Functional Medicine Assessment

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Frequently Asked Questions

Do you think you can help me with my health problem?

Our clinic uses an innovative approach to assessing and treating your health-care concerns. Perhaps you have experienced being examined by a doctor, had blood tests, X-rays, or other diagnostic tests, only to have the doctor report that all your tests are normal. Usually, that is good news. But how would you feel getting those results when you know something is wrong, when you're not feeling well and know that you're not normal? Unfortunately that experience is all too common.

Most physicians are trained to look only in specific places for answers, using the same diagnostic tests processed by the same labs. Yet, many causes of illness cannot be found in routine tests. Diagnosing food allergies, environmental toxins, mold exposure, hidden infections, nutritional deficiencies, and metabolic imbalances often requires specialized testing.

We use a variety of innovative testing techniques and procedures to help our patients recover from many chronic and difficult-to-treat conditions, and to prevent future illness. Dr. Zembroski is highly skilled in evaluating chronic problems such as fibromyalgia, fatigue syndromes, autoimmune diseases, inflammatory disorders, mood and behavior disorders, memory problems, and other chronic, "age-related," and complex conditions. He also focuses on the prevention of heart disease, diabetes, dementia, hormonal imbalances, and digestive disorders, all of which, research has shown, respond well to lifestyle modifications.

Can all the tests I need be done at this clinic?

Some testing is done at our clinic; some tests are handled by conventional laboratories, and others are available only through specialized laboratories. During your consultation, Dr. Zembroski will determine which tests are needed; our office assistants then review testing instructions (*i.e.,* fasting or non-fasting, etc.), recommendations, and costs. Some tests can be started with at-home kits to collect urine, saliva, or stool. Blood can be drawn in our office and sent out for testing. Occasionally, we may recommend certain tests that require an outside facility. In those instances, we can provide you with a requisition form that you can take to a facility near your home, or we can schedule an appointment to have testing done near our office. In all cases, we will assist you in coordinating initial and follow-up testing.

Do you accept insurance?

We do not participate in any insurance networks, but we will provide a detailed receipt for services for you to submit to your insurance carrier. Some insurance carriers may partially cover medical services and laboratory tests. Payment in full by check, cash, or credit card is due at the time services are provided.

Medicare does not cover services for nutritional counseling. In 2013, Medicare adopted a new policy which limits coverage for most testing only when ordered by a medical doctor (M.D.). Tests ordered by other practitioners (naturopaths, chiropractors, nurse practitioner, etc.) are not covered.

What credit cards do you accept?

We accept the following credit cards: MasterCard, Visa, American Express, and Discover. As an added convenience, you may choose to maintain an active credit card on file at the office to facilitate billing.

Our office partners with CareCredit ®, a third-party payor providing payment plans interest-free for six months from the date of purchase. More information, as well as promotional materials, can be obtained in our office, or by visiting **www.carecredit.com**.

Getting Started . . .

It is Dr. Zembroski's opinion that you should be well informed about our clinical procedures. To prevent any misunderstandings or confusion, please read the steps below and provide your signature as an acknowledgement that you have read and understand what you should do in order to get the most benefit from our office.

1. Complete the Functional Diagnosis Questionnaire; that information will help to quickly zero in on the probable cause of your health problems.

   It is VERY important for you to carefully and thoroughly complete the questionnaire prior to your first consultation with Dr. Zembroski. Deliver the completed questionnaire to our office, either by hand, mail or email (info@darienfm.com). Please do not fax the document.

2. Arrange to have medical records sent from all physicians you have seen since first diagnosed with your health condition. These, too, should be received by us prior to scheduling an appointment. These records may be sent via fax (203-655-7577).

3. Once we have your completed questionnaire and the copies of your medical records, we will schedule a 45-minute appointment to review your case. The cost for this appointment includes Dr. Zembroski's time spent reviewing your questionnaire and medical records, his interpretation of all the data you have provided, and his recommendations to improve your health.

4. Based on your medical history, questionnaire, medical records, and initial consultation, it may be necessary to order additional laboratory tests. You will be given detailed information about the specific tests recommended. The cost for additional tests will be discussed at that time. If you have insurance, we will verify your coverage for the tests needed and let you know what is likely to be covered. We will also provide the necessary forms to submit for insurance reimbursement. If your insurance does not cover the testing, Care Credit can be used to cover the expense of any medical fees. Information about Care Credit can be obtained from our office or by visiting www.carecredit.com.

5. Your treatment may consist of dietary and lifestyle changes, as well as prescribed natural compounds, such as nutritional supplements, bio-identical hormones, etc.

6. Abnormal laboratory tests will need to be re-evaluated. The success of your treatment will be measured not only by the reduction or elimination of physical symptoms, but on abnormal tests returning to a normal status. This same kind of follow-up testing is routine when treated by other practitioners. For example, many physicians prescribe Lipitor for individual with high cholesterol levels. Periodic blood tests are required to monitor the success of the medication.

Careful attention to these steps will ensure that you get full benefit from your treatment in our office. If you have questions about any of these steps, please call our office at 203-655-4494.

Authorization for Release of Medical Records

Requesting Records of Doctor:

Name of Facility or Person: ____

Address: ____

Telephone Number (   ) ______–____________   Fax Number (   ) ______–____________

THE PURPOSE FOR THIS RELEASE

You are hereby authorized to furnish and release to Dr. Robert Zembroski and the Darien Center for Integrative Medicine all information from my medical, psychological, and other health records, with no limitation placed on history of illness or diagnostic or therapeutic information, including the furnishing of photocopies of all written documents pertinent thereto.

In addition to the above general authorization to release my protected health information, I further authorize release of the following information if it is contained in those records:

Alcohol or Drug Abuse*:* O Yes O No

Communicable disease-related information, including AIDS or ARC diagnosis
and/or HIT or HTLA-III test results or treatment: O Yes O No

Genetic Testing O Yes O No

Note: With respect to drug- and alcohol-abuse treatment information, or records regarding communicable disease information, the information is from confidential records which are protected by State and Federal laws that prohibit disclosure without the specific written consent of the person to whom they pertain, or as otherwise permitted by law. A general authorization for the release of the protected health information is not sufficient for this purpose.

This authorization can be revoked in writing at any time, except to the extent that disclosure made in good faith has already occurred in reliance on this authorization.

I hereby release Dr. Robert Zembroski, the Darien Center for Functional Medicine, its employees, agents managing members, and the attending physician(s) from legal responsibility or liability for the release of the above information to the extent authorized. A copy of this authorization shall be as valid as the original.

I understand the there may be a fee for this service, depending on the number of pages photocopied. However; no such fee will be charged if these records are requested for continuing medical care.

Patient's Name: ________________________________ D.O.B. ______________
Please Print

Signature: ________________________________ Date ______________

PLEASE INCLUDE A COPY OF YOUR DRIVER'S LICENSE OR PASSPORT ALONG WITH THE COMPLETED AND SIGNED FORM

Records Requested by:

Doctor's Name: ____

Address: ________________________________ Telephone: (   ) ____–__________

Signature: ____

Functional Medicine Questionnaire

General Information

Please print or write legibly

Name Date

Preferred Name Sex (circle) Female Male

Address City State Zip Code

Home Phone Work Phone

Cell Phone Email

Age Date of Birth Place of Birth

Marital Status (circle) Single Married Partnered Separated Divorced Widowed

Spouse's Name

Your Occupation Hours per week Retired

Nature of Business

How did you hear about our clinic? (circle) Book Website Media Friend/Family

Other (please specify)

Has any member of your family been a patient at our clinic? Y N Name

Next of Kin/Emergency Contact

Relationship Phone

Address

Primary Medical Physician—Name

Office Address

Office Phone Office Fax

Personal Descriptive Information

Please print or write legibly.

