227 N. El Camino Real Suite 203 Encinitas, CA 92024
Phone: (760) 632-0100 Fax: (760) 632-0102 Email: info@linaehealthspan.com Website: www.linaehealthspan.com

Adult Wellness Intake

PERSONAL INFORMATION

Name *First* ________ *Middle* ________ *Last* ________

Preferred Name ________

Date of Birth ________

Age ________

Gender ◯ Male ◯ Female

Genetic Background ☐ African ☐ European ☐ Native American ☐ Mediterranean ☐ Asian ☐ Ashkenazi ☐ Middle Eastern ☐ Other________

Highest Education Level ◯ High School ◯ Under-Graduate ◯ Post-Graduate

Job Title ________

Nature of Business ________

Primary Address *Number, Street* ________ *Apt. No.* ________
City ________ *State* ________ *Zip* ________

Alternate Address *Number, Street* ________ *Apt. No.* ________
City ________ *State* ________ *Zip* ________

Home Phone 1 ________

Home Phone 2 ________

Work Phone ________

Cell Phone ________

Fax ________

Email ________

Emergency Contact *Name* ________ *Phone Number* ________
Address ________ *Apt No.* ________
City ________ *State* ________ *Zip* ________

Physician *Name* ________ *Phone Number* ________
Fax ________

Referred by ◯ Website
◯ Media ◯ Friend or Family Member ◯ Other ________

PHARMACY INFORMATION

Primary Pharmacy

Name ____________________ *Phone Number* ____________________

Address ____

City ____________ *State* ____________ *Zip* ____________

Email: ____________________ ***Fax**** ____________________

***It's extremely important that you list the pharmacy's fax number.**

Secondary Pharmacy

Name ____________________ *Phone Number* ____________________

Address ____

City ____________ *State* ____________ *Zip* ____________

Email: ____________________ ***Fax**** ____________________

***It's extremely important that you list the pharmacy's fax number.**

CREDIT CARD INFORMATION

Patient ____ Date ______________________________

DOB ____

Preferred Method of Payment *(please circle one):* Cash / Check / Credit Card

If paying by credit card, we accept VISA, MasterCard and Discover
I, ______________________________________, authorize Linae Healthspan Institute, Inc. to process a transaction on my credit card or debit card for payments due as invoiced.

Signature: ___________________________________ Date: _____________

PRIMARY CARD

Name on Card ____________________________

Card Type ☐ *Visa* ☐ *MasterCard* ☐ *Discover*

Account Number ____________________________

Expiration Date (mm/yy) ____________________

CVV# ____________________________

SECONDARY CARD

Name on Card ____________________________

Card Type ☐ *Visa* ☐ *MasterCard* ☐ *Discover*

Account Number ____________________________

Expiration Date (mm/yy) ____________________

CVV# ____________________________

Medical Questionnaire:

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 current and ongoing problems in order of priority:

Describe Problem	Mild	Moderate	Severe	Prior Treatment/Approach	*Success* Excellent	Good	Fair

MEDICAL HISTORY

☒ = *Past Condition* ☒ = *Ongoing Condition*

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

GASTROINTESTINAL

☐ ☐ Irritable Bowel Syndrome ________
☐ ☐ Inflammatory Bowel Disease ________
☐ ☐ Crohn's ________
☐ ☐ Ulcerative Colitis ________
☐ ☐ Gastritis or Peptic Ulcer Disease ________
☐ ☐ GERD (reflux) ________
☐ ☐ Celiac Disease ________
☐ ☐ Other ________

CARDIOVASCULAR

☐ ☐ Heart Attack ________
☐ ☐ Other Heart Disease ________
☐ ☐ Stroke ________
☐ ☐ Elevated Cholesterol ________
☐ ☐ Arrhythmia (irregular heart beat) ________
☐ ☐ Hypertension (high blood pressure) ________
☐ ☐ Rheumatic Fever ________
☐ ☐ Mitral Valve Prolapse ________
☐ ☐ Other ________

