

Intake Date _____
 Client/Pt Name _____ Parent/Custodian Name _____
 Address _____
 Primary email _____ Alternate email _____
 Tel Home _____ Cell _____ Work _____ Fax _____
 Referred by _____ Occupation _____ Age _____ DOB _____ SS# _____
 Reason for office visit _____

Current health problems (list main ones—on the next sheet please list **all in greater detail**, with physicians, treatment, etc) _____

Do you experience any of these general symptoms **EVERY DAY**?

___ debilitating fatigue ___ shortness of breath ___ insomnia ___ constipation ___ depression ___ chronic pain anywhere ___ nausea ___ diarrhea
 ___ vomiting ___ fecal incontinence ___ bleeding ___ disinterest in sex ___ headaches ___ urinary incontinence ___ discharge ___ dizziness
 ___ disinterest in eating ___ itching or rash ___ low grade fever ___ difficulty thinking (brain fog) ___ muscle weakness ___ Other _____.

Allergies, intolerances and adverse reactions to medications & substances:

Please describe any adverse or allergic reactions that you have had to any of the following: plants, prescription drugs, nonprescription drugs, recreational drugs, vaccinations, vitamins, minerals, herbs, homeopathic preparations, or anything else:

Name of substance	Describe the adverse reaction

Environmental and food allergies & sensitivities (Please indicate reactions to any food, mold, animals, pollens, chemicals, strong vapors or odors such as perfume, contact irritants such as soap, metals in jewelry, or other items)

Name of offender	Describe the adverse reaction

Exposure to toxins	YES	NO
Has moving into a new home or new office, or exposure to new carpets, sheet rock, furniture or other installations ever caused you health problems?		
Have you had health problems after exposure to solvents, paint, fumes, pesticide sprays, household or commercial cleaners, disinfectants, chemicals, gasoline, heavy metals, or stagnant water?		
Have you ever lived near a refinery, polluted area, or near power lines?		
Have you ever lived in a home or apartment more than 40 years old?		
Do you have mercury dental fillings or any dental root canal procedures?		
Do you have any surgical implants or prostheses (cosmetic or medical)? If so, write it here:		
Do you eat barbequed, or smoked foods more than once a month?		
Does your work/hobby/school create any potential health problem, such as poor air quality, chemical exposure, or risky activity?		

Mental/Emotional (Check those that have been or are significant in your life): ___ Abuse ___ Memory problems ___ Anxiety/nervousness
 ___ Mental Illness ___ Depression ___ Mood swings ___ Anger easily ___ Panic attacks ___ Indecision ___ Phobias ___
 ___ Irritability ___ Prolonged sadness or grief ___ Happy ___ Type A ___ Relaxed ___ Resentful ___ Worrier ___ Envious ___ Fearful ___ Nervous
 ___ Anxious ___ Very dissatisfied ___ Pessimistic ___ Optimistic ___ No use in complaining, so I put up with it.

Has there been an event or illness in your life from which you never recovered physically or mentally? Yes ___ No ___.

Estimate your current **stress level** in each category (1=least stressful and 10=most stressful):

___ Family ___ Spirituality ___ Love relationship ___ Other relationships ___ Work or School ___ Physical health
 ___ Sense of self-fulfillment and purpose ___ Mental health ___ Finances ___ Legal hassles ___ Weight

Rate your stress on a scale of 1 to 10: Total stress level _____.

Lifestyle:

How many times do you eat fast food per week? _____. How many drinks containing sugar or added sugar do you consume per day? _____.

How many meals with red meat do you eat daily? _____. Do you have any dietary restrictions? Type: _____

What are your hobbies or ways to relax? _____ How many times/week do you do it? _____.

What pets do you have? _____. I think I am ___ underweight ___ overweight ___ just right. Have you lost or gained over 10 lbs in the past 3 months unintentionally? Yes ___ No _____.

Medical History

arthritis
 allergies/hay fever
 asthma
 alcoholism
 Alzheimer's disease
 Autoimmune disease
 Blood pressure problems
 Bronchitis
 Cancer
 Chronic fatigue syndrome
 Carpal tunnel syndrome
 Cholesterol, elevated
 Circulatory problems
 Colitis
 Dental problems
 Depression
 Diabetes
 Diverticular disease
 Drug addiction
 Eating addiction
 Epilepsy
 Emphysema
 Eyes, ear, nose, throat, problems
 Environmental sensitivities
 Fibromyalgia
 Food intolerance
 Gastroesophageal reflux disease
 Genetic disorder
 Glaucoma
 Gout
 Heart disease
 Infection, chronic
 Inflammatory bowel disease
 Irritable bowel syndrome
 Kidney/bladder disease
 Learning disabilities
 Liver/gallbladder disease (stones)
 Mental illness
 Mental retardation
 Migraine headaches
 Neurological problems (Parkinson's, paralysis)
 Sinus problems
 Stroke
 Thyroid trouble
 Obesity
 Osteoporosis
 Pneumonia
 Sexually transmitted diseases
 Seasonal affective disorder
 Skin problems
 Tuberculosis
 Ulcer
 Urinary tract infection
 Varicose veins
 Other _____