Genetic Background—check appropriate box(es)

❑ African American ❑ Asian ❑ Caucasian ❑ Hispanic

❑ Mediterranean ❑ Native American ❑ Northern European ❑ Other: ___________________

Siblings: Number of Sisters (# deceased) Number of Brothers (# deceased)

Your Position in Birth Order

Dominant Hand (circle one): Right Left Mixed

Children:

Name	Age	Sex

With whom do you live? Include spouse, children, parents, relatives, and/or friends. Please include ages. (Example: Wendy, age 7, sister)

____

____

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

If yes, where do they live? ❑ Indoors ❑ Outdoors ❑ Both indoors and outdoors

Have you ever lived or traveled outside the United States? ❑ Yes ❑ No

If so, when and where?

____

____

Have you or your family recently experienced any major life changes? ❑ Yes ❑ No

If yes, please describe:

____

____

Have you experienced any major losses in life? ❑ Yes ❑ No

If so, please describe:

____

____

How much time have you lost from work or school in the past year due to health problems?

❑ 0-2 days ❑ 3-14 days ❑ more than 15 days

Previous jobs (describe):

____

____

Please indicate your highest level of education:

❑ High School

❑ College ____________________ Major: ______________ Year: __________

❑ Graduate School ______________ Field: _______________ Year: __________

❑ Professional School ____________ Field: _______________ Year: __________

❑ Did you have learning problems? ____

Please complete the following questionnaire to the best of your ability. You may need family members to supply some information. Your thoroughness and accuracy in answering all appropriate questions will help Dr. Zembroski to evaluate the root cause of your health concerns in order to determine an effective treatment program.

When filling out the forms, note that so-called minor symptoms can be just as revealing as major problems. Some people tend not to mention minor symptoms for fear of being labeled a hypochondriac. The approach in our office is different. We are interested in any odd or unusual message you are getting from your body, even though it may be considered irrelevant to "making a diagnosis," or it may seem to you to be of no consequence to your health. Such symptoms are often useful clues for Dr. Zembroski. Please include as much information as you can on this form.

Please print or write legibly.

Complaints/Concerns

Please print or write legibly.

Please list your chief symptoms in order of decreasing severity, starting with the worst one. Please note how long each symptoms has been present.

Problem	Onset	Frequency	Severity
Ex: Headaches	June 2007	4 times per week	Mild / moderate / severe
1.			
2.			
3.			
4.			
5.			
6.			

What diagnosis or explanation has been determined?

When was the last time your health was good?

Are you aware of something that triggered your change in health?

What makes you feel worse?

What makes you feel better?

Please list all physicians you have seen for the conditions you listed above:

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
- ❑ Nutritional Therapy
- ❑ Acupuncture
- ❑ Reiki
- ❑ Ayurveda
- ❑ Biological Dentistry
- ❑ Iridology
- ❑ Homeopathy
- ❑ Light Therapy
- ❑ IV (Chelation) Therapy
- ❑ Colonics
- ❑ Biofeedback
- ❑ Meditation
- ❑ Naturopathic Medicine
- ❑ Other: ____________________

Medical & Surgical History

Please print or write legibly.

	Date	Date	Date	Comments
ILLNESSES				
Chicken Pox				
German Measles				
Measles				
Mumps				
Whooping cough				
Anemia				
Arthritis				
Asthma				
Bronchitis				
Cancer				
Chronic Fatigue				
Crohn's Disease or Ulcerative Colitis				
Diabetes				
Emphysema				
Epilepsy, convulsions				
Gallstones				

	Date	Date	Date	Comments
Gout				
Heart attack/Angina				
Heart failure				
Hepatitis				
High blood pressure				
Irritable bowel				
Kidney stones				
Mononucleosis				
Pneumonia				
Rheumatic fever				
Sinusitis				
Sleep apnea				
Stroke				
Thyroid disease				
Other (describe)				
INJURIES	**Date**	**Date**	**Date**	**Comments**
Head Injury				
Neck Injury				
Back Injury				
Fracture				
Other (describe)				
DIAGNOSTIC STUDIES	**Date**	**Date**	**Date**	**Comments**
Chest X-ray				
Mammogram				
EKG				
Sigmoidoscopy				
Colonoscopy				
Upper GI Series				
Barium Enema				
CAT scan of Abdomen				
CAT scan of brain				
CAT scan of spine				
Liver scan				
Bone scan				
Neck X-rays				
Back X-rays				
MRI				
Bone Density Test				
Carotid Artery Ultrasound				

	Date	Date	Date	Comments
Blood Tests				
Other (describe)				
Other (describe)				
OPERATIONS	**Date**	**Date**	**Date**	**Comments**
Tonsillectomy				
Tubes in Ears				
Appendectomy				
Gall Bladder				
Hernia				
Hysterectomy				
Dental Surgery				
Other (describe)				
Other (describe)				

Hospitalizations

Please print or write legibly.

Where Hospitalized	When	For What Reason

Patient Birth History

Please print or write legibly.

Question	Yes	No	Don't Know	Comment
Were you a full term baby?				
A Preemie?				
Forcep delivery?				
Cesarean section?				
Epidural used?				
Breast fed?				
Bottle fed?				
When your mother was pregnant with you, did she:				
Smoke tobacco?				
Drink alcohol?				
Take estrogen?				

Childhood Health History

Please print or write legibly.

Question	Yes	No	Don't Know	Comment
Did you live in an area with soft water?				
hard water?				
As a child, did you consume a lot of the following:				
Sugar?				
Candy?				
Sweet foods?				
Soda?				
Diet soda?				
White bread?				
Cookies?				
Ice Cream?				
Meat, vegetable & potato/rice/pasta diet?				
Vegetarian & grain based diet with little meat?				
Vegetarian diet with milk & eggs?				
Vegetarian diet without milk & eggs?				

As a child, were there any foods that you had to avoid because they gave you symptoms? Yes _____ No _____

If yes, please name the food and symptom (*e.g.,* wheat – gas and bloating).

Food	Symptom	Other comments

CHILDHOOD PROBLEMS/CONDITIONS

Please indicate which, if any, of the following problems/conditions developed when you were a child (birth to age 12) by indicating the approximate age of onset.

_____ Frequent colds or flu

_____ Bronchitis

_____ Measles

_____ Chicken Pox

_____ Strep Infections

_____ Significant dental work

_____ ADD

_____ Difficulty learning

_____ Frequent absence from school

_____Tonsillitis

_____ Ear Infections

_____ Mumps

_____ Whooping Cough

_____ Seasonal allergies

_____ Behavior problems

_____ Hyperactivity

_____ Frequent headaches

_____ Upset stomach, indigestion

_____ Jaundice
_____ Ear infections
_____ Premature at birth
_____ Fever blisters
_____ Abusive or alcoholic parent(s)
_____ Major illness(es) that required hospitalization
_____ Colic
_____ Congenital abnormalities
_____ Pneumonia
_____ Parent(s) smoked
_____ Skin disorders (eczema)

If yes, please explain your illness:

____

____

____

____

____

Immunization History

Please print or write legibly.

Please indicate if you have been vaccinated against any of the following diseases:

- ❑ Smallpox
- ❑ Tetanus
- ❑ Diphtheria
- ❑ Pertussis
- ❑ Polio (oral)
- ❑ Polio (Injection)
- ❑ Mumps
- ❑ Measles
- ❑ Rubella (German measles)
- ❑ Typhoid
- ❑ Cholera

Female Medical History (women only)

Please print or write legibly.

