)	
☐	☐	Blood Clots / Bleeding Disorder		☐	☐	Leukemia / Lymphoma (Circle one)	
☐	☐	Abnormal Blood Cells		☐	☐	Skin Cancer – Type?	
☐	☐	Other:		☐	☐	Other:	

* Use the highlight tool (green T icon) to "circle" options if needed if filling out electronically

Diagnostic Studies				Past Surgical History		
Normal	Abnormal	Check Box if test was performed. Indicate "Normal" or "Abnormal" and provide date.	Date	Check Box if surgery was performed and provide date.		Date
○	○	Full Physical Exam		☐	Appendectomy	
○	○	Mammogram / Breast Ultrasound (Circle)		☐	Tonsillectomy	
○	○	Bone Density Test		☐	Tubal Ligation/Vasectomy	
○	○	Colonoscopy		☐	Gall Bladder	
○	○	Cardiac Stress Test		☐	Joint Replacement — Knee / Hip (circle one)	
○	○	EKG		☐	Heart Surgery — Bypass / Valve (circle one)	
○	○	Chest X-ray		☐	Angioplasty or Stent	
○	○	Upper GI / Gastroscopy		☐	Vascular (Blood Vessel) Surgery	
○	○	Carotid Artery Ultrasound		☐	Pacemaker insertion	
○	○	Pelvic Ultrasound		☐	Hysterectomy — Why?	
○	○	Abdominal Ultrasound		☐	Ovary Surgery — Why?	
○	○	Prostate Ultrasound		☐	Breast Surgery — Why?	
○	○	MRI / CT Scan		☐	Prostate Surgery — Why?	
○	○	Eye Exam		☐	Other:	

Hospitalizations

Where Hospitalized	When	For What Reason

Injuries

Type of Injury	How did it occur?	Date

Comments or Additional Medical History:

Female Medical History (for women only)

Obstetrics history *Check box if yes and provide appropriate information in the blanks*

- ☐ # of Pregnancies _____
- ☐ # of Miscarriages _____
- ☐ Post partum depression _____
- ☐ Breast feeding For how long? ____
- ☐ # of Caesarean _____
- ☐ # of Abortions _____
- ☐ Toxemia _____
- ☐ Infertility Treatments: ___
- ☐ # of Vaginal births _____
- ☐ # of Living Children____
- ☐ Gestational diabetes
- ☐ Fibroids _____
- ☐ Pre-term Labor
- ☐ Other:_____
- ☐ Baby over 8 pounds
- ☐ Endometriosis

Menstrual history

Age at 1st period: ____ Menses Frequency: ____ Days Length: ____ Days Pain: ◯ Yes ◯ No Clotting: ◯ Yes ◯ No

Last Menstrual Period: ____/____/_____ Has your period skipped: ◯ Yes ◯ No Heavy Bleeding: ◯ Yes ◯ No

Do you currently use contraception? ◯ Yes ◯ No If yes, what type do you use? ☐ Other: _____

☐ Condom ☐ Diaphragm ☐ IUD ☐ Partner vasectomy

Have you ever used hormonal contraception? ◯ Yes ◯ No If yes, when _____

Use of hormonal contraception: ☐ Birth control pills ☐ Patch ☐ Nuva Ring How long?_____

Are you using the pill now? ◯ Yes ◯ No Did taking the pill agree with you? ◯ Yes ◯ No

In the 2nd half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)? ◯ Yes ◯ No

Recent screening tests & results

Date of Last PAPTest: ___/___/_____ ◯ Normal ◯ Abnormal (Results: _____)

Date of Last Mammogram ___/___/_____ ◯ Normal ◯ Abnormal (Results:_____)

Date of Breast Biopsy(if applicable) ___/___/_____ ◯ Normal ◯ Abnormal (Results: _____)

Date of last Bone Density: ___/___/_____ Results: ◯ High ◯ Low ◯ Within normal range

Hormonal imbalance issues

Are you in menopause? ◯ Yes ◯ No Age at Menopause _____ *(Check all applicable symptoms below)*

☐ Hot Flashes ☐ Night Sweats ☐ Mood Swings ☐ Concentration/ Memory Problems ☐ Vaginal Dryness
☐ Decreased Libido ☐ Weight Gain ☐ Headaches ☐ Urine Leaking/Bladder Problems ☐ Palpitations

Are you on hormone replacement? ◯ Yes ◯ No How Long? _____

Other Issues: _____
_____
_____

Men's History (for Men only)