Medical (Men)

Benign prostatic hyperplasia
 Prostate cancer
 Decreased sex drive
 Infertility
 Sexually transmitted disease

Medical (Women)

Menstrual irregularities
 Endometriosis
 Infertility
 Fibrocystic breasts
 Fibroids/ovarian cysts
 Premenstrual syndrome (PMS)
 Breast cancer
 Pelvic inflammatory disease
 Vaginal infections
 Decreased sex drive
 Sexually transmitted disease
 Other _____
Date of last OB/GYN exam _____

PAP Exam _____
of children _____
of pregnancies _____
C-section _____
Age of first period _____
Date of last menstrual cycle _____
Length of cycle _____ days
Interval of time between cycles _____ days
Any recent changes in normal menstrual flow (i.e. heavier, scanty) _____
 Surgical menopause
 Menopause

Family Health

History (Parents & Siblings)

Arthritis
 Asthma
 Alcoholism
 Alzheimer's Disease
 Cancer
 Depression
 Diabetes
 Drug addiction
 Eating Disorder
 Drug addiction
 Eating disorder
 Genetic disorder
 Glaucoma
 Heart disease
 Infertility
 Learning disabilities
 Mental illness
 Mental retardation
 Migraine headaches
 Neurological disorders (Parkinson's, paralysis)
 Obesity
 Osteoporosis
 Stroke
 Suicide
 Other _____

Health Habits

Cigarettes: #/day _____
 Cigars: #day _____
 Wine: #glasses/day _____
 Liquor: #ounces/day _____
 Beer: #glasses/day _____
 Coffee: #6oz cups/day _____
 Tea: #6 oz cups/day _____
 Soda w/caffeine: #/day _____
 Water: #glasses/day _____

Exercise

5-7 days per week
 3-4 days per week
 1-2 days per week
 45 min or more per workout
 30-45 min per workout
 Less than 30 minutes
Walk: # days/wk _____
Run, jog, other aerobic #days/week _____
Weights: #days/wk _____
Stretch: #days/wk _____
Other _____

Nutrition and Diet

Mixed food diet (animal and vegetable sources)
 Vegetarian
 Vegan
 Salt restriction
 Starch/carb restriction
 The Zone Diet
 Total calorie restriction
Specific food restrictions:
 Dairy Wheat Egg
 Soy Gluten Corn
 Other _____

Food Frequency

Number of servings/day:
Fruits _____
Dark green vegetables _____
Yellow/orange veg. _____
Grains (Unprocessed) _____
Beans, peas, legumes _____
Dairy, eggs _____
Meat, poultry, fish _____

Eating Habits

Skip meals – which ones _____
 One meal/day
 Two meals/day
 Three meals/day
 Graze (small, frequent meals)
 Generally eat on the run
 Eat constantly whether hungry or not

Current

Supplements

Multivitamin/multimineral
 Vitamin C
 Vitamin E
 EPA/DHA
 Evening Primrose/GLA
 Calcium
 Magnesium
 Minerals, describe _____
 Zinc
 Probiotics (acidophilus)
 Digestive enzymes
 Amino acids
 CoQ10
 Antioxidants
 Herbs
 Homeopathy
 Protein shakes
 Liquid meals (Ensure)
 Other _____

I Would Like To:

ENERGY – VITALITY
 Feel more vital
 Have more energy
 Have more endurance
 Be less tired after lunch
 Sleep better
 Be free of pain
 Get fewer colds and flu
 Get rid of allergies
 Not be dependent on over-the-counter medications
 Stop using laxatives and stool softeners
 Improve sex drive
BODY COMPOSITION
 Lose weight
 Burn more body fat
 Be stronger
 Have better muscle tone
 Be more flexible
STRESS
 Learn how to reduce stress
 Think more clearly and be more focused
 Improve memory
 Be less depressed
 Be less moody
 Be less indecisive
 Feel more motivated
LIFE ENRICHMENT
 Reduce my risk of degenerative disease
 Slow down accelerated aging
 Maintain a healthier life for a longer time
 Change from "treating illness" to creating a wellness lifestyle