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

❑ Pregnancies ____ ❑ Caesarean ____ ❑ Vaginal deliveries ____

❑ Miscarriage ____ ❑ Abortion ____ ❑ Living Children ____

❑ Postpartum depression ____ ❑ Toxemia ____ ❑ Gestational diabetes ____

❑ Baby over 8 pounds ____ ❑ Breast feeding ____ For how long? ______________________

GYNECOLOGICAL HISTORY

Menstrual: Age at first period: _____ Menses Frequency: _____________ Length: ___________________

Pain: ❑ Yes ❑ No Clotting: ❑ Yes ❑ No Last Menstrual Period: ______________________

Has your period skipped? ❑ Yes ❑ No For how long? ____

Do you currently use contraception? ❑ Yes ❑ No

If yes, what type do you use? ❑ Condom ❑ Diaphragm ❑ IUD ❑ Partner vasectomy

Have you ever used hormonal contraception? ❑ Yes ❑ No If yes, when? ____________________

Type of hormonal contraception: ❑ Birth-control pills ❑ Patch ❑ Nuva Ring How long? __________

Are you using birth-control pills now? ❑ Yes ❑ No Did taking the pills agree with you? ❑ Yes ❑ No

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

Date of last mammogram: ____________________ Breast biopsy? Date: ____________________

Date of last PAP test: ____________________ ❑ Normal ❑ Abnormal

Date of last bone-density test: ____________________ Results: ❑ High ❑ Low ❑ Normal

Are you in menopause? ❑ Yes ❑ No Age at menopause: ________

Do you take: ❑ Estrogen ❑ Ogen ❑ Estrace ❑ Premarin ❑ Other: ____________________

❑ Progesterone ❑ Provera ❑ Other: ____________________

How long have you been on hormone-replacement therapy? ____________________

Family History

Please print or write legibly.

(Place mark any health problem(s) your family has suffered either now or in the past)

Check Family Members that Apply	**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)												
Heart Attack												
Stroke												
Uterine Cancer												
Colon Cancer												
Breast Cancer												
Ovarian Cancer												
Prostate Cancer												
Skin Cancer												

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
ADD/ADHD												
ALS or other Motor Neuron Diseases												
Alzheimer's												
Anemia												
Anxiety												
Arthritis												
Asthma												
Autism												
Autoimmune Diseases (such as Lupus, Multiple Sclerosis)												
Bipolar Disease												
Bladder disease												
Blood clotting problems												
Celiac disease												
Dementia												
Depression												
Diabetes												
Eczema												
Emphysema												
Environmental Sensitivities												
Epilepsy												
Flu												
Food Allergies, Sensitivities, Intolerances												
Genetic disorders												
Glaucoma												
Headache												
Heart Disease												
High Blood Pressure												
High Cholesterol												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing spondylitis)												
Inflammatory Bowel Disease												
Insomnia												

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Irritable Bowel Syndrome												
Kidney disease												
Multiple Sclerosis												
Nervous breakdown												
Obesity												
Osteoporosis												
Parkinson's												
Pneumonia/Bronchitis												
Psoriasis												
Psychiatric disorders												
Schizophrenia												
Sleep Apnea												
Smoking addiction												
Stroke												
Substance abuse (such as alcoholism)												
Ulcers												
Other:												
Other:												
Other:												

Is there any other family history we should know about? ☐ Yes ☐ No

If yes, please comment: ____

____

____

____

What is the attitude of those close to you about your illness? ☐ Supportive ☐ Non-supportive

Symptoms & Conditions

Please print or write legibly.

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

GENERAL

- ❑ Fever
- ❑ Chills/cold all over
- ❑ Aches/pains
- ❑ General weakness
- ❑ Difficulty sweating
- ❑ Excessive sweating
- ❑ Swollen glands
- ❑ Cold hands & feet
- ❑ Fatigue
- ❑ Difficulty falling asleep
- ❑ Night walker
- ❑ Nightmares
- ❑ No dream recall
- ❑ Early waking
- ❑ Daytime sleepiness
- ❑ Distorted vision

SKIN:

- ❑ Cuts heal slowly
- ❑ Bruise easily
- ❑ Rash
- ❑ Pigmentation
- ❑ Changing moles
- ❑ Calluses
- ❑ Eczema
- ❑ Psoriasis
- ❑ Dryness
- ❑ Oiliness
- ❑ Itching
- ❑ Acne
- ❑ Boils
- ❑ Hives
- ❑ Fungus on nails
- ❑ Peeling skin
- ❑ Cracking skin
- ❑ Shingles
- ❑ Nails split
- ❑ White spots/lines on nails
- ❑ Crawling sensation
- ❑ Burning on bottom of feet
- ❑ Athletes foot
- ❑ Cellulite
- ❑ Bugs love to bite you
- ❑ Have bumps on the back of arms and front of thighs
- ❑ Skin cancer
- ❑ Strong body odor

Is your skin sensitive to:

- ❑ Sun
- ❑ Fabrics: ______________________________
- ❑ Detergents: ___________________________

HEAD:

- ❑ Poor concentration
- ❑ Confusion
- ❑ Headaches:
  - ❑ After meals
  - ❑ Severe
  - ❑ Migraine
  - ❑ Frontal
  - ❑ Afternoon
  - ❑ Occipital
  - ❑ Afternoon
  - ❑ Daytime
- ❑ Relieved by:
  - ❑ Eating sweets
- ❑ Concussion/whiplash
- ❑ Mental sluggishness
- ❑ Forgetfulness
- ❑ Indecisive
- ❑ Face twitch
- ❑ Poor memory
- ❑ Hair loss

EYES:

- ❑ Sand in eyes
- ❑ Double vision
- ❑ Blurred vision
- ❑ Poor night vision
- ❑ Bright flashes
- ❑ Halo around lights
- ❑ Eye pains
- ❑ Dark circles under eyes
- ❑ Strong light irritates
- ❑ Cataracts
- ❑ Floaters in eyes
- ❑ Visual hallucinations

EARS:

- ❑ Aches
- ❑ Discharge/conjunctivitis
- ❑ Pains
- ❑ Ringing
- ❑ Deafness/hearing loss
- ❑ Itching
- ❑ Pressure
- ❑ Wear a hearing aid
- ❑ Frequent infections
- ❑ Tubes in ears
- ❑ Sensitive to loud noises
- ❑ Hearing hallucinations

NOSE/SINUSES

- ❑ Stuffy
- ❑ Bleeding
- ❑ Running
- ❑ Discharge
- ❑ Watery nose
- ❑ Congested
- ❑ Infection
- ❑ Polyps
- ❑ Acute smell
- ❑ Drainage
- ❑ Sneezing spells
- ❑ Post nasal drip
- ❑ No sense of smell

- ❑ Change of season makes symptoms worse?

If yes, is it worse in the:

- ❑ Spring
- ❑ Summer
- ❑ Fall
- ❑ Winter

MOUTH:

- ❑ Coated tongue
- ❑ Sore tongue
- ❑ Teeth problems
- ❑ Bleeding gums
- ❑ Canker sores
- ❑ TMJ
- ❑ Cracked lips/ corners
- ❑ Chapped lips
- ❑ Fever blisters
- ❑ Wear dentures
- ❑ Grind teeth when sleeping
- ❑ Bad breath
- ❑ Dry mouth

THROAT:

- ❑ Mucus
- ❑ Difficulty swallowing
- ❑ Frequent hoarseness
- ❑ Tonsillitis
- ❑ Enlarged glands
- ❑ Constant clearing of throat
- ❑ Throat closes up

NECK:

- ❑ Stiffness
- ❑ Swelling
- ❑ Lumps
- ❑ Neck glands swell

CIRCULATION/RESPIRATION:

- ❑ Swollen ankles
- ❑ Sensitive to heat
- ❑ Sensitive to cold
- ❑ Extremities cold or clammy
- ❑ Hands/feet go to sleep/numb
- ❑ High blood pressure
- ❑ Chest pain

- ❑ Pain between shoulders
- ❑ Dizziness upon standing
- ❑ Fainting spells
- ❑ High cholesterol
- ❑ High triglycerides
- ❑ Wheezing
- ❑ Irregular heartbeat
- ❑ Palpitations
- ❑ Low exercise tolerance
- ❑ Frequent coughs
- ❑ Breathing heavily
- ❑ Frequent sighing
- ❑ Shortness of breath
- ❑ Night sweats
- ❑ Varicose veins
- ❑ Mitral valve prolapse
- ❑ Murmurs
- ❑ Skipped heartbeat
- ❑ Heart enlargement
- ❑ Angina pain
- ❑ Bronchitis/pneumonia
- ❑ Emphysema
- ❑ Croup
- ❑ Frequent colds
- ❑ Heavy/tight chest
- ❑ Past heart attack – when ________
- ❑ Phlebitis
- ❑ Spider veins

