AvicennaAcupuncture
CLINIC

Female Intake Questionnaire

General Information

Name _____ Age _____ Today's Date _____

Date of Birth _____ Email _____

Address _____ City _____

State _____ Zip _____

Phone (Home) _____ (Cell) _____ (Work) _____

Genetic Background: ☐ African American ☐ Hispanic ☐ Mediterranean ☐ Asian
☐ Native American ☐ Caucasian ☐ Northern European
☐ Other _____

When, where and from whom did you last receive medical or health care?

_____

Emergency Contact: _____ Relationship _____ Phone (Home) _____
(Cell) _____ (Work) _____

How did you hear about our practice?

☐ Clinic website ☐ IFM website ☐ Referral from doctor ☐ Referral from friend/family member ☐ Social media
☐ Other _____

Current Health Concerns

Please rank current and ongoing health concerns in order of priority

Describe Problem	Severity	Prior Treatment/Approach	Success
Example: Post Nasal Drip	☐ Mild ☐ Moderate ☐ Severe	Elimination Diet	☐ Good ☐ Excellent ☐ Fair
	☐ Mild ☐ Moderate ☐ Severe		☐ Good ☐ Excellent ☐ Fair
	☐ Mild ☐ Moderate ☐ Severe		☐ Good ☐ Excellent ☐ Fair
	☐ Mild ☐ Moderate ☐ Severe		☐ Good ☐ Excellent ☐ Fair
	☐ Mild ☐ Moderate ☐ Severe		☐ Good ☐ Excellent ☐ Fair
	☐ Mild ☐ Moderate ☐ Severe		☐ Good ☐ Excellent ☐ Fair
	☐ Mild ☐ Moderate ☐ Severe		☐ Good ☐ Excellent ☐ Fair
	☐ Mild ☐ Moderate ☐ Severe		☐ Good ☐ Excellent ☐ Fair
	☐ Mild ☐ Moderate ☐ Severe		☐ Good ☐ Excellent ☐ Fair
	☐ Mild ☐ Moderate ☐ Severe		☐ Good ☐ Excellent ☐ Fair

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Allergies

1. Name of Medication/Supplement/Food: _____
   Reaction: _____
2. Name of Medication/Supplement/Food: _____
   Reaction: _____
3. Name of Medication/Supplement/Food: _____
   Reaction: _____
4. Name of Medication/Supplement/Food: _____
   Reaction: _____
5. Name of Medication/Supplement/Food: _____
   Reaction: _____

Lifestyle Review

Sleep

How many hours of sleep do you get each night on average? _____

Do you have problems falling asleep? ☐ Yes ☐ No Staying asleep? ☐ Yes ☐ No

Do you have problems with insomnia? ☐ Yes ☐ No Do you snore? ☐ Yes ☐ No

Do you feel rested upon awakening? ☐ Yes ☐ No

Do you use sleeping aids? ☐ Yes ☐ No

If yes, explain: _____

Exercise

Current Exercise Program:

Activity	Type	# of Times Per Week	Time/Duration (Minutes)
Cardio/Aerobic			
Strength/Resistance			
Flexibility/Stretching			
Balance			
Sports/Leisure (e.g., golf)			
Other:			

Do you feel motivated to exercise? ☐ Yes ☐ A little ☐ No

Are there any problems that limit exercise? ☐ Yes ☐ No

If yes, explain: _____

Do you feel unusually fatigued or sore after exercise? ☐ Yes ☐ No

If yes, explain: _____

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Nutrition

Do you currently follow any of the following special diets or nutritional programs? (Check all that apply)

☐ Vegetarian ☐ Vegan ☐ Allergy ☐ Elimination ☐ Low Fat ☐ Low Carb ☐ High Protein
☐ Blood Type ☐ Low sodium ☐ No Dairy ☐ No Wheat ☐ Gluten Free
☐ Other: _____

Do you have sensitivities to certain foods? ☐ Yes ☐ No
If yes, list food and symptoms: _____

Do you have an aversion to certain foods? ☐ Yes ☐ No
If yes, explain: _____

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

☐ Monosodium glutamate (MSG) ☐ Artificial sweeteners ☐ Garlic/onion ☐ Cheese ☐ Citrus foods
☐ Chocolate ☐ Alcohol ☐ Red wine ☐ Sulfite–containing foods (wine, dried fruit, salad bars)
☐ Preservatives ☐ Food colorings ☐ Other food substances: _____

Are there any foods that you crave or binge on? ☐ Yes ☐ No
If yes, what foods? _____

Do you eat 3 meals a day? ☐ Yes ☐ No If no, how many _____

Does skipping a meal greatly affect you? ☐ Yes ☐ No

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

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

☐ Fast eater
☐ Eat too much
☐ Late-night eating
☐ Dislike healthy foods
☐ Time constraints
☐ Travel frequently
☐ Eat more than 50% of meals away from home
☐ Healthy foods not readily available
☐ Poor snack choices
☐ Significant other or family members don't like healthy foods
☐ Significant other or family members have special dietary needs
☐ Love to eat
☐ Eat because I have to
☐ Have negative relationship to food
☐ Struggle with eating issues
☐ Emotional eater (eat when sad, lonely, bored, etc.)
☐ Eat too much under stress
☐ Eat too little under stress
☐ Don't care to cook
☐ Confused about nutrition advice

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Diet

Please record what you eat in a typical day:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Fluids _____

How many servings do you eat in a typical week of these foods:

Fruits (not juice) _____ Vegetables (not including white potatoes) _____

Legumes (beans, peas, etc) _____ Red meat _____ Fish _____

Dairy/Alternatives _____ Nuts & Seeds _____ Fats & Oils _____

Cans of soda (regular or diet) _____ Sweets (candy, cookies, cake, ice cream, etc.) _____

Do you drink caffeinated beverages? ☐ Yes ☐ No If yes, check amounts:

Coffee (cups per day) ☐ 1 ☐ 2-4 ☐ More than 4 Tea (cups per day) ☐ 1 ☐ 2-4 ☐ More than 4