METABOLIC/ENDOCRINE

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

CANCER

☐ ☐ Lung Cancer ________
☐ ☐ Breast Cancer ________
☐ ☐ Colon Cancer ________
☐ ☐ Ovarian Cancer ________
☐ ☐ Prostate Cancer ________
☐ ☐ Skin Cancer ________

GENITAL AND URINARY SYSTEMS

☐ ☐ Kidney Stones ________
☐ ☐ Gout ________
☐ ☐ Interstitial Cystitis ________
☐ ☐ Frequent Urinary Tract Infections ________
☐ ☐ Frequent Yeast Infections ________
☐ ☐ Erectile Dysfunction ________
☐ ☐ Or Sexual Dysfunction ________
☐ ☐ Other ________

MUSCULOSKELETAL/PAIN

☐ ☐ Osteoarthritis ________
☐ ☐ Fibromyalgia ________
☐ ☐ Chronic Pain ________
☐ ☐ Other ________

INFLAMMATORY/AUTOIMMUNE

☐ ☐ Chronic Fatigue Syndrome ________
☐ ☐ Autoimmune Disease ________
☐ ☐ Rheumatoid Arthritis ________
☐ ☐ Lupus SLE ________
☐ ☐ Immune Deficiency Disease ________
☐ ☐ Herpes-Genital ________
☐ ☐ Severe Infectious Disease ________
☐ ☐ Poor Immune Function ________
(frequent infections)
☐ ☐ Food Allergies ________
☐ ☐ Environmental Allergies ________
☐ ☐ Multiple Chemical Sensitivities ________
☐ ☐ Latex Allergy ________
☐ ☐ Other ________

RESPIRATORY DISEASES

☐ ☐ Asthma ________
☐ ☐ Chronic Sinusitis ________
☐ ☐ Bronchitis ________
☐ ☐ Emphysema ________
☐ ☐ Pneumonia ________
☐ ☐ Tuberculosis ________
☐ ☐ Sleep Apnea ________
☐ ☐ Other ________

SKIN DISEASES

☐ ☐ Eczema ________
☐ ☐ Psoriasis ________
☐ ☐ Acne ________
☐ ☐ Melanoma ________
☐ ☐ Skin Cancer ________
☐ ☐ Other ________

☐ ☐ Other ______

MEDICAL HISTORY (Continued)

☒ = *Past Condition* ☒ = *Ongoing Condition*

NEUROLOGIC/MOOD

☐ ☐ Depression ______
☐ ☐ Anxiety ______
☐ ☐ Bipolar Disorder ______
☐ ☐ Schizophrenia ______
☐ ☐ Headaches ______
☐ ☐ Migraines ______
☐ ☐ ADD/ADHD ______
☐ ☐ Autism ______
☐ ☐ Mild Cognitive Impairment ______
☐ ☐ Memory Problems ______
☐ ☐ Parkinson's Disease ______
☐ ☐ Multiple Sclerosis ______
☐ ☐ ALS ______
☐ ☐ Seizures ______
☐ ☐ Other Neurological Problems ______

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 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
Check box if yes

☐ Back Injury ☐ Head Injury
☐ Neck Injury ☐ Broken Bones
☐ Other ______

BLOOD TYPE: ○ A ○ B ○ AB ○ O ○ Rh+ ○ unknown

HOSPITALIZATIONS ☐ None

Date	Reason

COMMENTS

______
______
______
______
______
______

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 lbs.

☐ Breast Feeding For how long? _______________

MENSTRUAL HISTORY

Age at First Period _______ Menes Frequency _______ Length _____ Pain ○ Y ○ N Clotting ○ Y ○ N

Has your period ever skipped? ________ For how long? _______

Last Menstrual Period: ________________

Use of hormonal contraception such as: ☐ Birth Control Pills ☐ Patch ☐ NuvaRing How long? _______

☐ Depo Provera Shot

Do you use contraception? ○ Yes ○ No ☐ Condom ☐ Diaphragm ☐ IUD ☐ 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

Age at Menopause ___________________

☐ Hot Flashes ☐ Mood Swings ☐ Concentration/Memory Problems ☐ Vaginal Dryness ☐ Decreased Libido