Have you had a PSA done? ◯ Yes ◯ No PSA Level: ☐ 0–2 ☐ 2–4 ☐ 4–10 ☐ > 10

☐ Prostate Enlarged ☐ Prostate Infections ☐ Change in Libido ☐ Impotence
☐ Difficulty Obtaining an Erection ☐ Difficulty Maintaining an Erection
☐ Nocturia (getting up to urinate at night) How many times per night? _____
☐ Urgency/Hesitancy/Change in Urinary Stream ☐ Loss of Control of Urine

Other Issues: _____
_____
_____
_____

Medications

Current Medications

Medication Name	Dose	# Times per day	Start Date (month/year)	Reason for Use

Previous Medications (Last 10 Years)

Medication Name	Dose	# Times per day	Start Date (month/year)	Reason for Use

Nutritional supplements (vitamins/minerals/herbs/homeopathy)

Supplement Name/Brand	Dose	Frequency	Start Date (month/year)	Reason for Use

Allergies (or Adverse Reactions)

Medication / Supplement / Food	Reaction

Do you have symptoms **immediately after** eating, such as belching, bloating, sneezing, hives, etc.?…….. ○ Yes ○ No
If yes, please explain:_____
If yes, are these symptoms associated with a particular food or supplement? ……..... ○ Yes ○ No
Which food or supplement? _____

Have you had?

Prolonged or regular use of NSAIDs (Advil, Aleve, Motrin etc.) ……... ○ Yes ○ No
Prolonged or regular use of Tylenol ……... ○ Yes ○ No
Prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, Nexium, etc.) …… ○ Yes ○ No
Frequent antibiotics (greater than 3 times per year) …….. ○ Yes ○ No
Long Term antibiotics (longer than 1 month at a time …….. ○ Yes ○ No
Use of Steroids (Prednisone, Medrol Dose Pack, Nasal Allergy Sprays) …….. ○ Yes ○ No
Use of Oral Contraceptives ……. ○ Yes ○ No

Family History

Check All Family Members that Apply Place an "X" by any health problem(s) your family members have suffered with either now or in the past.	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age (if still alive)												
Age at death (if deceased)												
ADD/ADHD (Attention Deficit Disorder)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Alzheimer's	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Autoimmune Diseases (Lupus, Hashimoto's, Rheumatoid Arthritis)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bipolar Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Blood clotting problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer - Colon	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer - Breast	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer - Uterine / Ovarian (circle one)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer – Skin: Melanoma / Squamous / Basal Cell (circle one)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer - Prostate / Bladder (circle one)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer – Other:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Celiac disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Eczema / Psoriasis (circle one)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Emphysema / Chronic Bronchitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Epilepsy (Seizure Disorder)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Food Allergies, Sensitivities, Intolerances	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Genetic disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease: Heart Attack / Bypass / Valve Disease (circle one)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Problem: Irregular Rhythm / Pacemaker (circle one)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure (Hypertension)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol (Hyperlipidemia)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Inflammatory Arthritis (Rheumatoid, Psoriatic,Ankylosing spondylitis)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Inflammatory Bowel Disease (Crohn's or Ulcerative Colitis)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Irritable Bowel Syndrome	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Migraine Headaches	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Multiple Sclerosis / ALS (circle one)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Parkinson's	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sleep Apnea	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Substance abuse (alcoholism, etc.)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Number of Sisters: ____ (Number deceased: ____) Number of Brothers: ____ (Number deceased: ____) Birth Order: ____

Nutrition & Lifestyle 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

Do you currently follow a special diet or nutritional program? ……..... ○ Yes ○ No

Check all that apply:

☐**Low Carbohydrate** ☐**Low Fat** ☐**High Protein** ☐**Low Sodium** ☐**Diabetic** ☐**No Dairy** ☐**No Wheat**
☐**Gluten Restricted** ☐**Vegetarian** ☐**Blood Type Diet** ☐**Vegan** ☐**Zone Diet**

☐**Specific Program for Weight Loss / Maintenance – Type:** _____

Height (feet/inches) _____	Current Weight _____
Usual weight range +/- 5 lbs _____	Desired Weight range +/- 5 lbs _____
Highest adult weight _____	Lowest adult weight _____
Weight fluctuations (>10lbs) ○ Yes ○ No	Body Fat % (if known) _____%

How often do you weigh yourself? ☐Daily ☐Weekly ☐Monthly ☐Rarely ☐Never
Are there any foods that you avoid because they give you symptoms? ○ Yes ○ No
If yes, please name the food and symptom e.g. wheat – gas and bloating