Caffeinated sodas—regular or diet (cans per day) ☐ 1 ☐ 2-4 ☐ More than 4

Do you have adverse reactions to caffeine? ☐ Yes ☐ No

If yes, explain: _____

When you drink caffeine do you feel: ☐ Irritable or wired ☐ Aches or pains

Smoking

Do you smoke currently? ☐ Yes ☐ No Packs per day: _____ Number of years _____

What type? ☐ Cigarettes ☐ Smokeless ☐ Pipe ☐ Cigar ☐ E-Cig

Have you attempted to quit? ☐ Yes ☐ No

If yes, using what methods: _____

If you smoked previously: Packs per day: _____ Number of years _____

Are you regularly exposed to second-hand smoke? ☐ Yes ☐ No

Alcohol

How many alcoholic beverages do you drink in a week? *(1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits)*

☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ More than 10 ☐ None

Previous alcohol intake? ☐ Yes ☐ (Mild ☐ Moderate ☐ High) ☐ None

Have you ever had a problem with alcohol? ☐ Yes ☐ No

If yes, when? _____

Explain the problem: _____

Have you ever thought about getting help to control or stop your drinking? ☐ Yes ☐ No

Other Substances

Are you currently using any recreational drugs? ☐ Yes ☐ No

If yes, type: _____

Have you ever used IV or inhaled recreational drugs? ☐ Yes ☐ No

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Stress

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

How much stress do each of the following cause on a daily basis *(Rate on scale of 1-10, 10 being highest)*

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

Do you use relaxation techniques? ☐ Yes ☐ No

If yes, how often? _____

Which techniques do you use? *(Check all that apply)*

☐ Meditation ☐ Breathing ☐ Tai Chi ☐ Yoga ☐ Prayer ☐ Other: _____

Have you ever sought counseling? ☐ Yes ☐ No

Are you currently in therapy? ☐ Yes ☐ No

If yes, describe: _____

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

What are your hobbies or leisure activities? _____

Relationships

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Gay/Lesbian ☐ Long-Term Partner ☐ Widow/er

With whom do you live? (Include children, parents, relatives, friends, pets)

_____

Current occupation: _____

Previous occupations: _____

Do you have resources for emotional support? ☐ Yes ☐ No *(Check all that apply)*

☐ Spouse/Partner ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other: _____

Do you have a religious or spiritual practice? ☐ Yes ☐ No

If yes, what kind? _____

How well have things been going for you?

*(Enter score on scale of 1-10, with 1 being **poorly**, 5 being **fine**, and 10 being **very well**; choose **N/A** if not applicable)*

How Well Have Things Been Going for You?		
Overall	☐ N/A	Score_____
At school	☐ N/A	Score_____
In your job	☐ N/A	Score_____
In your social life	☐ N/A	Score_____
With close friends	☐ N/A	Score_____
With sex	☐ N/A	Score_____
With your attitude	☐ N/A	Score_____
With your boyfriend/girlfriend	☐ N/A	Score_____
With your children	☐ N/A	Score_____
With your parents	☐ N/A	Score_____
With your spouse	☐ N/A	Score_____

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History

Patient's Birth/Childhood History:

You were born: ☐ Term ☐ Premature ☐ Don't know

Were there any pregnancy or birth complications? ☐ Yes ☐ No

If yes, explain: _____

You were: ☐ Breast-fed/How long? _____ ☐ Bottle-fed/Type of formula: _____ ☐ Don't know

Age of introduction of: Solid food: _____ Wheat _____ Dairy _____

As a child, were there any foods that were avoided because they gave you symptoms? ☐ Yes ☐ No

If yes, what foods and what symptoms? (Example: milk—gas and diarrhea)

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

Dental History:

Check if you have any of the following, and provide number if applicable:

☐ Silver mercury fillings _____ ☐ Gold fillings _____ ☐ Root canals _____ ☐ Implants _____
☐ Caps/Crowns _____ ☐ Tooth pain _____ ☐ Bleeding gums _____ ☐ Gingivitis _____
☐ Problems with chewing _____ ☐ Other dental concerns (explain): _____

Have you had any mercury fillings removed? ☐ Yes ☐ No If yes, when: _____

How many fillings did you have as a kid? _____

Do you brush regularly? ☐ Yes ☐ No Do you floss regularly? ☐ Yes ☐ No

Environmental/Detoxification History

Do any of these significantly affect you?

☐ Cigarette smoke ☐ Perfume/colognes ☐ Auto exhaust fumes ☐ Other: _____

In your work or home environment are you regularly exposed to: *(Check all that apply)*

☐ Mold ☐ Water leaks ☐ Renovations ☐ Chemicals ☐ Electromagnetic radiation
☐ Damp environments ☐ Carpets or rugs ☐ Old paint ☐ Stagnant or stuffy air ☐ Smokers
☐ Pesticides ☐ Herbicides ☐ Harsh chemicals (solvents, glues, gas, acids, etc) ☐ Cleaning chemicals
☐ Heavy metals (lead, mercury, etc.) ☐ Paints ☐ Airplane travel ☐ Other _____

Have you had a significant exposure to any harmful chemicals? ☐ Yes ☐ No

If yes: Chemical name, length of exposure, date: _____

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

If yes, do they live: ☐ Inside ☐ Outside ☐ Both inside and outside

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Women's History

Obstetric History: *(Check box and provide number if applicable)*

☐ Pregnancies _____ ☐ Miscarriages _____ ☐ Abortions _____ ☐ Living children _____
☐ Vaginal deliveries _____ ☐ Cesarean _____ ☐ Term births _____ ☐ Premature birth _____
Birth weight of largest baby _____ Birth weight of smallest baby _____

Did you develop any problems in or after pregnancy, for example, toxemia (high blood pressure), diabetes, post-partum depression, issues with breast feeding, etc.? ☐ Yes ☐ No
If yes, please explain _____

Menstrual History:

Age at first period _____ Date of last menstrual period _____
Length of cycle _____ Time between cycles _____

Cramping? ☐ Yes ☐ No Pain? ☐ Yes ☐ No

Have you ever had premenstrual problems (bloating, breast tenderness, irritability, etc.)? ☐ Yes ☐ No
If yes, please describe: _____

Do you have other problems with your periods (heavy, irregular, spotting, skipping, etc.)? ☐ Yes ☐ No
If yes, please describe: _____

Use of hormonal birth control: ☐ Birth control pills ☐ Patch ☐ Nuva ring
☐ Other How Long _____

Any problems with hormonal birth control? ☐ Yes ☐ No
If yes, explain _____

Use of other contraception? ☐ Yes ☐ No ☐ Condoms ☐ Diaphragm ☐ IUD ☐ Partner vasectomy

Are you in menopause? ☐ Yes ☐ No If yes, age at last period: _____

Was it surgical menopause? ☐ Yes ☐ No
If yes, explain surgery: _____

Do you currently have symptomatic problems with menopause? *(Check all that apply)*

☐ Hot flashes ☐ Mood swings ☐ Concentration/memory problems ☐ Headaches ☐ Joint pain
☐ Vaginal dryness ☐ Weight gain ☐ Decreased libido ☐ Loss of control of urine ☐ Palpitations

Are you on hormone replacement therapy? ☐ Yes ☐ No
If yes, for how long and for what reason (hot flashes, osteoporosis prevention, etc.)?