GASTROINTESTINAL/DIGESTION

- ❑ Peptic/duodenal ulcer
- ❑ Poor appetite
- ❑ Excessive appetite
- ❑ Gallstones
- ❑ Gallbladder pain
- ❑ Nervous stomach
- ❑ Full feeling after meal
- ❑ Indigestion
- ❑ Heartburn
- ❑ Acid reflux
- ❑ Hiatal hernia
- ❑ Nausea
- ❑ Vomiting
- ❑ Vomiting blood
- ❑ Abdominal pains/cramps
- ❑ Gas
- ❑ Diarrhea
- ❑ Constipation
- ❑ Changes in bowels
- ❑ Rectal bleeding
- ❑ Tarry stools
- ❑ Rectal itching
- ❑ Use laxatives
- ❑ Bloating
- ❑ Belch frequently
- ❑ Anal itching
- ❑ Anal fissures
- ❑ Bloody stools
- ❑ Undigested food in stools

KIDNEY/URINARY TRACT:

- ❑ Burning
- ❑ Frequent urination
- ❑ Blood in urine
- ❑ Night-time urination
- ❑ Problem passing urine
- ❑ Kidney pain
- ❑ Kidney stones
- ❑ Painful urination
- ❑ Bladder infections
- ❑ Kidney infections
- ❑ Syphilis
- ❑ Bedwetting
- ❑ Have trichomonas

WOMEN'S HISTORY (for women only)

- ❑ Fibrocystic breasts
- ❑ Lumps in breast
- ❑ Fibroid tumors/breast
- ❑ Spotting
- ❑ Heavy periods
- ❑ Fibroid tumors/uterus
- ❑ Painful periods
- ❑ Change in period

- ❑ Breast soreness before period
- ❑ Endometriosis
- ❑ Non-period bleeding
- ❑ Breast soreness during period
- ❑ Vaginal dryness
- ❑ Vaginal discharge
- ❑ Had partial/total hysterectomy
- ❑ Hot flashes
- ❑ Mood swings
- ❑ Concentration/memory problems
- ❑ Breast cancer
- ❑ Ovarian cysts
- ❑ Pregnant
- ❑ Infertility
- ❑ Decreased libido
- ❑ Heavy bleeding
- ❑ Joint pains
- ❑ Headaches
- ❑ Weight gain
- ❑ Loss of control of urine
- ❑ Palpitations

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
- ❑ Diminished libido
- ❑ Poor libido
- ❑ Infertility
- ❑ Lumps in testicles
- ❑ Sore on penis
- ❑ Genital pain
- ❑ Hernia
- ❑ Prostate cancer
- ❑ Low sperm count
- ❑ Difficulty obtaining erection
- ❑ Difficulty maintaining erection
- ❑ Nocturia (urination at night)
  How many times at night? __________
- ❑ Urinary urgency/hesitancy/change
- ❑ Loss of control of urine

JOINT/MUSCLES/TENDONS

- ❑ Pain wakes me up
- ❑ Weakness in legs and arms
- ❑ Balance problems
- ❑ Muscle cramping
- ❑ Head injury
- ❑ Muscle stiffness in morning
- ❑ Damp weather bothers you

EMOTIONAL

- ❑ Convulsions
- ❑ Dizziness
- ❑ Fainting spells
- ❑ Blackouts
- ❑ Amnesia
- ❑ Had shock therapy
- ❑ Frequently keyed up and jittery
- ❑ Shaky
- ❑ Startled by sudden noises
- ❑ Often feel suddenly scared
- ❑ Go to pieces easily
- ❑ Forgetful
- ❑ Listless
- ❑ Withdrawn feeling
- ❑ Feel “lost” in time
- ❑ Had nervous breakdown
- ❑ Had “burnout”
- ❑ Feel groggy
- ❑ Unable to concentrate
- ❑ Short attention span
- ❑ Vision changes
- ❑ Unable to reason
- ❑ Considered a nervous person
- ❑ Worried over little things
- ❑ Anxiety
- ❑ Unusual tension
- ❑ Frustration

- ❑ Numbness
- ❑ Often break out in cold sweats
- ❑ Profuse sweating
- ❑ Depressed
- ❑ Been admitted for psychiatric care
- ❑ Often awakened by frightening dreams
- ❑ Family member had nervous breakdown
- ❑ Use tranquilizers
- ❑ Aggressive
- ❑ Misunderstood by others
- ❑ Irritable
- ❑ Easily flare in anger
- ❑ Feeling of hostility
- ❑ Fatigue
- ❑ Hyperactive
- ❑ Restless-leg syndrome
- ❑ Considered clumsy
- ❑ Unable to coordinate muscles
- ❑ Have difficulty falling asleep
- ❑ Have difficulty staying asleep
- ❑ Daytime sleepiness
- ❑ Am a workaholic
- ❑ Have had hallucinations
- ❑ Have considered suicide
- ❑ Have overused alcohol
- ❑ Family history of overused alcohol
- ❑ Cry often
- ❑ Feel insecure
- ❑ Have overused drugs
- ❑ Have been addicted to drugs
- ❑ Extremely shy

Dental History

Please print or write legibly.

Have you had sore gums (gingivitis) often over the years? ❑ Yes ❑ No

Has ringing in the ears (tinnitus) been present? ❑ 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 regularly? ❑ Yes ❑ No

Did your mother have dental fillings prior to giving birth to you? ❑ Yes ❑ No

Did you have fillings as a child? ❑ Yes ❑ No

If yes, about how many fillings did you have up to 18 yrs? ______

Did you have dental fillings as an adult? ❑ Yes ❑ No

If yes, about how many fillings did you have after age 18 yrs? ______

How many amalgam fillings do you have now? ______

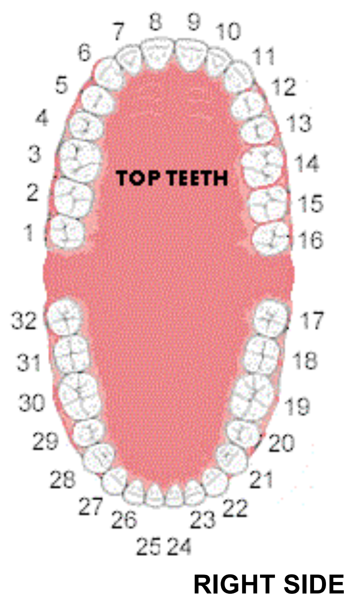
Did you play with mercury as a child or adult? ❑ Yes ❑ No

Have you eaten a lot of fish in your life? ❑ Yes ❑ No

List the approximate age and the type of dental work done from childhood until present:

Age	Describe Dental Work	Health Problems following dental work? (describe)

Please circle the tooth or teeth you have had or still have problems with. Please state what type of problem you have had, for example: root canal, crown, abscessed tooth, partials, etc. and indicate which teeth have fillings (If you know).



RIGHT SIDE

RECORD ANSWERS:

____

____

____

____

____

____

____

____

____

Medications & Supplements

Please print or write legibly.

ANTIBIOTIC USE

Antibiotics: How often have you taken antibiotics?

	Less than 5 times	More than 5 times
Infancy/Childhood		
Teen		
Adulthood		

STEROID USE

Oral Steroids: How often have you taken oral steroids (e.g. Prednisone, Cortisone, etc.)?

	Less than 5 times	More than 5 times
Infancy/Childhood		
Teen		
Adulthood		

Indicate any medications you're currently taking or have taken in the last month:

- ❑ Acid-blocking drugs
- ❑ Anti-anxiety medications
- ❑ Antibiotics
- ❑ Anticonvulsants
- ❑ Antidepressants
- ❑ Diuretics
- ❑ Estrogen or progesterone (pharmaceutical, prescription)
- ❑ Estrogen or progesterone (natural)
- ❑ Heart medications

- [ ] Anti-fungals
- [ ] Aspirin/Ibuprofen
- [ ] Asthma inhalers
- [ ] Beta blockers
- [ ] Birth-control pills/implant contraceptives
- [ ] Chemotherapy
- [ ] Cholesterol-lowering medications
- [ ] Cortisone/steroids
- [ ] Diabetic medications/insulin
- [ ] High-blood-pressure medications
- [ ] Laxatives
- [ ] Relaxants/sleeping pills
- [ ] Testosterone (natural or prescription)
- [ ] Thyroid medication
- [ ] Acetaminophen (Tylenol)
- [ ] Ulcer medications
- [ ] Sildenafil citrate (Viagra or similar)

MEDICATION LOG

Please indicate the type of medications you are taking now. Please include non-prescription drugs.