Food	Symptom	Other Comments

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

- ☐ Fast eater
- ☐ Erratic eating habits
- ☐ Eat too much
- ☐ Late night eater
- ☐ Dislike health food
- ☐ Time constraints
- ☐ Eat more than 50% of meals away from home
- ☐ Travel frequently
- ☐ Non-availability of healthy foods
- ☐ Do not plan meals or menus
- ☐ Reliance on convenience items
- ☐ Poor snack choices
- ☐ Significant other or family members don't like healthyfoods
- ☐ Significant other or family members have special dietary needs of food preferences
- ☐ Love to eat
- ☐ Eat because I have to
- ☐ Have a negative relationship to food
- ☐ Struggle with eating issues
- ☐ Emotional eater (eat when sad, lonely, depressed, bored)
- ☐ Eat too much under stress
- ☐ Eat too little under stress
- ☐ Don't care to cook
- ☐ Eating in the middle of the night
- ☐ Confused about nutritional advise
- ☐ Diet often for weight control

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

Smoking

Currently Smoking? ◯Yes ◯No How many years? _____ Packs per day: _____

If yes, what type? ☐Cigarette ☐Smokeless Cigarettes ☐Cigar ☐Pipe ☐Hookah

How many attempts to quit: _____How: ☐Patch/Gum ☐Medication ☐Acupuncture ☐Hypnosis

Previous Smoking: How many years? _____ Packs per day:_____When did you quit? _____How? _____

Are you exposed to 2nd hand smoke now? If yes, please explain: _____

Alcohol intake

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

☐None ☐ 1-3 ☐ 4-6 ☐7-10 ☐>10 _____ *If none skip to "Other Substances"*

Previous alcohol intake? ☐Yes (☐Mild 0-4/week ☐Moderate 5-10/week ☐High > 10/week)

Have you ever been told 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 been arrested or hospitalized because of 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/☐Tea How Many Cups/ Day: ☐1 ☐2-4 ☐>4 a day

☐Caffeinated Soda /☐Diet Soda Intake: ◯Yes ◯No How Many Cans or Bottles/Day: ☐1 ☐2-4 ☐>4 a day

Are you currently using recreational drugs? ◯Yes ◯No If yes, what types?:_____

Have you ever used IV or inhaled recreational drugs? ◯Yes ◯No If yes, what types?:_____

EXERCISE

Current Exercise program: *Activity (list type, number of sessions/week, and duration of activity)*

Activity	Type	Frequency per week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength Training			
Other (Pilates, yoga, etc.)			
Sports or Leisure Activities (golf, tennis, rollerblading etc.)			

Rate your level of motivation for including exercise in your life? ☐Low ☐Medium ☐High

List problems that limit activity: _____

_____

_____

Do you feel unusually fatigued after exercise? ◯Yes ◯No

If yes, please describe: _____

_____

_____

Do you usually sweat when exercising? ◯Yes ◯No

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 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

Currently? ◯Yes ◯No Previously? ◯Yes ◯No , If previously, from _____ to _____
Comments: _____
Do you feel you have an excessive amount of stress in your life? ..... ◯Yes ◯No
Do you feel you can easily handle the stress in your life? ..... ◯Yes ◯No
Daily stressors: *Rate on a scale of 1 –10 (1= not stressful –10 = very stressful)*
Work_____ 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
Occupation _____# Hours worked per week _____ ☐Retired
How many days have you lost from work or school in the past year? ☐0 - 2 ☐3 – 7 ☐7 - 14 ☐> 15 days
How many vacation days do you take each year: ..... ☐None ☐1- 7 ☐7-14 ☐14-21 ☐> 21

Sleep/Rest

Average number of hours you sleep ..... ☐<6 ☐6 – 8 ☐8 – 10 ☐> 10
Average number of times you wake up each night ..... ☐1 ☐2 ☐3 ☐4+
Do you have trouble falling asleep? ◯Yes ◯No Do you feel rested upon awakening? ◯Yes ◯No
If you wake up, how long does it take you to fall back asleep? ☐0 -15 Min ☐15 - 30 Min ☐30 – 60 Min ☐> 60 Min
Do you snore? ◯Yes ◯No Do you stop breathing or gasp/choke while sleeping? ◯Yes ◯No
Do you use sleeping aids? ◯Yes ◯No What time do you go to bed? _____ What time do you get up?_____
Rate your energy level throughout the day: *(0 = SLEEPING, 1= exhausted, 2 = somewhat tired, 3 = OK, 4 = somewhat energetic, 5 = great)*
Wake up: _____ 10 -11 AM:_____ 12 Noon:_____ 2-3 PM:_____ 5-6 PM:_____ 8-9 PM:_____ 11-12PM:____ 2-3 AM:_____