_____

Other Gynecological Symptoms: *(Check if applicable)*

☐ Endometriosis ☐ Infertility ☐ Fibrocystic breasts ☐ Vaginal infection ☐ Fibroids
☐ Ovarian cysts ☐ Pelvic inflammatory disease ☐ Reproductive cancer
☐ Sexually transmitted disease *(describe)*:

_____

Gynecological Screening/Procedures: *(If applicable, provide date)*

Last Pap test: _____ ☐ Normal ☐ Abnormal
Last mammogram: _____ ☐ Normal ☐ Abnormal
Last bone density: _____ Results: ☐ High ☐ Low ☐ Within Normal Range
Other tests/procedures (list type and dates):

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Family History

Check family members *that have/had any of the following*

Mother

Age (if still alive)_____ Age at death (if deceased)_____

- ☐ Cancer
- ☐ Heart disease
- ☐ Hypertension
- ☐ Obesity
- ☐ Diabetes
- ☐ Stroke
- ☐ Autoimmune disease
- ☐ Arthritis
- ☐ Kidney disease
- ☐ Thyroid problems
- ☐ Seizures/epilepsy
- ☐ Psychiatric disorders
- ☐ Anxiety
- ☐ Depression
- ☐ Asthma
- ☐ Allergies
- ☐ Eczema
- ☐ ADHD
- ☐ Autism
- ☐ Irritable Bowel Syndrome
- ☐ Dementia
- ☐ Substance abuse
- ☐ Genetic disorders
- ☐ Other:

Father

Age (if still alive)_____ Age at death (if deceased)_____

- ☐ Cancer
- ☐ Heart disease
- ☐ Hypertension
- ☐ Obesity
- ☐ Diabetes
- ☐ Stroke
- ☐ Autoimmune disease
- ☐ Arthritis
- ☐ Kidney disease
- ☐ Thyroid problems
- ☐ Seizures/epilepsy
- ☐ Psychiatric disorders
- ☐ Anxiety
- ☐ Depression
- ☐ Asthma
- ☐ Allergies
- ☐ Eczema
- ☐ ADHD
- ☐ Autism
- ☐ Irritable Bowel Syndrome
- ☐ Dementia
- ☐ Substance abuse
- ☐ Genetic disorders
- ☐ Other:

Brother

Age (if still alive)_____ Age at death (if deceased)_____

- ☐ Cancer
- ☐ Heart disease
- ☐ Hypertension
- ☐ Obesity
- ☐ Diabetes
- ☐ Stroke
- ☐ Autoimmune disease
- ☐ Arthritis
- ☐ Kidney disease
- ☐ Thyroid problems
- ☐ Seizures/epilepsy
- ☐ Psychiatric disorders
- ☐ Anxiety
- ☐ Depression
- ☐ Asthma
- ☐ Allergies
- ☐ Eczema
- ☐ ADHD
- ☐ Autism
- ☐ Irritable Bowel Syndrome
- ☐ Dementia
- ☐ Substance abuse
- ☐ Genetic disorders
- ☐ Other:

Sister

Age (if still alive)_____ Age at death (if deceased)_____

- ☐ Cancer
- ☐ Heart disease
- ☐ Hypertension
- ☐ Obesity
- ☐ Diabetes
- ☐ Stroke
- ☐ Autoimmune disease
- ☐ Arthritis
- ☐ Kidney disease
- ☐ Thyroid problems
- ☐ Seizures/epilepsy
- ☐ Psychiatric disorders
- ☐ Anxiety
- ☐ Depression
- ☐ Asthma
- ☐ Allergies
- ☐ Eczema
- ☐ ADHD
- ☐ Autism
- ☐ Irritable Bowel Syndrome
- ☐ Dementia
- ☐ Substance abuse
- ☐ Genetic disorders
- ☐ Other:

Child

Age (if still alive)_____ Age at death (if deceased)_____

- ☐ Cancer
- ☐ Heart disease
- ☐ Hypertension
- ☐ Obesity
- ☐ Diabetes
- ☐ Stroke
- ☐ Autoimmune disease
- ☐ Arthritis
- ☐ Kidney disease
- ☐ Thyroid problems
- ☐ Seizures/epilepsy
- ☐ Psychiatric disorders
- ☐ Anxiety
- ☐ Depression
- ☐ Asthma
- ☐ Allergies
- ☐ Eczema
- ☐ ADHD
- ☐ Autism
- ☐ Irritable Bowel Syndrome
- ☐ Dementia
- ☐ Substance abuse
- ☐ Genetic disorders
- ☐ Other:

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Family History *(continued)*

Child

Age (if still alive)_____ Age at death (if deceased)_____

- ☐ Cancer
- ☐ Heart disease
- ☐ Hypertension
- ☐ Obesity
- ☐ Diabetes
- ☐ Stroke
- ☐ Autoimmune disease
- ☐ Arthritis
- ☐ Kidney disease
- ☐ Thyroid problems
- ☐ Seizures/epilepsy
- ☐ Psychiatric disorders
- ☐ Anxiety
- ☐ Depression
- ☐ Asthma
- ☐ Allergies
- ☐ Eczema
- ☐ ADHD
- ☐ Autism
- ☐ Irritable Bowel Syndrome
- ☐ Dementia
- ☐ Substance abuse
- ☐ Genetic disorders
- ☐ Other:

Child

Age (if still alive)_____ Age at death (if deceased)_____

- ☐ Cancer
- ☐ Heart disease
- ☐ Hypertension
- ☐ Obesity
- ☐ Diabetes
- ☐ Stroke
- ☐ Autoimmune disease
- ☐ Arthritis
- ☐ Kidney disease
- ☐ Thyroid problems
- ☐ Seizures/epilepsy
- ☐ Psychiatric disorders
- ☐ Anxiety
- ☐ Depression
- ☐ Asthma
- ☐ Allergies
- ☐ Eczema
- ☐ ADHD
- ☐ Autism
- ☐ Irritable Bowel Syndrome
- ☐ Dementia
- ☐ Substance abuse
- ☐ Genetic disorders
- ☐ Other:

Child

Age (if still alive)_____ Age at death (if deceased)_____

- ☐ Cancer
- ☐ Heart disease
- ☐ Hypertension
- ☐ Obesity
- ☐ Diabetes
- ☐ Stroke
- ☐ Autoimmune disease
- ☐ Arthritis
- ☐ Kidney disease
- ☐ Thyroid problems
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- ☐ Depression
- ☐ Asthma
- ☐ Allergies
- ☐ Eczema
- ☐ ADHD
- ☐ Autism
- ☐ Irritable Bowel Syndrome
- ☐ Dementia
- ☐ Substance abuse
- ☐ Genetic disorders
- ☐ Other:

Child

Age (if still alive)_____ Age at death (if deceased)_____

- ☐ Cancer
- ☐ Heart disease
- ☐ Hypertension
- ☐ Obesity
- ☐ Diabetes
- ☐ Stroke
- ☐ Autoimmune disease
- ☐ Arthritis
- ☐ Kidney disease
- ☐ Thyroid problems
- ☐ Seizures/epilepsy
- ☐ Psychiatric disorders
- ☐ Anxiety
- ☐ Depression
- ☐ Asthma
- ☐ Allergies
- ☐ Eczema
- ☐ ADHD
- ☐ Autism
- ☐ Irritable Bowel Syndrome
- ☐ Dementia
- ☐ Substance abuse
- ☐ Genetic disorders
- ☐ Other:

Maternal Grandmother

Age (if still alive)_____ Age at death (if deceased)_____

- ☐ Cancer
- ☐ Heart disease
- ☐ Hypertension
- ☐ Obesity
- ☐ Diabetes
- ☐ Stroke
- ☐ Autoimmune disease
- ☐ Arthritis
- ☐ Kidney disease
- ☐ Thyroid problems
- ☐ Seizures/epilepsy
- ☐ Psychiatric disorders
- ☐ Anxiety
- ☐ Depression
- ☐ Asthma
- ☐ Allergies
- ☐ Eczema
- ☐ ADHD
- ☐ Autism
- ☐ Irritable Bowel Syndrome
- ☐ Dementia
- ☐ Substance abuse
- ☐ Genetic disorders
- ☐ Other:

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Family History *(continued)*

Maternal Grandfather

Age (if still alive)_____ Age at death (if deceased)_____

- ☐ Cancer
- ☐ Heart disease
- ☐ Hypertension
- ☐ Obesity
- ☐ Diabetes
- ☐ Stroke
- ☐ Autoimmune disease
- ☐ Arthritis
- ☐ Kidney disease
- ☐ Thyroid problems
- ☐ Seizures/epilepsy
- ☐ Psychiatric disorders
- ☐ Anxiety
- ☐ Depression
- ☐ Asthma
- ☐ Allergies
- ☐ Eczema
- ☐ ADHD
- ☐ Autism
- ☐ Irritable Bowel Syndrome
- ☐ Dementia
- ☐ Substance abuse
- ☐ Genetic disorders
- ☐ Other:

Paternal Grandmother

Age (if still alive)_____ Age at death (if deceased)_____

- ☐ Cancer
- ☐ Heart disease
- ☐ Hypertension
- ☐ Obesity
- ☐ Diabetes
- ☐ Stroke
- ☐ Autoimmune disease
- ☐ Arthritis
- ☐ Kidney disease
- ☐ Thyroid problems
- ☐ Seizures/epilepsy
- ☐ Psychiatric disorders
- ☐ Anxiety
- ☐ Depression
- ☐ Asthma
- ☐ Allergies
- ☐ Eczema
- ☐ ADHD
- ☐ Autism
- ☐ Irritable Bowel Syndrome
- ☐ Dementia
- ☐ Substance abuse
- ☐ Genetic disorders
- ☐ Other:

Paternal Grandfather

Age (if still alive)_____ Age at death (if deceased)_____

- ☐ Cancer
- ☐ Heart disease
- ☐ Hypertension
- ☐ Obesity
- ☐ Diabetes
- ☐ Stroke
- ☐ Autoimmune disease
- ☐ Arthritis
- ☐ Kidney disease
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- ☐ Allergies
- ☐ Eczema
- ☐ ADHD
- ☐ Autism
- ☐ Irritable Bowel Syndrome
- ☐ Dementia
- ☐ Substance abuse
- ☐ Genetic disorders
- ☐ Other:

Other

Age (if still alive)_____ Age at death (if deceased)_____

- ☐ Cancer
- ☐ Heart disease
- ☐ Hypertension
- ☐ Obesity
- ☐ Diabetes
- ☐ Stroke
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- ☐ Eczema
- ☐ ADHD
- ☐ Autism
- ☐ Irritable Bowel Syndrome
- ☐ Dementia
- ☐ Substance abuse
- ☐ Genetic disorders
- ☐ Other:

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Medical History: Illnesses/Conditions

Check YES = a condition you currently have, ***Check PAST*** = a condition you've had in the past.

