

# Male 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	Severity			Prior Treatment/Approach	Success	Success		
		Mild	Moderate	Severe			Excellent	Good	Fair
<i>Example: Post Nasal Drip</i>		X			<i>Elimination Diet</i>		X		
1.									
2.									
3.									
4.									
5.									
7.									
8.									
9.									
9.									
10.									

## Allergies

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

## 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    >5 meals per week

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

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

## 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  >4 Tea (cups per day)  1  2-4  >4

Caffeinated sodas—regular or diet (cans per day)  1  2-4  >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  >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

**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?** *(Mark on scale of 1–10, or N/A if not applicable)*

	N/A	Poorly			Fine			Very Well			
Overall	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
At school	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
In your job	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
In your social life	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With close friends	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With sex	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your attitude	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your boyfriend/girlfriend	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your children	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your parents	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your spouse	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10

## 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

### Men's History

(Check box if applicable)

- Testicular mass  Testicular pain  Prostate enlargement  Prostate infection
- Change in sex drive  Impotence  Premature ejaculation  Difficulty obtaining an erection
- Difficulty maintaining an erection  Loss of control of urine  Urinary urgency/hesitancy/change in stream
- Vasectomy  Nocturia (urination at night) # of times per night \_\_\_\_\_
- Sexually transmitted diseases (describe) \_\_\_\_\_

**Men's History** (cont.)

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

Last PSA test: \_\_\_\_\_ PSA Level:  0–2  2–4  4–10  >10

Other tests/procedures (list type and dates) \_\_\_\_\_

**Family History:**

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

	Mother	Father	Brother (s)	Sister (s)	Child	Child	Child	Child	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other
Age (if still alive)													
Age at death (if deceased)													
Cancer	<input type="checkbox"/>												
Heart disease	<input type="checkbox"/>												
Hypertension	<input type="checkbox"/>												
Obesity	<input type="checkbox"/>												
Diabetes	<input type="checkbox"/>												
Stroke	<input type="checkbox"/>												
Autoimmune disease	<input type="checkbox"/>												
Arthritis	<input type="checkbox"/>												
Kidney disease	<input type="checkbox"/>												
Thyroid problems	<input type="checkbox"/>												
Seizures/epilepsy	<input type="checkbox"/>												
Psychiatric disorders	<input type="checkbox"/>												
Anxiety	<input type="checkbox"/>												
Depression	<input type="checkbox"/>												
Asthma	<input type="checkbox"/>												
Allergies	<input type="checkbox"/>												
Eczema	<input type="checkbox"/>												
ADHD	<input type="checkbox"/>												
Autism	<input type="checkbox"/>												
Irritable Bowel Syndrome	<input type="checkbox"/>												
Dementia	<input type="checkbox"/>												
Substance abuse	<input type="checkbox"/>												
Genetic disorders	<input type="checkbox"/>												
Other: _____	<input type="checkbox"/>												

## Medical History: Illnesses/Conditions

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

<b>Gastrointestinal</b>	<b>Yes</b>	<b>Past</b>
Irritable bowel syndrome	<input type="checkbox"/>	<input type="checkbox"/>
GERD (reflux)	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's disease/ulcerative colitis	<input type="checkbox"/>	<input type="checkbox"/>
Peptic ulcer disease	<input type="checkbox"/>	<input type="checkbox"/>
Celiac disease	<input type="checkbox"/>	<input type="checkbox"/>
Gallstones	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
<b>Respiratory</b>		
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>
Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
<b>Urinary/Genital</b>		
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>
Interstitial cystitis	<input type="checkbox"/>	<input type="checkbox"/>
Frequent yeast infections	<input type="checkbox"/>	<input type="checkbox"/>
Frequent urinary tract infections	<input type="checkbox"/>	<input type="checkbox"/>
Sexual dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Sexually transmitted diseases	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
<b>Endocrine/Metabolic</b>		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hypothyroidism (low thyroid)	<input type="checkbox"/>	<input type="checkbox"/>
Hyperthyroidism (overactive thyroid)	<input type="checkbox"/>	<input type="checkbox"/>
Infertility	<input type="checkbox"/>	<input type="checkbox"/>
Metabolic syndrome/insulin resistance	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
<b>Inflammatory/Immune</b>		
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic fatigue syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Food allergies	<input type="checkbox"/>	<input type="checkbox"/>
Environmental allergies	<input type="checkbox"/>	<input type="checkbox"/>
Multiple chemical sensitivities	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>
Immune deficiency	<input type="checkbox"/>	<input type="checkbox"/>
Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>