☐ Heavy Bleeding ☐ Joint Pains ☐ Headaches ☐ Weight Gain ☐ Loss of Urine Control ☐ Palpitations

☐ Use of hormone replacement therapy. How long? ___________________

MEN'S HISTORY *(for men only)*

Have you had a PSA done? ○ Yes ○ No

PSA Level: ☐ 0-2 ☐ 2-4 ☐ 4-10 ☐ > 10

☐ Prostate Enlargement ☐ Prostate Infection ☐ Change in Libido ☐ Impotence

☐ Difficulty Obtaining an Erection ☐ Difficulty Maintaining an Erection

☐ Nocturia (urination at night) How many times at night? ___________________

☐ Urgency/Hesitancy/Change in Urinary Stream ☐ Loss of Control of Urine

GI HISTORY

Foreign Travel? ☐ Yes ☐ No Where? ________________

Wilderness Camping? ☐ Yes ☐ No Where? ________________

Have you ever had severe: ☐ Gastroentertis ☐ 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 of introduction of Solid Foods: ________ Dairy: ________ Wheat: ________

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

DENTAL HISTORY

DENTAL SURGERY

☐ Silver Mercury Fillings How many? ________________

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

☐ Gingivitis ☐ Problems with Chewing

Do you floss regularly? ☐ Yes ☐ No

MEDICATIONS

CURRENT MEDICATIONS

Medication	Dose	Frequency	Start Date (Month/Year)	Reason For Use

PREVIOUS MEDICATIONS: *Last 10 years*

Medication	Dose	Frequency	Start Date (Month/Year)	Reason For Use

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

Supplication/Brand	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 had prolonged or regular us of NSAIDs (Advil, Aleve, etc.), Motrin, Aspirin? ☐ Yes ☐ No

Have you had prolonged or regular use of Tylenol? ☐ Yes ☐ No

Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.) ☐ Yes ☐ No

Frequent antibiotics > 3/times/year ☐ Yes ☐ No

Long term antibiotics ☐ Yes ☐ No

Use of steroids (prednisone, nasal allergy inhalers) in the past ☐ Yes ☐ No

Use of oral contraceptives ☐ Yes ☐ No

FAMILY HISTORY

Check family members that apply	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age (is still alive)												
Age at death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis												
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)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												

SOCIAL HISTORY

NUTRITION HISTORY

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

Have you made any changes in your eating habits because of your health? ☐ Yes ☐ No Describe ________

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

Check all that apply:

☐ Low fat ☐ Low Carbohydrate ☐ High Protein ☐ Low Sodium ☐ Diabetic ☐ No Dairy ☐ No Wheat

☐ Gluten Restricted ☐ Vegetarian ☐ Vegan ☐ Ultrametabolism

☐ Specific Program for Weight Loss/Maintenance Type: ____________________ ☐ Other _______________

Height (feet/inches)	__________________	Current Weight	______________
Usual Weight Range +/- 5 lbs.	__________________	Desired Weight Range +/- 5 lbs.	______________
Highest adult weight	__________________	Lowest adult weight	______________
Weight Fluctuations (. 10 lbs.)	☐ Yes ☐ No	Body Fat %	______________

How often do you weigh yourself? ☐ Daily ☐ Monthly ☐ Rarely ☐ Never

Have you ever had your metabolism (resting metabolic rate) checked? ☐ Yes ☐ No If yes, what is it? ___________

Do you avoid any particular foods? ☐ Yes ☐ No If yes, types and reason ______________________

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

Do you grocery shop? ☐ Yes ☐ No If no, who does the shopping? ______________________

Do you read food labels? ☐ Yes ☐ No ____

Do you cook? ☐ Yes ☐ No If no, who does the cooking? ______________________________

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

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

☐ Fast eater
☐ Erratic eating pattern
☐ Eat too much
☐ Late night eating
☐ Dislike healthy food
☐ Time constraints
☐ Eat more than 50% of my 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 or bored)
☐ Eat too much under stress
☐ Eat too little under stress
☐ Don't care to cook
☐ Eating in the middle of the night
☐ Confused about nutrition advice