Medication Name	Date started	Dated Stopped	Dosage	# per day

SUPPLEMENT LOG

Supplements: List all vitamins, minerals and other nutritional supplements

Supplement Name/Brand	Dose	Frequency	Dated Started	Reason for use

Have your medications or supplements ever caused you unusual side effects or problems?

❑ Yes ❑ No

If yes, please describe:

____

____

____

Allergies

Please print or write legibly.

Medication / Supplement / Food	Reaction

Nutrition & Lifestyle History

Please print or write legibly.

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 fat
❑ Mixed-food diet (animal & vegetable sources)
❑ High protein
❑ Vegetarian
❑ Vegan
❑ Gluten-restricted
❑ Low sodium
❑ Fat restriction
❑ Low starch/carbohydrate
❑ The Blood-Type Diet
❑ Metabolic typing diet
❑ The Zone Diet
❑ Total calorie restriction
❑ Ovo-lacto diet
❑ Diabetic
❑ No dairy
❑ No wheat
❑ Specific program for weight loss/maintenance Type: ________________________________

Please check any specific food restrictions you have:

- ❑ Dairy
- ❑ Wheat
- ❑ Eggs
- ❑ Soy
- ❑ Corn
- ❑ All gluten
- ❑ Other: ______________________________

Is there anything special about your diet that I should know?

____

____

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 ❑ 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 eat only a few foods a week, what would they be? ______________________________

____

____

Do you grocery shop? ❑ Yes ❑ No If no, who does the shopping? ______________________________

When you shop do you purchase the following?

❑ Organic foods ❑ Hormone-free/antibiotic-free meat

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 our 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 healthful foods
- ❑ Do not plan meals or menus
- ❑ Reliance on convenience items
- ❑ Poor snack choices
- ❑ Significant other or family members don’t like healthful foods
- ❑ 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 advice
- ❑ Diet often for weight control

FOOD DIARY

Place a check mark next to the food/drink that applies to your current diet. (List continues on next page.)

Usual Breakfast	Usual Lunch	Usual Dinner
❑ None	❑ None	❑ None
❑ Bacon/sausage	❑ Butter	❑ Beans (legumes)
❑ Bagel	❑ Coffee	❑ Brown rice
❑ Butter	❑ Eat in a cafeteria	❑ Butter
❑ Cereal	❑ Eat in restaurant	❑ Carrots
❑ Coffee	❑ Fish sandwich	❑ Coffee
❑ Donut	❑ Fried foods	❑ Fish
❑ Eggs	❑ Hamburger	❑ Green vegetables
❑ Fruit	❑ Hot dogs	❑ Juice
❑ Juice	❑ Juice	❑ Margarine
❑ Margarine	❑ Leftovers	❑ Milk
❑ Milk	❑ Lettuce	❑ Pasta
❑ Oat bran	❑ Margarine	❑ Potato
❑ Sugar	❑ Mayo	❑ Poultry
❑ Sweet roll	❑ Meat sandwich	❑ Red meat
❑ Sweetener	❑ Milk	❑ Rice
❑ Tea	❑ Pizza	❑ Salad
❑ Toast	❑ Potato chips	❑ Salad dressing
❑ Water	❑ Salad	❑ Soda
❑ Wheat bran	❑ Salad dressing	❑ Sugar
❑ Yogurt	❑ Soda	❑ Sweetener
❑ Oat meal	❑ Soup	❑ Tea
❑ Milk protein shake	❑ Sugar	❑ Vinegar
❑ Slim Fast	❑ Sweetener	❑ Water
❑ Carnation shake	❑ Tea	❑ White rice
❑ Soy protein	❑ Tomato	❑ Yellow vegetables
❑ Whey protein	❑ Vegetables	❑ Other: (List below)
❑ Rice protein	❑ Water	
❑ Other: (list below)	❑ Yogurt	
	❑ Slim Fast	
	❑ Carnation shake	
	❑ Protein shake	

Check foods/drinks that you consume a minimum of 3 days or more each week.

- ❑ Alcohol
- ❑ Almond butter
- ❑ Almonds
- ❑ Apples
- ❑ Asparagus
- ❑ Avocado
- ❑ Bacon
- ❑ Bagel
- ❑ Banana
- ❑ Barley
- ❑ Bean, lima
- ❑ Bean, pinto
- ❑ Bean, string
- ❑ Biscuit
- ❑ Blueberries
- ❑ Bread, rye
- ❑ Bread, white
- ❑ Bread, whole wheat
- ❑ Broccoli
- ❑ Brazil nuts
- ❑ Brussels sprouts
- ❑ Burger King
- ❑ Butter
- ❑ Cabbage
- ❑ Candy
- ❑ Carnation drink
- ❑ Carrot
- ❑ Cashew
- ❑ Celery
- ❑ Cereal, bran
- ❑ Cereal, corn
- ❑ Cereal, Special K
- ❑ Cereal, ___________
- ❑ Cereal, ___________
- ❑ Cheese
- ❑ Chewing gum, sugar free
- ❑ Chewing gum, sweetened
- ❑ Chicken
- ❑ Chili pepper
- ❑ Chinese food
- ❑ Cinnamon
- ❑ Clam
- ❑ Cloves
- ❑ Cocoa/chocolate
- ❑ Coconut
- ❑ Cod
- ❑ Coffee
- ❑ Corn
- ❑ Crab
- ❑ Cranberry
- ❑ Cream cheese
- ❑ Cucumber
- ❑ Deli meat
- ❑ Deli sandwich
- ❑ Desserts
- ❑ Eggplant
- ❑ Ensure
- ❑ Flounder
- ❑ French fries
- ❑ French toast
- ❑ Fried foods
- ❑ Garlic
- ❑ Ginger
- ❑ Grape
- ❑ Grape Nuts
- ❑ Grapefruit
- ❑ Greek food
- ❑ Grits
- ❑ Haddock
- ❑ Halibut
- ❑ Ham
- ❑ Hamburger
- ❑ Hardee's food
- ❑ Herring
- ❑ Honey
- ❑ Hot dogs, beef

- ❑ Hot dogs, pork
- ❑ Ice cream
- ❑ Indian food
- ❑ Italian food
- ❑ Jack in the Box food
- ❑ Japanese food
- ❑ Jelly
- ❑ Ketchup
- ❑ Lamb
- ❑ Lemon
- ❑ Lentil
- ❑ Lettuce
- ❑ Lime
- ❑ Lobster
- ❑ Mackerel
- ❑ Malt
- ❑ Margarine
- ❑ McDonald's food
- ❑ Mexican food
- ❑ Milk, almond
- ❑ Milk, cow
- ❑ Milk, goat
- ❑ Milk, rice
- ❑ Milk, soy
- ❑ Millet
- ❑ Mung bean
- ❑ Mushroom
- ❑ Mustard
- ❑ Nutmeg
- ❑ NutriSweet
- ❑ Oatmeal, regular
- ❑ Oatmeal, instant
- ❑ Olive
- ❑ Onion
- ❑ Orange
- ❑ Orange juice
- ❑ Oregano
- ❑ Oyster
- ❑ Pancakes
- ❑ Papaya
- ❑ Parsley
- ❑ Peach
- ❑ Peanut
- ❑ Peanut butter
- ❑ Peas
- ❑ Pecan
- ❑ Pepper,
- ❑ Pepper, green
- ❑ Perch
- ❑ Pineapple
- ❑ Plum
- ❑ Pop Tarts
- ❑ Pork
- ❑ Potato, sweet
- ❑ Potato, white
- ❑ Protein shake, milk
- ❑ Protein shake, soy
- ❑ Protein shake, whey
- ❑ Pumpkin
- ❑ Quinoa
- ❑ Radish
- ❑ Rye
- ❑ Safflower
- ❑ Sage
- ❑ Salad bar
- ❑ Salmon
- ❑ Salt
- ❑ Sardines
- ❑ Sausage
- ❑ Scallops
- ❑ Sesame
- ❑ Shrimp
- ❑ Slim Fast
- ❑ Snapper
- ❑ Soft drinks
- ❑ Sole
- ❑ Sour cream
- ❑ Soybean
- ❑ Spinach
- ❑ Squash
- ❑ Strawberry
- ❑ Sucralose