Gastrointestinal		
Irritable bowel syndrome	☐ Yes	☐ Past
GERD (reflux)	☐ Yes	☐ Past
Crohn's disease/ulcerative colitis	☐ Yes	☐ Past
Peptic ulcer disease	☐ Yes	☐ Past
Celiac disease	☐ Yes	☐ Past
Gallstones	☐ Yes	☐ Past
Other:	☐ Yes	☐ Past
Respiratory		
Bronchitis	☐ Yes	☐ Past
Asthma	☐ Yes	☐ Past
Emphysema	☐ Yes	☐ Past
Pneumonia	☐ Yes	☐ Past
Sinusitis	☐ Yes	☐ Past
Sleep apnea	☐ Yes	☐ Past
Other:	☐ Yes	☐ Past
Urinary/Genital		
Kidney stones	☐ Yes	☐ Past
Gout	☐ Yes	☐ Past
Interstitial cystitis	☐ Yes	☐ Past
Frequent yeast infections	☐ Yes	☐ Past
Frequent urinary tract infections	☐ Yes	☐ Past
Sexual dysfunction	☐ Yes	☐ Past
Sexually transmitted diseases	☐ Yes	☐ Past
Other:	☐ Yes	☐ Past
Endocrine/Metabolic		
Diabetes	☐ Yes	☐ Past
Hypothyroidism (low thyroid)	☐ Yes	☐ Past
Hyperthyroidism (overactive thyroid)	☐ Yes	☐ Past
Polycystic ovarian syndrome	☐ Yes	☐ Past
Infertility	☐ Yes	☐ Past
Metabolic syndrome/insulin resistance	☐ Yes	☐ Past
Eating disorder	☐ Yes	☐ Past
Hypoglycemia	☐ Yes	☐ Past
Other:	☐ Yes	☐ Past
Inflammatory/Immune		
Rheumatoid arthritis	☐ Yes	☐ Past
Chronic fatigue syndrome	☐ Yes	☐ Past
Food allergies	☐ Yes	☐ Past
Environmental allergies	☐ Yes	☐ Past
Multiple chemical sensitivities	☐ Yes	☐ Past
Autoimmune disease	☐ Yes	☐ Past
Immune deficiency	☐ Yes	☐ Past
Mononucleosis	☐ Yes	☐ Past
Hepatitis	☐ Yes	☐ Past
Other:	☐	☐
Musculoskeletal		
Fibromyalgia	☐ Yes	☐ Past
Osteoarthritis	☐ Yes	☐ Past
Chronic pain	☐ Yes	☐ Past
Other:	☐ Yes	☐ Past
Skin		
Eczema	☐ Yes	☐ Past
Psoriasis	☐ Yes	☐ Past
Acne	☐ Yes	☐ Past
Skin cancer	☐ Yes	☐ Past
Other:	☐ Yes	☐ Past
Cardiovascular		
Angina	☐ Yes	☐ Past
Heart attack	☐ Yes	☐ Past
Heart failure	☐ Yes	☐ Past
Hypertension (high blood pressure)	☐ Yes	☐ Past
Stroke	☐ Yes	☐ Past
High blood fats (cholesterol, triglycerides)	☐ Yes	☐ Past
Rheumatic fever	☐ Yes	☐ Past
Arrythmia (irregular heart rate)	☐ Yes	☐ Past
Murmur	☐ Yes	☐ Past
Mitral valve prolapse	☐ Yes	☐ Past
Other:	☐ Yes	☐ Past
Neurologic/Emotional		
Epilepsy/Seizures	☐ Yes	☐ Past
ADD/ADHD	☐ Yes	☐ Past
Headaches	☐ Yes	☐ Past
Migraines	☐ Yes	☐ Past
Depression	☐ Yes	☐ Past
Anxiety	☐ Yes	☐ Past
Autism	☐ Yes	☐ Past
Multiple sclerosis	☐ Yes	☐ Past
Parkinson's disease	☐ Yes	☐ Past
Dementia	☐ Yes	☐ Past
Other:	☐ Yes	☐ Past
Cancer		
Lung	☐ Yes	☐ Past
Breast	☐ Yes	☐ Past
Colon	☐ Yes	☐ Past
Ovarian	☐ Yes	☐ Past
Skin	☐ Yes	☐ Past
Other:	☐ Yes	☐ Past

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Medical History *(continued)*

Diagnostic Studies		
Bone Density	Date:	Comments:
CT scan	Date:	Comments:
Colonoscopy	Date:	Comments:
Cardiac stress test	Date:	Comments:
EKG	Date:	Comments:
MRI	Date:	Comments:
Upper endoscopy	Date:	Comments:
Upper GI series	Date:	Comments:
Chest X-ray	Date:	Comments:
Other X-rays	Date:	Comments:
Barium enema	Date:	Comments:
Other:	Date:	Comments:
Injuries		
Broken bone(s)	Date:	Comments:
Back injury	Date:	Comments:
Neck injury	Date:	Comments:
Head injury	Date:	Comments:
Other:	Date:	Comments:
Surgeries		
Appendectomy	Date:	Comments:
Dental	Date:	Comments:
Gallbladder	Date:	Comments:
Hernia	Date:	Comments:
Hysterectomy	Date:	Comments:
Tonsillectomy	Date:	Comments:
Joint Replacement	Date:	Comments:
Heart surgery	Date:	Comments:
Other:	Date:	Comments:
Hospitalizations		
	Date:	Reason:
	Date:	Reason:
	Date:	Reason:
	Date:	Reason:
	Date:	Reason:

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Symptom Review

Please check if these symptoms occur presently or have occurred in the last 6 months

General			
Cold hands and feet	Mild	Moderate	Severe
Cold intolerance	Mild	Moderate	Severe
Daytime sleepiness	Mild	Moderate	Severe
Difficulty falling asleep	Mild	Moderate	Severe
Early waking	Mild	Moderate	Severe
Fatigue	Mild	Moderate	Severe
Fever	Mild	Moderate	Severe
Flushing	Mild	Moderate	Severe
Heat intolerance	Mild	Moderate	Severe
Night waking	Mild	Moderate	Severe
Nightmares	Mild	Moderate	Severe
Can't remember dreams	Mild	Moderate	Severe
Low body temperature	Mild	Moderate	Severe
Head, Eyes, and Ears			
Conjunctivitis	Mild	Moderate	Severe
Distorted sense of smell	Mild	Moderate	Severe
Distorted taste	Mild	Moderate	Severe
Ear fullness	Mild	Moderate	Severe
Ear ringing/buzzing	Mild	Moderate	Severe
Eye crusting	Mild	Moderate	Severe
Eye pain	Mild	Moderate	Severe
Eyelid margin redness	Mild	Moderate	Severe
Headache	Mild	Moderate	Severe
Hearing loss	Mild	Moderate	Severe
Hearing problems	Mild	Moderate	Severe
Migraine	Mild	Moderate	Severe
Sensitivity to loud noises	Mild	Moderate	Severe
Vision problems	Mild	Moderate	Severe
Musculoskeletal			
Back muscle spasm	Mild	Moderate	Severe
Calf cramps	Mild	Moderate	Severe
Chest tightness	Mild	Moderate	Severe
Foot cramps	Mild	Moderate	Severe
Joint deformity	Mild	Moderate	Severe
Joint pain	Mild	Moderate	Severe
Joint redness	Mild	Moderate	Severe
Joint stiffness	Mild	Moderate	Severe
Muscle pain	Mild	Moderate	Severe
Muscle spasms	Mild	Moderate	Severe
Muscle stiffness	Mild	Moderate	Severe
Muscle twitches	Mild	Moderate	Severe
Around eyes	Mild	Moderate	Severe
Arms or legs	Mild	Moderate	Severe