Roles/Relationships

Marital Status: ☐Single ☐Married ☐Divorced ☐Long Term Partnership
Children: (Please List Names, Age, & Gender) _____
_____

Resources for emotional support? ☐Spouse ☐Family ☐Friends ☐Religious/Spiritual ☐Pets ☐Other _____
What is the attitude of those close to you about your illness? ☐Supportive ☐Non-supportive

How Well Have Things Been Going for You? :	Very Well	Fine	Poorly	Very Poorly	Does not Apply	Comments
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	☐	☐	☐	☐	☐	

Review Of Systems

Check only those items with which you identify, ***past or present***. Ignore anything that does not apply to you.

GENERAL

- ☐ Cold Hands & Feet
- ☐ Cold Intolerance
- ☐ Daytime Sleepiness
- ☐ Difficulty Falling Asleep
- ☐ Difficulty Staying Asleep
- ☐ Fatigue
- ☐ Fever
- ☐ Heat Intolerance
- ☐ Sweating - Excessive
- ☐ Swollen Glands
- ☐ Weakness - Generalized
- ☐ Weight Gain

Skin

- ☐ Acne / Oily / Boils (circle one)
- ☐ Athletes Foot
- ☐ Bruise Easily
- ☐ Bumps on Back of Upper Arms
- ☐ Burning on Bottom of Feet
- ☐ Changing Moles
- ☐ Crawling Sensation
- ☐ Cuts Heal slowly
- ☐ Dryness
- ☐ Hives
- ☐ Itching
- ☐ Peeling/Cracking Skin
- ☐ Pigmentation Changes
- ☐ Rash
- ☐ Strong Body Odor

Is your skin sensitive to?

- ☐ Sun
- ☐ Fabrics _____
- ☐ Detergents _____
- ☐ Latex
  - ☐ Metals

HAIR

- ☐ Hair Growth - Excessive (Where: _____)
- ☐ Hair Loss / Thinning
  - ☐ Head
    - ☐ Crown
    - ☐ Temples
    - ☐ All Over
  - ☐ Eyebrows/Lashes
  - ☐ Legs / Underarms
  - ☐ Bald Spots- Scalp

NAILS

- ☐ Brittle
- ☐ Fungal Nails
- ☐ Splitting & Peeling
- ☐ Pitted / Ridges (circle one)
- ☐ Thickened
- ☐ White Spots/Lines on Nails

HEAD:

- ☐ Balance Problems
- ☐ Confusion
- ☐ Dizziness
- ☐ Fainting Spells
- ☐ Forgetfulness/ Poor Memory
- ☐ Mental Sluggishness
- ☐ Poor Focus & Concentration
- ☐ **Headaches:**
  - ❑ **Location:**
    - ☐ Frontal
    - ☐ Back of Head / Neck
    - ☐ Behind Eyes
    - ☐ Temples
    - ☐ Sinuses
  - ☐ After Meals
  - ☐ After Not Eating (too long)
  - ☐ **Migraines**
    - ☐ Triggered by:
      - ☐ Menstrual Cycles
      - ☐ Stress
      - ☐ Sleep Changes
      - ☐ Caffeine Changes
    - ☐ Relieved by:
      - ☐ Eating
      - ☐ Dark Quiet Room

EYES:

- ☐ Irritation / Inflammation
- ☐ Double / Blurred Vision
- ☐ Puffy Eyes / Eyelids
- ☐ Decreasing Vision
- ☐ Bright Flashes
- ☐ Eye Pain
- ☐ Dark Circles Under Eyes
- ☐ Sensitivity to Light
- ☐ “Floaters” in Vision

EARS:

- ☐ Aches/Pain/Pressure
- ☐ Discharge
- ☐ Frequent Infections
- ☐ Hearing Loss
- ☐ Itching
- ☐ Ringing / Buzzing
- ☐ Sensitive to Loud Noises

NOSE / SINUSES:

- ☐ Decreased Sense of Smell
- ☐ Nasal Congestion
- ☐ Nasal Drainage
- ☐ Nasal Polyps
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Recurrent Sinus Infections
- ☐ Sneezing Spells

NOSE / SINUSES (cont.)