- ❑ Sugar
- ❑ Sunflower
- ❑ Sweet & Low
- ❑ Taco Bell food
- ❑ Tangerine
- ❑ Tea, black
- ❑ Tea, decaffeinated
- ❑ Thai food
- ❑ Tomato
- ❑ Trout
- ❑ Tuna
- ❑ Turkey
- ❑ Vinegar
- ❑ Waffles
- ❑ Walnut
- ❑ Wendy's food
- ❑ Wheat
- ❑ Whitefish
- ❑ Yam
- ❑ Yeast, baker's
- ❑ Yeast, brewer's
- ❑ Yogurt
- ❑ Zucchini

What snacks do you eat or drink between:

Breakfast & Lunch: ____________________

Lunch & Dinner: ____________________

After Dinner: ____________________

How much of the following do you consume each day/week?

Item	Daily	Weekly	Favorite Type
Candy			
Cheese			
Chocolate			
Cups of caffeine containing coffee			
Cups of decaffeinated coffee or tea			
Cups of hot chocolate			
Cups of caffeine containing tea			
Diet sodas (12-ounce can/bottle)			
Sodas with caffeine (12-ounce can/bottle)			
Sodas without caffeine (12-ounce can/bottle)			
Energy Drinks (12-ounce can/bottle)			
Ice cream			
Salty foods			
Slices of white bread (rolls/bagels)			

Water: Glasses per day _____ **Type**: ❑ Tap ❑ Distilled ❑ Spring ❑ Well ❑ Reverse Osmosis

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(s)? ❑ Yes ❑ No

If yes, please name the food and symptom (*e.g.,* wheat – gas and bloating)

Food	Symptom	Other Comments

Do you feel you have **delayed** symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? ❑ Yes ❑ No

Do you feel **worse** when you eat a lot of:

❑ High-fat foods
❑ High-protein foods
❑ High-carbohydrate foods (breads, pasta, potatoes)
❑ Refined sugar (junk food)
❑ Fried foods
❑ 1 or 2 alcoholic drinks
❑ Other: ______________________

Do you feel **better** when you eat a lot of:

❑ High-fat foods
❑ High-protein foods
❑ High-carbohydrate foods (breads, pasta, potatoes)
❑ Refined sugar (junk food)
❑ Fried foods
❑ 1 or 2 alcoholic drinks
❑ Other: ______________________

Does skipping meals greatly affect your symptoms? ❑ Yes ❑ No

Has there ever been a food that you have craved or really "pigged out" on over a period of time?

❑ Yes ❑ No If yes, what food(s):

____

____

____

Do you have an aversion to certain foods? ❑ Yes ❑ No If yes, what food(s):

____

____

____

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

____

____

____

TOBACCO HISTORY

Currently using tobacco? ❑ Yes ❑ No How many years? _____ Packs per day: _____

If yes, what type? ❑ Cigarette ❑ Smokeless ❑ Cigar ❑ Pipe ❑ Patch ❑ Gum

Number of attempts to quit: _____

Previous smoking: How many years? _____ Packs per day: _____ Date you quit: ______________

Are you exposed to second-hand smoke? 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 ❑ Moderate ❑ High ❑ No

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

Was your mother an alcoholic? ❑ Yes ❑ No Father? ❑ Yes ❑ No

Other family member? ❑ Yes ❑ No

OTHER SUBSTANCES

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/Leisure (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

Social History

Please print or write legibly.

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 a majority of your time and money fulfilling responsibilities and obligations? ❑ Yes ❑ No

Would you describe your experience as a child in your family as happy and secure? ❑ Yes ❑ No

STRESS/COPING

Unfortunately, abuse and violence of all kinds—verbal, emotional, physical, and sexual—are leading contributors to chronic stress, illness, and immune-system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life, it is very important that you feel safe telling us about it, so that we can support you and optimize your treatment outcomes.

Please do your best to answer the following questions:

Did you feel safe growing up? ❑ Yes ❑ No

Have you ever been involved in abusive relationships in your life? ❑ Yes ❑ No

Was alcoholism or substance abuse present in your childhood home? ❑ Yes ❑ No

Is alcoholism or substance abuse present in your relationships now? ❑ Yes ❑ No

Have you ever sought counseling? ❑ Yes ❑ No

Currently? ❑ Yes ❑ No Previously? ❑ Yes ❑ No If previously, from __________ to__ ________

What kind of counseling? ____

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 if not stressful, 10 if very stressful)*

Work _____ Family _____ Social _____ Finances _____ Health _____ Other ____________

Do you practice meditation or relaxation techniques? ❑ Yes ❑ No If yes, how often? ___________

Check all that apply:

❑ Yoga ❑ Meditation ❑ Imagery ❑ Breathing ❑ Tai Chi ❑ Prayer ❑ Other: ____________

Hobbies and leisure activities: ____

____

How important is religion (or spirituality) for you and your family's life?

❑ Not at all important ❑ Somewhat important ❑ Extremely important

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

How well have things been going for you lately?

	Very well	Fine	Poorly	Very poorly	Does not apply
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					

Which of the following provide you emotional support? *Check all that apply*

❑ Spouse ❑ Family ❑ Friends ❑ Religious/Spiritual ❑ Pets ❑ Other ____________

STRESS EVALUATION

This section of the questionnaire is an assessment of stressors and related stress symptoms and complaints. The questions have assigned scores/point values. To obtain score, multiply points (column 1) by duration (column 2). Add the scores of each section and make a note at the bottom under total score.

Symptom	Score	Duration (years)			Score
❑ Excessive Fatigue	10	½	1	2	
❑ Dry & Thin Skin	10	½	1	2	
❑ Nervous/Irritability	9	½	1	2	
❑ Low body temperature	8	½	1	2	
❑ Premenstrual tension	8	½	1	2	
❑ Inability to concentrate	8	½	1	2	
❑ Mental depression	8	½	1	2	
❑ Food allergies & sensitivities	7	½	1	2	
❑ Craving for sweets	7	½	1	2	
❑ Headaches	6	½	1	2	
❑ Alcohol intolerance	6	½	1	2	
❑ Poor memory	5	½	1	2	
❑ Heart palpitations	5	½	1	2	
TOTAL SCORE					

Do you have chronic pain? ❑ Yes ❑ No

Do you have chronic inflammation? ❑ Yes ❑ No

SOCIAL READJUSTMENT RATING SCALE*

Check YES or NO to each life event in this list that happened in the last twelve months. For every "Yes" that applies, give yourself the points as listed. Upon completion, total the score and enter in box below.