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

____

SMOKING

Currently smoking? ○ Yes ○ No How many years? ___________ Packs per day: ___________

Attempts to quit ______________

Previous smoking: How many years? ______________________ Packs per day: ____________________

Second Hand Smoke Exposure? _______________ Smokeless Tobacco? ______________________________

ALCOHOL INTAKE

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

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

Previous alcohol intake? ○ Yes ○ Mild ○ Moderate ○ High ○ None

Have you ever been told you should cut down 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 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 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 per day

List favorite type (Ex. Diet Coke, Pepsi, etc.): ______________________________

Are you currently using any recreational drugs? ○ Yes ○ No 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, 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 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 like 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 mediation or relaxation techniques? ☐ Yes ☐ No How Often? ______________

Check all the apply: ☐ Yoga ☐ Meditation ☐ Imagery ☐ Breathing ☐ Tai Chi ☐ Prayer ☐ Other ________

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

SLEEP/REST

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

Do you have trouble falling asleep? ☐ Yes ☐ No

Do you feel rested upon awakening? ☐ Yes ☐ No

Do you have problems with insomnia? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No

Do you use sleeping aids? ☐ Yes ☐ No Explain: ______________________________

ROLES/RELATIONSHIPS

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Gay/Lesbian ☐ Long Term Partnership ☐Widow

List Children

Child's Name	Age	Gender

Who is Living in 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	Does Not Apply
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 ☐ No List all: ____________________

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

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

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

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

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

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

☐ Other ____________________

Which of these significantly affects 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 turned yellow (jaundiced)? ☐ Yes ☐ No

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

Explain: ____________________

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

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

☐ Heavy Metals ☐ Other ____________________

Chemical Name, Date, Length of Exposure: ____________________

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

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

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

SYMPTOM REVIEW

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

GENERAL

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

HEAD, EYES & EARS

- ☐ Conjunctivitis
- ☐ Distorted Sense of Smell
- ☐ Distorted Taste
- ☐ Ear Fullness
- ☐ Ear Pain
- ☐ Ear Ringing/Buzzing
- ☐ Lid Margin Redness
- ☐ Eye Crusting
- ☐ Eye Pain
- ☐ Hearing Loss
- ☐ Hearing Problems
- ☐ Headache
- ☐ Migraine
- ☐ Sensitivity to Loud Noise
- ☐ Vision Problems (other than
- ☐ 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
  - ☐ Arms or Legs
- ☐ Muscle Weakness
- ☐ Neck Muscle Spasm
- ☐ Tendonitis
- ☐ Tension Headache
- ☐ TMJ Problems

MOOD/NERVES

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

EATING

- ☐ Binge Eating
- ☐ Bulimia
- ☐ Can't Gain Weight
- ☐ Can't Lose Weight
- ☐ Can't Maintain Healthy Weight
- ☐ Frequent Dieting
- ☐ Poor Appetite
- ☐ Salt Cravings
- ☐ Carbohydrate Cravings (breads)
- ☐ Sweet Cravings (candy, cookies)
- ☐ Chocolate Cravings
- ☐ Caffeine Dependency

DIGESTION

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

SKIN PROBLEMS
- ☐ Acne on Back
- ☐ Acne on Chest
- ☐ Acne of 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
- ☐ Throat

SKIN, DRYNESS OF
- ☐ Eyes
- ☐ Feet
  - ☐ Any Cracking?
  - ☐ Any Peeling?
- ☐ Hair
  - ☐ And Unmanageable?
- ☐ Hands
  - ☐ Any Cracking?
  - ☐ Any Peeling?
- ☐ Mouth/Throat
- ☐ Scalp
  - ☐ Any Dandruff?
- ☐ Skin in General

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

NAILS
- ☐ Bitten
- ☐ Brittle
- ☐ Curve Up
- ☐ Frayed
- ☐ Fungus – Fingers
- ☐ Fungus – Toes
- ☐ Pitting
- ☐ Ragged Cuticles
- ☐ Ridges
- ☐ Soft
- ☐ Thickening of:
  - ☐ Fingernails
  - ☐ 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 Seasons
- ☐ Nasal Stuffiness
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Fullness
- ☐ Sinus Infection
- ☐ Snoring
- ☐ Wheezing
- ☐ Winter Stuffiness