Making Lifestyle

Changes

I am comfortable with making large changes quickly
 I prefer to make small changes at first
 I am willing to change my diet immediately if it will make me feel better
 I prefer to make small changes in my diet each week
 I have taken supplements before and am comfortable taking a variety of items/day.
 I would prefer to start with just a few items
 I can easily work the cost of supplements and office visits into my budget and want to start with the fastest program possible
 My budget will allow me to spend \$200 - \$400 per month on supplements and office visits
 I need to keep the cost below \$200 each month

HEALTH HISTORY

WHICH OF THESE PREVENTIVE SERVICES HAVE YOU RECEIVED? (PUT THE DATE NEXT TO THE TEST BELOW)

COLONOSCOPY _____ RECTAL EXAM _____ PAP/GYN EXAM _____
 PNEUMONIA SHOT _____ TETANUS (or DT) SHOT _____ FLU SHOT _____
 BLOOD TEST (ANY KIND) _____ CHOLESTEROL PROFILE _____ THYROID TEST _____

PLEASE LIST ALL MEDICAL PROBLEMS OTHER DOCTORS HAVE DIAGNOSED THROUGHOUT THE YEARS:

- 1. _____ 5. _____
- 2. _____ 6. _____
- 3. _____ 7. _____
- 4. _____ 8. _____

PLEASE DESCRIBE WHAT THOSE DOCTORS ADVISED YOU TO DO ABOUT EACH CONDITION LISTED ABOVE, WHETHER IT DID ANY GOOD OR NOT, AND WHAT YOU THOUGHT ABOUT IT:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____

PLEASE LIST THE NAMES, ADDRESSES, TELEPHONE AND FAX NUMBERS OF ALL HOSPITALS, CLINICS, DOCTORS, AND ALTERNATIVE PRACTITIONERS YOU HAVE CONSULTED AND/OR TREATED YOU FOR THE LAST 20 YEARS (WITH DATES IF YOU CAN) (OLD BUSINESS CARDS, RECEIPTS, PRESCRIPTION BOTTLES, AND YOUR CELL PHONE MAY HELP)

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____ *CONTINUE ON OTHER SIDE*

PLEASE LIST ALL PRESCRIPTION DRUGS, THEIR SIZE (mg), HOW MANY TIMES/DAY YOU TAKE THEM (continue on other side if needed):

- 1. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____

PLEASE LIST ALL SUPPLEMENTS (VITAMINS, MINERALS, NUTRIENTS, PROTEIN SHAKES, HERBS, ETC) YOU TAKE OR HAVE TAKEN RECENTLY, THE BRAND, STRENGTHS (SIZES), HOW YOU TOOK THEM, THEIR EFFECTIVENESS, YOUR REACTION TO THEM, AND WHAT YOU THOUGHT ABOUT THEM. THE BRAND IS EXTREMELY IMPORTANT WHEN IT COMES TO THESE.

- _____
- _____
- _____
- _____
- _____ *CONTINUE ON OTHER SIDE*

PLEASE BRING ANY HEALTH RECORDS WITH YOU WHEN YOU VISIT. EVEN BETTER, FAX OR E-MAIL COPIES BEFORE YOUR VISIT. PLEASE BRING ACTUAL BOTTLES OF ALL MEDICATIONS AND SUPPLEMENTS WITH YOU AS WELL, AS WELL AS ANY PRESCRIPTIONS, EVEN IF NOT FILLED.

All the information given above is true and correct, and I consent to this consultation. I understand and agree that I am responsible for the cost of services and supplies furnished.

_____ Signature

SYMPTOM SURVEY FORM

INSTRUCTIONS

NUMBER EACH ITEM THAT APPLIES TO YOU AS FOLLOWS:

- Leave **BLANK**, if it does not apply to you
- USE **1** for **MILD** symptoms (occur once or twice a year)
- USE **2** for **MODERATE** symptoms (occur several times a year)
- USE **3** for **SEVERE** symptoms (you are aware of it almost constantly)

Panel 1

1. ___ Acid foods upset
2. ___ Get chilled, often
3. ___ "Lump" in throat
4. ___ Dry mouth - eyes - nose
5. ___ Pulse speeds after meals
6. ___ Keyed up - fail to calm down
7. ___ Cuts heal slowly
8. ___ Gag easily
9. ___ Unable to relax; startles easily
10. ___ Extremities cold, clammy
11. ___ Strong light irritates
12. ___ Urine amount reduced
13. ___ Heart pounds after retiring
14. ___ "Nervous" stomach
15. ___ Appetite reduced
16. ___ Cold sweats often
17. ___ Fever easily raised
18. ___ Neuralgia-like pains
19. ___ Staring, blinks little
20. ___ Sour stomach frequent