Life Event	Answer		Points
Death of spouse	❑ Yes	❑ No	100
Divorce	❑ Yes	❑ No	73
Marital separation	❑ Yes	❑ No	65
Jail term	❑ Yes	❑ No	63
Death of close family member	❑ Yes	❑ No	63
Personal injury or illness	❑ Yes	❑ No	53
Marriage	❑ Yes	❑ No	50
Fired from work	❑ Yes	❑ No	47
Marital reconciliation	❑ Yes	❑ No	45
Retirement	❑ Yes	❑ No	45
Change in family members health	❑ Yes	❑ No	44
Pregnancy	❑ Yes	❑ No	40
Sex difficulties	❑ Yes	❑ No	39
Addition to family	❑ Yes	❑ No	39
Business readjustment	❑ Yes	❑ No	39
Change in financial status	❑ Yes	❑ No	38
Death of close friend	❑ Yes	❑ No	37
Change in line of work	❑ Yes	❑ No	36
Change in # of marital arguments	❑ Yes	❑ No	35
Mortgage or loan over $10,000	❑ Yes	❑ No	31
Foreclosure of mortgage or loan	❑ Yes	❑ No	30
Change in work responsibilities	❑ Yes	❑ No	29
Son or daughter leaving home	❑ Yes	❑ No	29
Trouble with in-laws	❑ Yes	❑ No	29
Outstanding personal achievement	❑ Yes	❑ No	28
Spouse begins or stops work	❑ Yes	❑ No	26
Starting or finishing school	❑ Yes	❑ No	26
Change in living conditions	❑ Yes	❑ No	25
Revision of personal habits	❑ Yes	❑ No	24
Trouble with boss	❑ Yes	❑ No	23

Life Event	Answer		Points
Change in work hours, conditions	❑ Yes	❑ No	20
Change in residence	❑ Yes	❑ No	20
Change in schools	❑ Yes	❑ No	20
Change in recreational habits	❑ Yes	❑ No	19
Mortgage or loan under $10,000	❑ Yes	❑ No	18
Change in sleeping habits	❑ Yes	❑ No	16
Change in eating habits	❑ Yes	❑ No	15
Vacation	❑ Yes	❑ No	13
		TOTAL SCORE	

* Holmes, TH and Rahe, RH Booklet for Schedule of Recent Experience (SRE) Seattle, University of Washington, 1967

TOXIC STRESS TRIGGERS

(These refer to on-going stress that has accumulated over months or years. Please mark any of the above that you have experienced in your lifetime)

- ❑ Childhood traumas
- ❑ Perfectionism
- ❑ Divorce or change in a relationship
- ❑ Care giving: *taking care of a sick family member*
- ❑ Job or career challenges
- ❑ Illness, either short-term or chronic
- ❑ Dieting: *constantly trying a new and improved diet program*
- ❑ Menopause

DO YOU WORRY OVER?

- ❑ Home life
- ❑ Marriage
- ❑ Children
- ❑ Job
- ❑ Income

IS YOUR LIFE:

- ❑ Satisfactory
- ❑ Boring
- ❑ Demanding
- ❑ Unsatisfactory
- ❑ Affected by Money Problems

SLEEP/REST

Average number of hours you sleep: ❑ >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: ______________________________

Environmental Influences

Please print or write legibly.

There are over 70,000 chemicals commercially produced in the United States. The long-term effects of many of these chemicals have never been investigated. But many chemicals are harmful in very low doses. Unless generated by the body (formaldehyde, pentane), the body's level for chemicals should be non-detectable, and not "low level". Chemicals are widespread in our environment, and constant exposure to low levels can cause dysfunction in many systems of the body. The purpose in the following questions is to determine if any of your health problems can be a result of chemical toxicity and to measure your **TOTAL TOXIN LOAD.**

Electromagnetic Factors

- ❑ Live or have you lived within 200 yards from high-voltage wires or transformers When? ______________________
- ❑ Live or have lived near an electric distribution substation
- ❑ Bed is close to the main electrical current
- ❑ Have a fan directly over your bed
- ❑ Have an alarm clock or radio close to your bed (plugged in)
- ❑ Live or have you lived near a television transmitter
- ❑ Sleep with an electric blanket, heating pad
- ❑ Sleep on a waterbed

Position of your head of your bed is facing:

- ❑ North
- ❑ South
- ❑ East
- ❑ West

- ❑ Work on a computer for longer than six hours/day
- ❑ Use a screening shield over your computer screen
- ❑ Live or have you lived near a power generating station
- ❑ Live near a radio tower
- ❑ You use a cellular phone more than 2 hours per day
- ❑ Use microwave ovens
- ❑ Bed has a wooden backboard
- ❑ Have fluorescent light fixtures

What is your occupation?

____

Toxin Exposure

Trichloroethylene/TCE

- ❑ Work close to a copy machine
- ❑ Worked in a printing shop
- ❑ Drink decaffeinated coffee
- ❑ Use typewriter correction fluid
- ❑ Use rug cleaners
- ❑ Use disinfectants
- ❑ Use carbonless paper
- ❑ Use spot removers
- ❑ Use cleaning supplies

- ❑ Use metal degreasers
- ❑ Do recreational painting

Formaldehyde

- ❑ Wear many dry-cleaned clothes
- ❑ Noticed changes of your health since you moved into your home
- ❑ Wear many polyester clothes and permanent press
- ❑ Use spray starch
- ❑ Have foam wall insulation
- ❑ Have particleboard, chip board or interior plywood
- ❑ Put up wallpaper in the last 2 years
- ❑ Have foam cushions or foam mattresses
- ❑ Live or lived in a trailer
- ❑ Worked in a laboratory
- ❑ Your home has been insulated since your illness
- ❑ Have new carpets When? _____________
- ❑ Use waxes and polishes on your floor
- ❑ Have been around resin glues and plastics
- ❑ Have exterior-grade plywood on your home
- ❑ Home is made of stucco, plaster or concrete
- ❑ Have a wood-burning stove
- ❑ Have draperies
- ❑ Have used acid-cured resin floor finishes
- ❑ Have fire-proof material in your home
- ❑ Smoke in your home
- ❑ Have a photography darkroom
- ❑ Use nail polish remover
- ❑ Use fingernail hardeners

Pesticides & Herbicides

(Organochlorines, Organophosphate, Carbamate, Chlorinated Cyclodiene, Botanical & Microbial)

- ❑ Use pesticides
- ❑ Use weed killer
- ❑ Use cleaning fluids, waxes
- ❑ Lived or worked at a dry-cleaning plant
- ❑ Have been around wood preservatives
- ❑ Drink tap water
- ❑ Work with electrical equipment
- ❑ Have mothballs in your closets
- ❑ Gasoline fumes bother you
- ❑ Eat store-bought meat
- ❑ Use insecticides
- ❑ Use crop-surface sprays
- ❑ Use aerosols
- ❑ Use fumigants

Volatile Organic Compounds (Paradichlorobenzenes, toluene, ethers, ketones, propane, polymers, tetrachloroethylene)

- ❑ Home has been painted in the last 2 years
- ❑ Use cleaning solvents
- ❑ Have soft vinyl floors
- ❑ Handle propane and butane
- ❑ Get your clothes dry-cleaned
- ❑ Store dry-cleaned clothes in closets
- ❑ Barbecue more than 2 times per month
- ❑ Work in a “tightly sealed building”
- ❑ Work close to a laser printer
- ❑ Use moth balls
- ❑ Have nylon carpet
- ❑ Use air fresheners
- ❑ Have a workshop in the home

Phenols

Do you use the following?