Musculoskeletal *(continued)*			
Muscle weakness	Mild	Moderate	Severe
Neck muscle spasm	Mild	Moderate	Severe
Tendonitis	Mild	Moderate	Severe
Tension headache	Mild	Moderate	Severe
TMJ problems	Mild	Moderate	Severe
Mood/Nerves			
Agoraphobia	Mild	Moderate	Severe
Anxiety	Mild	Moderate	Severe
Auditory hallucinations	Mild	Moderate	Severe
Blackouts	Mild	Moderate	Severe
Depression	Mild	Moderate	Severe
Difficulty:			
Concentrating	Mild	Moderate	Severe
With balance	Mild	Moderate	Severe
With thinking	Mild	Moderate	Severe
With judgment	Mild	Moderate	Severe
With speech	Mild	Moderate	Severe
With memory	Mild	Moderate	Severe
Dizziness (spinning)	Mild	Moderate	Severe
Fainting	Mild	Moderate	Severe
Fearfulness	Mild	Moderate	Severe
Irritability	Mild	Moderate	Severe
Light-headedness	Mild	Moderate	Severe
Numbness	Mild	Moderate	Severe
Other phobias	Mild	Moderate	Severe
Panic attacks	Mild	Moderate	Severe
Paranoia	Mild	Moderate	Severe
Seizures	Mild	Moderate	Severe
Suicidal thoughts	Mild	Moderate	Severe
Tremor/trembling	Mild	Moderate	Severe
Visual Hallucinations	Mild	Moderate	Severe
Cardiovascular			
Angina/chest pain	Mild	Moderate	Severe
Breathlessness	Mild	Moderate	Severe
Heart attack	Mild	Moderate	Severe
Heart murmur	Mild	Moderate	Severe
High blood pressure	Mild	Moderate	Severe
Irregular pulse	Mild	Moderate	Severe
Mitral valve prolapse	Mild	Moderate	Severe
Palpitations	Mild	Moderate	Severe
Phlebitis	Mild	Moderate	Severe
Swollen ankles/feet	Mild	Moderate	Severe
Varicose veins	Mild	Moderate	Severe

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Symptom Review *(continued)*

Please check if these symptoms occur presently or have occurred in the last 6 months

Urinary			
Bed wetting	☐ Mild	☐ Moderate	☐ Severe
Hesitancy	☐ Mild	☐ Moderate	☐ Severe
Infection	☐ Mild	☐ Moderate	☐ Severe
Kidney disease	☐ Mild	☐ Moderate	☐ Severe
Kidney stone	☐ Mild	☐ Moderate	☐ Severe
Leaking/incontinence	☐ Mild	☐ Moderate	☐ Severe
Pain/burning	☐ Mild	☐ Moderate	☐ Severe
Urgency	☐ Mild	☐ Moderate	☐ Severe
Digestion			
Anal spasms	☐ Mild	☐ Moderate	☐ Severe
Bad teeth	☐ Mild	☐ Moderate	☐ Severe
Bleeding gums	☐ Mild	☐ Moderate	☐ Severe
Bloating of:			
Lower abdomen	☐ Mild	☐ Moderate	☐ Severe
Whole abdomen	☐ Mild	☐ Moderate	☐ Severe
Bloating after meals	☐ Mild	☐ Moderate	☐ Severe
Blood in stools	☐ Mild	☐ Moderate	☐ Severe
Burping	☐ Mild	☐ Moderate	☐ Severe
Canker sores	☐ Mild	☐ Moderate	☐ Severe
Cold sores	☐ Mild	☐ Moderate	☐ Severe
Constipation	☐ Mild	☐ Moderate	☐ Severe
Cracking at corner of lips	☐ Mild	☐ Moderate	☐ Severe
Dentures w/poor chewing	☐ Mild	☐ Moderate	☐ Severe
Diarrhea	☐ Mild	☐ Moderate	☐ Severe
Difficulty swallowing	☐ Mild	☐ Moderate	☐ Severe
Dry mouth	☐ Mild	☐ Moderate	☐ Severe
Farting	☐ Mild	☐ Moderate	☐ Severe
Fissures	☐ Mild	☐ Moderate	☐ Severe
Foods "repeat" (reflux)	☐ Mild	☐ Moderate	☐ Severe
Heartburn	☐ Mild	☐ Moderate	☐ Severe
Hemorrhoids	☐ Mild	☐ Moderate	☐ Severe
Intolerance to:			
Lactose	☐ Mild	☐ Moderate	☐ Severe
All dairy products	☐ Mild	☐ Moderate	☐ Severe
Gluten (wheat)	☐ Mild	☐ Moderate	☐ Severe
Corn	☐ Mild	☐ Moderate	☐ Severe
Eggs	☐ Mild	☐ Moderate	☐ Severe
Fatty foods	☐ Mild	☐ Moderate	☐ Severe
Yeast	☐ Mild	☐ Moderate	☐ Severe
Liver disease/jaundice	☐ Mild	☐ Moderate	☐ Severe
(yellow eyes or skin)			
Lower abdominal pain	☐ Mild	☐ Moderate	☐ Severe