Panel 2

21. ___ Joint stiffness after arising
22. ___ Muscle-leg-toe cramps at night
23. ___ "Butterfly" stomach, cramps
24. ___ Eyes or nose watery
25. ___ Eyes blink often
26. ___ Eyelids swollen, puffy
27. ___ Indigestion soon after meals
28. ___ Always seems hungry; feels "lightheaded" often
29. ___ Digestion rapid

30. ___ Vomiting frequent
31. ___ Hoarseness frequent
32. ___ Breathing irregular
33. ___ Pulse slow; feels "irregular"
34. ___ Gagging reflex slow
35. ___ Difficulty swallowing
36. ___ Constipation, diarrhea alternating
37. ___ "Slow starter"
38. ___ Get "chilled" infrequently
39. ___ Perspire easily
40. ___ Circulation poor, sensitive to cold
41. ___ Subject to colds, asthma, bronchitis

Panel 3

42. ___ Eat when nervous
43. ___ Excessive appetite
44. ___ Hungry between meals
45. ___ Irritable before meals
46. ___ Get "shaky" if hungry
47. ___ Fatigue, eating relieves
48. ___ "Lightheaded" if meals delayed
49. ___ Heart palpitates if meals missed or delayed
50. ___ Afternoon headaches
51. ___ Overeating sweets upsets
52. ___ Awaken after few hours sleep - hard to get back to sleep
53. ___ Crave candy or coffee in afternoons
54. ___ Moods of depression - "blues" or melancholy
55. ___ Abnormal craving for sweets or snacks

Panel 4

56. ___ Hands and feet go to sleep easily, numbness
57. ___ Sigh frequently, "air hunger"
58. ___ Aware of "breathing heavily"
59. ___ High altitude discomfort
60. ___ Opens windows in closed
61. ___ Susceptible to colds and fevers

62. ___ Afternoon "yawner"
63. ___ Get "drowsy" often
64. ___ Swollen ankles worse at night
65. ___ Muscle cramps, worse during exercise; get "charley horses"
66. ___ Shortness of breath on exertion
67. ___ Dull pain in chest or radiating into left arm, worse on exertion
68. ___ Bruise easily, "black/blue" spots
69. ___ Tendency to anemia
70. ___ "Nose bleeds" frequent
71. ___ Noises in head or "ringing in ears"
72. ___ Tension under the breastbone, or feeling of "lightness", worse on exertion

Panel 5

73. ___ Dizziness
74. ___ Dry skin
75. ___ Burning feet
76. ___ Blurred vision
77. ___ Itching skin and feet
78. ___ Excessive falling hair
79. ___ Frequent skin rashes
80. ___ Bitter, metallic taste in mouth in AM
81. ___ Bowel movements difficult or painful
82. ___ Worrier, feels insecure
83. ___ Feeling queasy; headache over eyes
84. ___ Greasy foods upset
85. ___ Stools light-colored
86. ___ Skin peels on foot soles
87. ___ Pain between shoulder blades
88. ___ Use laxatives
89. ___ Stools alternate from soft to watery
90. ___ History of gallbladder attacks or gallstones
91. ___ Sneezing attacks
92. ___ Dreaming, nightmare-type bad dreams
93. ___ Bad breath (halitosis)
94. ___ Milk products cause distress

SYMPTOM SURVEY FORM

- 95. ___ Sensitive to hot weather
- 96. ___ Burning or itching anus
- 97. ___ Crave sweets

Panel 6

- 98. ___ Loss of taste for meat
- 99. ___ Lower bowel gas several hours after eating
- 100. ___ Burning stomach sensations, eating relieves
- 101. ___ Coated tongue
- 102. ___ Pass large amounts of foul smelling gas
- 103. ___ Indigestion ½ - 1 hour after eating: may be up to 3-4 hours
- 104. ___ Mucus colitis or "irritable bowel"
- 105. ___ Gas shortly after eating
- 106. ___ Stomach "bloating" after eating

GROUP 7

- 107. ___ Insomnia
- 108. ___ Nervousness
- 109. ___ Can't gain weight
- 110. ___ Intolerance to heat
- 111. ___ Highly emotional
- 112. ___ Flush easily
- 113. ___ Night sweats
- 114. ___ Thin, moist skin
- 115. ___ Inward trembling
- 116. ___ Heart palpitates
- 117. ___ Increased appetite without weight gain
- 118. ___ Pulse fast at rest
- 119. ___ Eyelids and face twitch
- 120. ___ Irritable and restless
- 121. ___ Can't work under pressure
- 122. ___ Increase in weight
- 123. ___ Decrease in appetite
- 124. ___ Fatigue easily
- 125. ___ Ringing in ears
- 126. ___ Sleepy during day
- 127. ___ Sensitive to cold
- 128. ___ Dry or scaly skin
- 129. ___ Constipation
- 130. ___ Mental sluggishness
- 131. ___ Hair coarse/Falls out