- ☐ Symptoms worse in the:
  - ☐ Spring
  - ☐ Summer
  - ☐ Fall
  - ☐ Winter

MOUTH:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Canker Sores
- ☐ Coated Tongue
- ☐ Cracking at Corners of Lips
- ☐ Dental Problems
- ☐ Dry Mouth
- ☐ Fever Blisters
- ☐ Grind Teeth When Sleeping
- ☐ Lips Swell - Angioedema
- ☐ Sore Tongue
- ☐ TMJ
- ☐ Wear Dentures

THROAT:

- ☐ Constant Clearing of Throat
- ☐ Difficulty Swallowing
- ☐ Frequent Hoarseness
- ☐ Frequent Sore Throat
- ☐ Throat Closes Up

NECK:

- ☐ Stiffness / Pain
- ☐ Lumps / Swollen Glands
- ☐ Goiter

CARDIOVASCULAR / CIRCULATION:

- ☐ Cold or Clammy Extremities
- ☐ Dizziness Upon Standing
- ☐ Heavy/Tight Chest
- ☐ Irregular Heartbeat
- ☐ Low Exercise Tolerance
- ☐ Numbness - Hands/Feet
- ☐ Palpitations
- ☐ Phlebitis
- ☐ Raynaud’s Syndrome
- ☐ Shortness of Breath
- ☐ Spider Veins
- ☐ Swollen Ankles
- ☐ Varicose Veins

RESPIRATION:

- ☐ Frequent Colds / Bronchitis
- ☐ Frequent Coughing
- ☐ Frequently Sighing
- ☐ Wheezing

DIGESTION

- ☐ Abdominal Pain
  - ☐ Upper
  - ☐ Lower
- ☐ Anal Fissures
- ☐ Anal Itching
- ☐ Belching Frequently
- ☐ Black/Tarry Stools
- ☐ Bloating
- ☐ Blood in Stools
- ☐ Changes in Bowels
- ☐ Constipation - Recurrent
- ☐ Cramping
- ☐ Diarrhea - Recurrent
- ☐ Excessive Flatulence (Gas)
- ☐ Excessive Fullness After Meal
- ☐ Gallbladder Pain
- ☐ Gallstones
- ☐ Heartburn / Acid Reflux
- ☐ Hemorrhoids
- ☐ Hepatitis - Type: _____
- ☐ Hiatal Hernia
- ☐ Indigestion
- ☐ Laxative Use
- ☐ Liver Disease
- ☐ Nausea
- ☐ Nervous Stomach
- ☐ Peptic/Duodenal Ulcer
- ☐ Poor Appetite
- ☐ Rectal Itching
- ☐ Strong Stool Odor
- ☐ Undigested Food in Stools
- ☐ Vomiting

EATING:

- ☐ Anorexia / Bulimia
- ☐ Binge Eating
- ☐ Caffeine Dependent
- ☐ Can't Gain Weight
- ☐ Can't Lose Weight
- ☐ Can't Maintain Healthy Weight
- ☐ Carbohydrate Cravings
- ☐ Chocolate Cravings
- ☐ Frequent Dieting
- ☐ Hypoglycemia
- ☐ Salt Cravings
- ☐ Sweets / Sugar Cravings

KIDNEY/URINARY TRACT:

- ☐ Burning / Pain with Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Night time Urination
- ☐ Problem Passing Urine

WOMEN'S HISTORY (women only)

- ☐ Breast Tenderness
- ☐ Change in Periods
- ☐ Decreased Libido
- ☐ Heavy Periods
- ☐ Hot Flashes
- ☐ Loss of Control of Urine
- ☐ Mood Swings
- ☐ Night Sweats
- ☐ Ovarian Cysts
- ☐ Painful Periods
- ☐ Pain With Intercourse
- ☐ Palpitations
- ☐ Spotting / Irregular Menses
- ☐ Vaginal Discharge
- ☐ Vaginal Dryness
- ☐ Weight Gain

MEN'S HISTORY (for men only)

- ☐ Decreased Libido
- ☐ Decreased Muscle Strength
- ☐ Diminished Urinary Stream
- ☐ Erectile Dysfunction
- ☐ Genital pain
- ☐ Hernia
- ☐ Infertility / Low sperm count
- ☐ Lumps in Testicles
- ☐ Prostate enlargement
- ☐ Prostate infections
- ☐ Sore on penis