Digestion *(continued)*			
Mucus in stools	☐ Mild	☐ Moderate	☐ Severe
Nausea	☐ Mild	☐ Moderate	☐ Severe
Periodontal disease	☐ Mild	☐ Moderate	☐ Severe
Sore tongue	☐ Mild	☐ Moderate	☐ Severe
Strong stool odor	☐ Mild	☐ Moderate	☐ Severe
Undigested food in stools	☐ Mild	☐ Moderate	☐ Severe
Upper abdominal pain	☐ Mild	☐ Moderate	☐ Severe
Vomiting	☐ Mild	☐ Moderate	☐ Severe
Eating			
Binge eating	☐ Mild	☐ Moderate	☐ Severe
Bulimia	☐ Mild	☐ Moderate	☐ Severe
Can't gain weight	☐ Mild	☐ Moderate	☐ Severe
Can't lose weight	☐ Mild	☐ Moderate	☐ Severe
Carbohydrate craving	☐ Mild	☐ Moderate	☐ Severe
Carbohydrate intolerance	☐ Mild	☐ Moderate	☐ Severe
Poor appetite	☐ Mild	☐ Moderate	☐ Severe
Salt cravings	☐ Mild	☐ Moderate	☐ Severe
Frequent dieting	☐ Mild	☐ Moderate	☐ Severe
Sweet cravings	☐ Mild	☐ Moderate	☐ Severe
Caffeine dependency	☐ Mild	☐ Moderate	☐ Severe
Respiratory			
Bad breath	☐ Mild	☐ Moderate	☐ Severe
Bad odor in nose	☐ Mild	☐ Moderate	☐ Severe
Cough – dry	☐ Mild	☐ Moderate	☐ Severe
Cough – productive	☐ Mild	☐ Moderate	☐ Severe
Hayfever:	☐ Mild	☐ Moderate	☐ Severe
Spring	☐ Mild	☐ Moderate	☐ Severe
Summer	☐ Mild	☐ Moderate	☐ Severe
Fall	☐ Mild	☐ Moderate	☐ Severe
Change of season	☐ Mild	☐ Moderate	☐ Severe
Hoarseness	☐ Mild	☐ Moderate	☐ Severe
Nasal stuffiness	☐ Mild	☐ Moderate	☐ Severe
Nose bleeds	☐ Mild	☐ Moderate	☐ Severe
Post nasal drip	☐ Mild	☐ Moderate	☐ Severe
Sinus fullness	☐ Mild	☐ Moderate	☐ Severe
Sinus infection	☐ Mild	☐ Moderate	☐ Severe
Snoring	☐ Mild	☐ Moderate	☐ Severe
Sore throat	☐ Mild	☐ Moderate	☐ Severe
Wheezing	☐ Mild	☐ Moderate	☐ Severe
Winter stuffiness	☐ Mild	☐ Moderate	☐ Severe

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Symptom Review *(continued)*

Please check if these symptoms occur presently or have occurred in the last 6 months

Nails			
Bitten	☐ Mild	☐ Moderate	☐ Severe
Brittle	☐ Mild	☐ Moderate	☐ Severe
Curve Up	☐ Mild	☐ Moderate	☐ Severe
Frayed	☐ Mild	☐ Moderate	☐ Severe
Fungus – fingers	☐ Mild	☐ Moderate	☐ Severe
Fungus – toes	☐ Mild	☐ Moderate	☐ Severe
Pitting	☐ Mild	☐ Moderate	☐ Severe
Ragged cuticles	☐ Mild	☐ Moderate	☐ Severe
Ridges	☐ Mild	☐ Moderate	☐ Severe
Soft	☐ Mild	☐ Moderate	☐ Severe
Thickening of:			
Fingernails	☐ Mild	☐ Moderate	☐ Severe
Toenails	☐ Mild	☐ Moderate	☐ Severe
White spots/lines	☐ Mild	☐ Moderate	☐ Severe
Lymph Nodes			
Enlarged/neck	☐ Mild	☐ Moderate	☐ Severe
Tender/neck	☐ Mild	☐ Moderate	☐ Severe
Other enlarged/tender lymph nodes	☐ Mild	☐ Moderate	☐ Severe
Skin, Dryness of			
Eyes	☐ Mild	☐ Moderate	☐ Severe
Feet	☐ Mild	☐ Moderate	☐ Severe
Any cracking?	☐ Mild	☐ Moderate	☐ Severe
Any peeling?	☐ Mild	☐ Moderate	☐ Severe
Hair	☐ Mild	☐ Moderate	☐ Severe
And unmanageable?	☐ Mild	☐ Moderate	☐ Severe
Hands	☐ Mild	☐ Moderate	☐ Severe
Any cracking?	☐ Mild	☐ Moderate	☐ Severe
Any peeling?	☐ Mild	☐ Moderate	☐ Severe
Mouth/throat	☐ Mild	☐ Moderate	☐ Severe
Scalp	☐ Mild	☐ Moderate	☐ Severe
Any dandruff	☐ Mild	☐ Moderate	☐ Severe
Skin in general	☐ Mild	☐ Moderate	☐ Severe
Skin Problems			
Acne on back	☐ Mild	☐ Moderate	☐ Severe
Acne on chest	☐ Mild	☐ Moderate	☐ Severe
Acne on face	☐ Mild	☐ Moderate	☐ Severe
Acne on shoulders	☐ Mild	☐ Moderate	☐ Severe
Athlete's foot	☐ Mild	☐ Moderate	☐ Severe
Bumps on back of upper arms	☐ Mild	☐ Moderate	☐ Severe
Cellulite	☐ Mild	☐ Moderate	☐ Severe
Dark circles under eyes	☐ Mild	☐ Moderate	☐ Severe
Ears get red	☐ Mild	☐ Moderate	☐ Severe
Easy bruising	☐ Mild	☐ Moderate	☐ Severe