- 132. ___ Headaches upon arising wears off during day
- 133. ___ Slow pulse, below 65
- 134. ___ Frequency or urination
- 135. ___ Impaired hearing
- 136. ___ Reduced initiative
- 137. ___ Failing memory
- 138. ___ Low blood pressure
- 139. ___ Increased sex drive
- 140. ___ Headaches "splitting or rending" type
- 141. ___ Decreased sugar tolerance
- 142. ___ Abnormal thirst
- 143. ___ Bloating of abdomen
- 144. ___ Weight gain around hips or waist
- 145. ___ Sex drive reduced or lacking
- 146. ___ Tendency to ulcers, colitis
- 147. ___ Increase sugar tolerance
- 148. ___ Women: menstrual disorders
- 149. ___ Young girls: lack of menstrual function
- 150. ___ Dizziness
- 151. ___ Headaches
- 152. ___ Hot flashes
- 153. ___ Increased blood pressure
- 154. ___ Hair growth on face or body (female)
- 155. ___ Sugar in urine (not diabetes)
- 156. ___ Masculine tendencies (female)
- 157. ___ Weakness, dizziness
- 158. ___ Chronic fatigue
- 159. ___ Low blood pressure
- 160. ___ Nails weak, ridged
- 161. ___ Tendency to hives
- 162. ___ Arthritic tendencies
- 163. ___ Perspiration increase
- 164. ___ Bowel disorders
- 165. ___ Poor circulation
- 166. ___ Swollen ankles
- 167. ___ Crave salt
- 168. ___ Brown spots or bronzing of skin
- 169. ___ Allergies - tendency to asthma
- 170. ___ Weakness after colds, influenza
- 171. ___ Exhaustion - muscular and nervous
- 172. ___ Respiratory disorders

FEMALE ONLY

- 173. ___ Very easily fatigued
- 174. ___ Premenstrual tension
- 175. ___ Painful menses
- 176. ___ Depressed feelings before menstruation
- 177. ___ Menstruation excessive and prolonged
- 178. ___ Painful breasts
- 179. ___ Menstruate too frequently
- 180. ___ Vaginal discharge
- 181. ___ Hysterectomy/ovaries removed
- 182. ___ Menopausal hot flashes
- 183. ___ Menses scanty or missed
- 184. ___ Acne, worse at menses
- 185. ___ Depression of long standing

MALE ONLY

- 186. ___ Prostate trouble
- 187. ___ Urination difficult or dribbling
- 188. ___ Frequent night urination
- 189. ___ Depression
- 190. ___ Pain on inside of legs or heels
- 191. ___ Feeling of incomplete bowel evacuation
- 192. ___ Lack of energy
- 193. ___ Migrating aches and pains
- 194. ___ Tire too easily
- 195. ___ Avoids activity
- 196. ___ Leg nervousness at night
- 197. ___ Diminished sex drive

FOOD FREQUENCY FORM—page 2 of 2										
Meats and Fish				Servings Per Day			Servings Per Week			
serving size: 4 oz				4-6	2-3	1	4-6	2-3	1	<1
turkey, chicken, beef, lamb, scallops				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
salmon, halibut, tuna, snapper, shrimp, venison				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
calf's liver				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dairy & Eggs				Servings Per Day			Servings Per Week			
serving size: 1 cup (exception- egg: 1 egg)				4-6	2-3	1	4-6	2-3	1	<1
low-fat cheese, yogurt, goat's milk				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
cow's milk, egg				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spices & Condiments				Servings Per Day			Servings Per Week			
serving size: 2 teaspoons (exceptions: garlic, ginger, miso, parsley, peppermint: 1 oz)				4-6	2-3	1	4-6	2-3	1	<1
sage, rosemary, ginger, cumin, coriander, black pepper, maple syrup				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
oregano, basil, soybean miso, tamari soy sauce, cloves, thyme, garlic, blackstrap molasses , chili peppers, turmeric				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
cinnamon, mustard seed, parsley, peppermint leaves				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

After you complete this form, we will do a computer analysis of nutrients that may be missing in your diet. This will give you the probability of each vitamin and mineral deficiency, with commentary. So take your time, and be sure the information is accurate. The report you will receive will also list common foods that will correct your probable deficiencies.