MUSCULOSKELETAL

- ☐ Back Pain
- ☐ Joint Pain /Stiffness
- ☐ Joint Swelling or Warmth
- ☐ Muscle Cramps – Legs / Feet
- ☐ Muscle Stiffness in Morning
- ☐ Muscle Twitches -_____
- ☐ Pain Wakes Me Up
- ☐ Restless Leg Syndrome
- ☐ Weakness in Legs and Arms
- ☐ Damp Weather Bothers Me

EMOTIONAL:

- ☐ ADD / Short Attention Span
- ☐ Aggressive / Anger Issues
- ☐ Agitated / Irritable
- ☐ Anxiety
- ☐ Burned Out
- ☐ Considered a Nervous Person
- ☐ Cry Often
- ☐ Depressed
- ☐ Difficulty Coping With Stress
- ☐ Easily Flare in Anger
- ☐ Extremely Shy
- ☐ Feel Insecure
- ☐ Frequently Keyed Up and Jittery
- ☐ Frustration
- ☐ Had Nervous Breakdown
- ☐ Have Considered Suicide
- ☐ Have Overused Alcohol
- ☐ Have Overused Drugs
- ☐ Hyperactive / Restless
- ☐ Listless / Withdrawn feeling
- ☐ Misunderstood by Others
- ☐ Nightmares
- ☐ Often Break Out in Cold Sweats
- ☐ Often Feel Suddenly Scared
- ☐ Panic Attacks
- ☐ Profuse sweating
- ☐ Startle Easily
- ☐ Tremors / Shaky Inside
- ☐ Use Tranquilizers
- ☐ Workaholic
- ☐ Worried Over Little Things

Dental History

Have you had sore gums (gingivitis) often over the years? ..... ○ Yes ○ No
Have TMJ (temporal mandibular joint) problems been a concern? ..... ○ Yes ○ No
Do you often have a 'metallic' taste in your mouth? ..... ○ Yes ○ No
Do you have a lot of bad breath (halitosis) or white tongue (thrush)? ..... ○ Yes ○ No
Have you worn or do you presently wear braces? ..... ○ Yes ○ No
Do you have problems chewing? ..... ○ Yes ○ No
Do you floss daily? ..... ○ Yes ○ No
amalgam fillings do you have now? _____How many Root Canals? _____
Did you play with mercury as a child or adult? ..... ○ Yes ○ No
Have you eaten a lot of fish in your life? ..... ○ Yes ○ No

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 relaxation techniques ……	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Engage in regular exercise ……	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Have periodic lab tests to assess 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 (not supportive at all).

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 ongoing support and contact (e.g. telephone consults, e-mail correspondence) from your professional staff would be helpful to you as you implement your personal health program?

☐5 ☐4 ☐3 ☐2 ☐1

Comments:

Notes:

Name: _____ Date _____/_____/_____

3 Day Food Diary *(Please Print)*

Instructions for Completing the Diet Diary

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 three consecutive days including one weekend day.

- Record information as soon as possible after the food has been consumed.
- Do not change your eating behavior at this time unless your doctor advises you to. The purpose of this food record is to analyze your present eating habits.
- Describe the food or beverage consumed. e.g., milk - what kind? (Whole, 2%, or nonfat); toast - (whole wheat, white, buttered); chicken - (fried, baked, breaded), etc.
- Record the amount of each food consumed using standard measurements as much as possible, such as 8 ounces, 1/2 cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon sugar, potato with 2 teaspoons butter, etc.
- Please record all beverages, including water. List them in the "Beverage" category.
- Please record all bowel movements and their consistency (regular, loose, firm, etc.).

Diet Diary –Day One:

Time	Food / Beverage / Amount	Comment

Bowel Movements (Number per day, form, color): _____

Stress / Mood / Emotions: _____

Other Comments: _____

Water: Glasses/day_____ **Type**: ☐Tap ☐Distilled ☐Spring ☐Well ☐Reverse Osmosis

Name: _____ Date _____/_____/_____

Diet Diary –Day two:

Time	Food / Beverage / Amount	Comment

Bowel Movements (Number per day, form, color): _____

Stress / Mood / Emotions: _____

Other Comments: _____

Water: Glasses/day_____ **Type**: ☐Tap ☐Distilled ☐Spring ☐Well ☐Reverse Osmosis

Diet Diary –Day three:

Time	Food / Beverage / Amount	Comment

Bowel Movements (Number per day, form, color): _____

Stress / Mood / Emotions: _____

Other Comments: _____

Water: Glasses/day_____ **Type**: ☐Tap ☐Distilled ☐Spring ☐Well ☐Reverse Osmosis