Skin problems *(continued)*			
Eczema	☐ Mild	☐ Moderate	☐ Severe
Herpes – genital	☐ Mild	☐ Moderate	☐ Severe
Hives	☐ Mild	☐ Moderate	☐ Severe
Jock itch	☐ Mild	☐ Moderate	☐ Severe
Lackluster skin	☐ Mild	☐ Moderate	☐ Severe
Moles w color/size change	☐ Mild	☐ Moderate	☐ Severe
Oily skin	☐ Mild	☐ Moderate	☐ Severe
Pale skin	☐ Mild	☐ Moderate	☐ Severe
Patchy dullness	☐ Mild	☐ Moderate	☐ Severe
Psoriasis	☐ Mild	☐ Moderate	☐ Severe
Rash	☐ Mild	☐ Moderate	☐ Severe
Red face	☐ Mild	☐ Moderate	☐ Severe
Sensitive to bites	☐ Mild	☐ Moderate	☐ Severe
Sensitive to poison ivy/oak	☐ Mild	☐ Moderate	☐ Severe
Shingles	☐ Mild	☐ Moderate	☐ Severe
Skin cancer	☐ Mild	☐ Moderate	☐ Severe
Skin darkening	☐ Mild	☐ Moderate	☐ Severe
Strong body odor	☐ Mild	☐ Moderate	☐ Severe
Thick calluses	☐ Mild	☐ Moderate	☐ Severe
Vitiligo	☐ Mild	☐ Moderate	☐ Severe
Itching Skin			
Anus	☐ Mild	☐ Moderate	☐ Severe
Arms	☐ Mild	☐ Moderate	☐ Severe
Ear canals	☐ Mild	☐ Moderate	☐ Severe
Eyes	☐ Mild	☐ Moderate	☐ Severe
Feet	☐ Mild	☐ Moderate	☐ Severe
Hands	☐ Mild	☐ Moderate	☐ Severe
Legs	☐ Mild	☐ Moderate	☐ Severe
Nipples	☐ Mild	☐ Moderate	☐ Severe
Nose	☐ Mild	☐ Moderate	☐ Severe
Genitals	☐ Mild	☐ Moderate	☐ Severe
Roof of mouth	☐ Mild	☐ Moderate	☐ Severe
Scalp	☐ Mild	☐ Moderate	☐ Severe
Skin in general	☐ Mild	☐ Moderate	☐ Severe
Throat	☐ Mild	☐ Moderate	☐ Severe

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Symptom Review *(continued)*

Please check if these symptoms occur presently or have occurred in the last 6 months

Female Reproductive			
Breast cysts	☐ Mild	☐ Moderate	☐ Severe
Breast lumps	☐ Mild	☐ Moderate	☐ Severe
Breast tenderness	☐ Mild	☐ Moderate	☐ Severe
Ovarian cysts	☐ Mild	☐ Moderate	☐ Severe
Poor libido (sex drive)	☐ Mild	☐ Moderate	☐ Severe
Endometriosis	☐ Mild	☐ Moderate	☐ Severe
Fibroids	☐ Mild	☐ Moderate	☐ Severe
Infertility	☐ Mild	☐ Moderate	☐ Severe
Vaginal discharge	☐ Mild	☐ Moderate	☐ Severe
Vaginal odor	☐ Mild	☐ Moderate	☐ Severe
Vaginal itch	☐ Mild	☐ Moderate	☐ Severe
Vaginal pain	☐ Mild	☐ Moderate	☐ Severe
Premenstrual:			
Bloating	☐ Mild	☐ Moderate	☐ Severe
Breast tenderness	☐ Mild	☐ Moderate	☐ Severe
Carbohydrate craving	☐ Mild	☐ Moderate	☐ Severe
Chocolate craving	☐ Mild	☐ Moderate	☐ Severe
Constipation	☐ Mild	☐ Moderate	☐ Severe
Decreased sleep	☐ Mild	☐ Moderate	☐ Severe
Diarrhea	☐ Mild	☐ Moderate	☐ Severe
Fatigue	☐ Mild	☐ Moderate	☐ Severe
Increased sleep	☐ Mild	☐ Moderate	☐ Severe
Irritability	☐ Mild	☐ Moderate	☐ Severe
Menstrual:			
Cramps	☐ Mild	☐ Moderate	☐ Severe
Heavy periods	☐ Mild	☐ Moderate	☐ Severe
Irregular periods	☐ Mild	☐ Moderate	☐ Severe
No periods	☐ Mild	☐ Moderate	☐ Severe
Scanty periods	☐ Mild	☐ Moderate	☐ Severe
Spotting between	☐ Mild	☐ Moderate	☐ Severe

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Medications/Supplements

Current medications (include prescription and over-the-counter)

Medication	Dosage	Start Date (mo/yr)	Reason for Use

Nutritional supplements (vitamins/minerals/herbs etc.)

Name and Brand	Dosage	Start Date (mo/yr)	Reason for Use

Have medications or supplements ever caused unusual side effects or problems? ☐ Yes ☐ No

If yes, describe: _____

Have you used any of these regularly or for a long time:

NSAIDs (Advil, Aleve, etc.), Motrin, Aspirin? ☐ Yes ☐ No Tylenol (acetaminophen)? ☐ Yes ☐ No

Acid-blocking drugs (Zantac, Prilosec, Nexium, etc.)? ☐ Yes ☐ No

How many times have you taken antibiotics?

Infancy/childhood ☐ Less than 5 ☐ 5 or more Reason for use _____

Teen ☐ Less than 5 ☐ 5 or more Reason for use _____

Adulthood ☐ Less than 5 ☐ 5 or more Reason for use _____

Have you ever taken long term antibiotics? ☐ Yes ☐ No

If yes, explain: _____

How often have you taken oral steroids (e.g., cortisone, prednisone, etc.)?

Infancy/childhood ☐ Less than 5 ☐ 5 or more Reason for use _____

Teen ☐ Less than 5 ☐ 5 or more Reason for use _____

Adulthood ☐ Less than 5 ☐ 5 or more Reason for use _____

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Readiness Assessment and Health Goals

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 _____
- Take several nutritional supplements each day _____
- Keep a record of everything you eat each day _____
- Modify your lifestyle (e.g., work demands, sleep habits) _____
- Practice a relaxation technique _____
- Engage in regular exercise _____

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? _____

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to follow through?

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? _____

Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact):

How much ongoing support (e.g., telephone consults, email correspondence) from our professional staff would be helpful to you as you implement your personal health program? _____

Comments:

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Health Goals

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

When was the last time you felt well?

Did something trigger your change in health?

What makes you feel better?

What makes you feel worse?

How does your condition affect you?

What do you think is happening and why?

What do you feel needs to happen for you to get better?

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