- ❑ Household cleaners
- ❑ Nasal sprays
- ❑ Styrofoam cups
- ❑ Cough syrup
- ❑ Decongestants
- ❑ Hair sprays
- ❑ Scented deodorants
- ❑ Scotch tape
- ❑ Newsprint

- ❑ Lysol
- ❑ Epoxy
- ❑ Listerine
- ❑ Chloraseptic throat sprays
- ❑ Noxema
- ❑ Mildew cleaners
- ❑ Perfumes
- ❑ Air fresheners
- ❑ Disinfectants
- ❑ Polishes
- ❑ Glues
- ❑ Waxes
- ❑ Mouthwash
- ❑ Saucepans with hard handles
- ❑ Do you smoke in the house
- ❑ Have you been exposed to chemicals?
  When?
  ____
- ❑ Have you had your home treated for termites?
  When?
  ____
- ❑ Do you wash your vehicle by hand?
  What type of cleaners do you use?
  ____

Carbon Monoxide/Nitrogen Oxide/Sulfur Dioxide

- ❑ Have oil or gas stove
- ❑ Have water heater
- ❑ Chimney is damaged
- ❑ Live near a busy street
- ❑ Garage is attached to your home
- ❑ Smoke at home
- ❑ Have an open fireplace

Ozone

- ❑ Use an electrical sewing machine
- ❑ Use power tools
- ❑ Use ion generators
- ❑ Work close to a photocopier

Carbon Dioxide

- ❑ Work in a crowded place
- ❑ Have poor ventilation at work

Asbestos

- ❑ Live in an old home
- ❑ Have old ceiling tiles, plaster, insulation board and heating-duct tape
- ❑ Lived in a large city with many trucks, buses, etc.
- ❑ Lived near a building which was torn down
- ❑ Mother exposed to any unusual chemicals or drugs during pregnancy (DES)
- ❑ Have fingernails treated with acrylic adhesives

Please note the "brand" of product you use

For example: Toothpaste: Crest

Shampoo: ______________________________

Toothpaste: ______________________________

Hair Conditioner: ______________________________

Makeup: ______________________________

Lipstick: ______________________________

Make-up Foundation: ______________________________

Deodorant: ______________________________

Perfume: ______________________________

Hairspray: ______________________________

Shaving Cream: ______________________________

Cologne: ______________________________

Facial Creams: ______________________________

Body Creams: ______________________________

Do you have hair permanents? ❑ Yes ❑ No

If yes, how often? ____________________

Do you have hair colorings? ❑ Yes ❑ No

If yes, is it ❑ permanent or ❑ temporary?

Do you use Latex products?

- ❑ Baby-bottle nipples
- ❑ Balloons

- ❑ Bandages
- ❑ Diaphragms
- ❑ Hot-water bottles
- ❑ Latex gloves
- ❑ Dishwashing gloves
- ❑ Rubber dams for dental work
- ❑ Tires
- ❑ Worked in a rubber industry

General Miscellaneous

- ❑ Have basement molds
- ❑ Home is damp
- ❑ Use a humidifier? If yes, when the last time you cleaned it?

  ____

- ❑ Use black hair dye (Nitrosamines)
- ❑ Worked in beauty shop
  When?

  ____

- ❑ Take any illicit drugs as an adolescent/young adult?
  What type?

  ____

- ❑ Open your windows at home
- ❑ Work in a machine shop
- ❑ Work in a garden
- ❑ Work or have you worked on a farm
  When?

  ____

- ❑ Have mercury fillings
- ❑ Had mercury fillings removed. When?

  ____

- ❑ Been exposed to radiation
  When?

  ____

- ❑ Have a hot tub
- ❑ Use chlorine or bromine
- ❑ Have a well
- ❑ Work around PVC pipe (Vinyl chloride)
- ❑ Home is well ventilated
- ❑ Moved to a new office in the last two years
- ❑ Live in an apartment (how old? __________)
- ❑ Eat at salad bars
- ❑ Eat raw fish (sushi)
- ❑ Buy food from street vendors
- ❑ **For Women:** Have breast implants
  Implant made of ❑ saline ❑ silicone
- ❑ Has any type of metal been used in implants or joint replacements in your body?
  What type? ______________________________
  Where? ______________________________
- ❑ Notice more symptoms at work than at home or vice versa?
- ❑ Symptoms worse going into a mall
- ❑ Have you ever worked in a mall?
  When? ______________________________
- ❑ Have live plants in your home
- ❑ Have pets in your home
- ❑ Bought new vehicle since symptoms began
- ❑ Furniture put in storage or possibly fumigated
- ❑ Stained furniture in the last 2 years
- ❑ Have a tool shop in your garage
- ❑ Live on or near a golf course
- ❑ Live in or near an industrial area
- ❑ Lived or traveled outside the US
  Where?

  ____

- ❑ Bought new furniture?
  What type of material?

  ____

- ❑ Installed drop ceilings
- ❑ Painted indoors
- ❑ Have siding on your home
- ❑ Changed your heating system, stove, clothes dryer, or water heater
- ❑ Lived in a brand-new home
- ❑ Worked in a new office

- ❑ Noticed changes of your health since you moved into your home
- ❑ Have a water-purification system
- ❑ Live near a landfill
- ❑ Have a water filter on your shower

Describe the contents of your bedroom

- ❑ What type of mattress?

  ____

- ❑ Hardwood floors
- ❑ Laminate floors
- ❑ Carpeting
- ❑ Window blinds
- ❑ Draperies
- ❑ Foam pillow
- ❑ Feather pillow
- ❑ Dacron pillow
- ❑ Wool blankets
- ❑ Cotton blankets
- ❑ Quilts
- ❑ Synthetic blankets
- ❑ Electric blanket
- ❑ Ceiling fan
- ❑ Material stored under the bed
- ❑ Real plants
- ❑ Artificial plants
- ❑ Aromatherapy
- ❑ Scented candles
- ❑ Central heating
- ❑ Fireplace
- ❑ Electric baseboard
- ❑ Gas heat
- ❑ Air filter

  What type?

  ____

- ❑ When was the last time you changed the air filter?

  ____

- ❑ Central air conditioning
- ❑ Sleep with windows open
- ❑ Live close to a high-traffic road
- ❑ Smoke in bed
- ❑ Allow any pets in your room

  What type?

  ____

- ❑ Plugged-in air fresheners

Art and Leisure Activities

- ❑ Silk-screening
- ❑ Stained glass
- ❑ Pottery & ceramics
- ❑ Make jewelry
- ❑ Use art-and-craft supplies
- ❑ Use airbrush and spray paints
- ❑ Quilting and weaving
- ❑ Gardening
- ❑ Make soapstone carvings
- ❑ Use acrylic paint

What hobbies do you have? Please list:

1. ____________________________
2. ____________________________
3. ____________________________

Please indicate the occupation of your parents during your childhood:

____

____

____

Readiness Assessment

Please print or write legibly.

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 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 people in your household will be to your implementing 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 ____

____

Thank you for taking the time to complete this health history questionnaire. The information derived from all of these forms will provide invaluable data. Each section builds upon the other, allowing me the opportunity to discover the **"missing key"** that will solve your health problem. Once all the sections of this form have been filled out, please return them to our office. We will then make an appointment for your initial consultation.

I thank you once again and look forward to helping you achieve a **"return to health and well being."**

Sincerely, ***Dr. Z***

Establishing Health Goals

Personal Message

Before we begin our journey together, I would like to discuss something very important that will have a major impact on your ability to recover and achieve maximum improvement. After many years in private practice, I have had the opportunity to work with thousands of patients and have seen many patients achieve significant improvement, while others have become frustrated and failed in their attempt to get well. After careful review, I have discovered the reasons why some people succeed and why others fail. This questionnaire is about much more than eliminating your symptoms; it's about living a life of vibrant health.

I've discovered that any discussion of the correct way to achieve health and stay healthy is, in actuality, a discussion of how you have lived your life up to this point and how you will live it in the future.

Therefore, to help you make significant changes in your present health, I want to ask you a few very important questions. I want you to be honest with yourself and really dig deep inside yourself for the answers.

What do you hope to achieve in your treatment with us?____

____

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

1. ____
2. ____
3. ____

Have you made the decision to change, and do what it takes to get well? ❑ **Yes** ❑ **No**

I have read something interesting: ***"The definition of insanity is to keep doing the same thing but to expect different results".*** If you keep following the same course of treatment you have been following, will your results really change? Have you ever wondered if you are on the right path to achieving optimal health? Sometimes it requires taking a new and improved road to reach your destination.

Most people I ask tell me they're made the decision to change. But how many people have truly decided to change? Very few! Why? Because there is a big difference between deciding something and having "reasons" to actually do it.

When you have made a decision to make a change and you know your reasons, you create an internal power that can propel you to achieving health and wellness?

List up to 5 things that you have been *unable* to do as a result of your present symptoms. Please be specific. (Use extra pages if necessary)

____

____

____

____

____

List up to 5 things that you plan to do once you are feeling better. Please be specific. (Use extra pages if necessary)

____

____

____

____

____

Are there any other health goals you want to achieve?

____

____

____

____

____

____