CARDIOVASCULAR
- ☐ Angina/chest pain
- ☐ Breathlessness
- ☐ Heart Murmur
- ☐ Irregular Pulse
- ☐ Palpitations
- ☐ Swollen Ankles/Feet
- ☐ Varicose Veins

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

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

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

Premenstrual:
- ☐ Bloating Breast Tender
- ☐ Carbohydrate Craving
- ☐ Chocolate Craving
- ☐ Constipation
- ☐ Decreased Sleep
- ☐ Diarrhea
- ☐ Fatigue
- ☐ Increased Sleep
- ☐ Irritability

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

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, email correspondence) from our professional staff would be helpful to you as you implement your personal health program? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Comments ____

____

____

3-DAY DIET DIARY INSTRUCTIONS

It is important to keep an accurate record of your usual food and beverage intake as a part of your treatment plan.

Please complete this Diet Diary for 3 consecutive days including one weekend day.

- Do not change your eating behavior at this time, as the purpose of this food record is to analyze your present eating habits.
- Record information as soon as possible after the food has been consumed.
- 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 cream).
- Record the amount of each food or beverage consumed using standard measurements such as 8 ounces., ½ cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon of honey, potato with 2 teaspoons butter, etc.
- Record all beverage, 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

Name: ______________________ Date: ______________________

DAY 1

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Bowel Movement (#, form, color) ______________________

Stress/Mood/Emotions ______________________

Other Comments ______________________

DAY 2

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Bowel Movement (#, form, color) ____________________

Stress/Mood/Emotions ____________________

Other Comments ____________________

DAY 3

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Bowel Movement (#, form, color) ____________________

Stress/Mood/Emotions ____________________

Other Comments ____________________

MEDICAL SYMPTOM/TOXICITY QUESTIONNAIRE

NAME: ______________________ **DATE:** ______________

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying cases of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are completing this after your first time, then record your symptoms for the last 48 hours ONLY.

POINT SCALE
0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

DIGESTIVE TRACT
_______ Nausea or vomiting
_______ Diarrhea
_______ Constipation
_______ Bloated feeling
_______ Belching or passing gas
_______ Heartburn
_______ Intestinal/Stomach pain
Total _______

EARS
_______ Itchy ears
_______ Earaches, ear infections
_______ Drainage from ear
_______ Ringing in ears, hearing loss
Total _______

EMOTIONS
_______ Mood Swings
_______ Anxiety, fear or nervousness
_______ Anger, irritability, aggressiveness
_______ Depression
Total _______

ENERGY/ACTIVITY
_______ Fatigue, sluggishness
_______ Apathy, lethargy
_______ Hyperactivity
_______ Restlessness
Total _______

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

HEAD
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia
Total _______

HEART
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain
Total _______

JOINTS/MUSCLES
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limited movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness
Total _______

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

MIND
_____ Poor Memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities
Total _______

MOUTH/THROAT
_____ Chronic coughing
_____ Gagging, clearing throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen/discolored tongue, gum, lips
_____ Canker sores
Total _______

NOSE
_____ Stuffy Nose
_____ Sinus Problems
_____ Hay Fever
_____ Sneezing attacks
_____ Excessive mucus formation
Total _______

SKIN
_____ Acne
Hives, rashes or dry skin
_____ Hair loss
_____ Flushing or hot flashes
_____ Excessive sweating
Total _______

WEIGHT
Binge eating/drinking
Craving certain foods
Excessive weight
Compulsive eating
Water retention
Underweight

OTHER
Frequent illness
Frequent or urgent urination
Genital itch or discharge
Total _______

GRAND TOTAL _______________

KEY TO QUESTIONNAIRE

Add individual scores and total each group. Add each group score and give a grand total.

• Optimal is less than 10 • Mild Toxicity : 10-50 • Moderate Toxicity: 50-100 • Severe Toxicity: over 100