<b>Musculoskeletal</b>	<b>Yes</b>	<b>Past</b>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
<b>Skin</b>		
Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
Acne	<input type="checkbox"/>	<input type="checkbox"/>
Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cardiovascular</b>		
Angina	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
Heart failure	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension (high blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
High blood fats (cholesterol, triglycerides)	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Arrhythmia (irregular heart rate)	<input type="checkbox"/>	<input type="checkbox"/>
Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
<b>Neurologic/Emotional</b>		
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>
Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cancer</b>		
Lung	<input type="checkbox"/>	<input type="checkbox"/>
Breast	<input type="checkbox"/>	<input type="checkbox"/>
Colon	<input type="checkbox"/>	<input type="checkbox"/>
Prostate	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>

**Medical History** *(cont.)*

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

## Symptom Review

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

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

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

## Symptom Review *(cont.)*

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

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

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

## Symptom Review *(cont.)*

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

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

<b>Skin Problems <i>(cont.)</i></b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>
Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Herpes – genital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jock itch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lackluster skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moles w color/size change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oily skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pale skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patchy dullness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Red face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to bites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to poison ivy/oak	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shingles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin darkening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strong body odor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thick calluses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vitiligo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Itching Skin</b>			
Anus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear canals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nipples	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genitals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Roof of mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scalp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin in general	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Male Reproductive</b>			
Discharge from penis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ejaculation problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genital pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impotence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lumps in testicles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor libido (low sex drive)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## 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?

	< 5	> 5	Reason for Use
Infancy/Childhood			
Teen			
Adulthood			

Have you ever taken long term antibiotics?  Yes  No

If yes, explain: \_\_\_\_\_

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

	< 5	> 5	Reason for Use
Infancy/Childhood			
Teen			
Adulthood			

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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                           | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Take several nutritional supplements each day            | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Keep a record of everything you eat each day             | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Modify your lifestyle (e.g., work demands, sleep habits) | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Practice a relaxation technique                          | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Engage in regular exercise                               | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |

**Rate on a scale of 5 (very confident) to 1 (not confident at all):**

How confident are you of your ability to organize and follow through on the above health-related activities?

- 5    4    3    2    1

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

- 5    4    3    2    1

**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?

- 5    4    3    2    1

Comments \_\_\_\_\_

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## Health Goals

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

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When was the last time you felt well? \_\_\_\_\_

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Did something trigger your change in health? \_\_\_\_\_

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What makes you feel better? \_\_\_\_\_

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---

What makes you feel worse? \_\_\_\_\_

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---

How does your condition affect you? \_\_\_\_\_

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What do you think is happening and why? \_\_\_\_\_

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

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# Medical Symptoms Questionnaire (MSQ)

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Rate each of the following symptoms based upon your typical health profile for the past 14 days.

- Point Scale**
- 0 – *Never or almost never* have the symptom
  - 1 – *Occasionally* have it, effect is *not severe*
  - 2 – *Occasionally* have it, effect is *severe*
  - 3 – *Frequently* have it, effect is *not severe*
  - 4 – *Frequently* have it, effect is *severe*

<b>HEAD</b>	<input type="text"/> Headaches <input type="text"/> Faintness <input type="text"/> Dizziness <input type="text"/> Insomnia	<b>Total</b> _____
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<b>EYES</b>	<input type="text"/> Watery or itchy eyes <input type="text"/> Swollen, reddened or sticky eyelids <input type="text"/> Bags or dark circles under eyes <input type="text"/> Blurred or tunnel vision <i>(Does not include near or far-sightedness)</i>	<b>Total</b> _____
-------------	---	--------------------

<b>EARS</b>	<input type="text"/> Itchy ears <input type="text"/> Earaches, ear infections <input type="text"/> Drainage from ear <input type="text"/> Ringing in ears, hearing loss	<b>Total</b> _____
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<b>NOSE</b>	<input type="text"/> Stuffy nose <input type="text"/> Sinus problems <input type="text"/> Hay fever <input type="text"/> Sneezing attacks <input type="text"/> Excessive mucus formation	<b>Total</b> _____
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<b>MOUTH/THROAT</b>	<input type="text"/> Chronic coughing <input type="text"/> Gagging, frequent need to clear throat <input type="text"/> Sore throat, hoarseness, loss of voice <input type="text"/> Swollen or discolored tongue, gums, lips <input type="text"/> Canker sores	<b>Total</b> _____
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<b>SKIN</b>	<input type="text"/> Acne <input type="text"/> Hives, rashes, dry skin <input type="text"/> Hair loss <input type="text"/> Flushing, hot flashes <input type="text"/> Excessive sweating	<b>Total</b> _____
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<b>HEART</b>	<input type="text"/> Irregular or skipped heartbeat <input type="text"/> Rapid or pounding heartbeat <input type="text"/> Chest pain	<b>Total</b> _____
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## MEDICAL SYMPTOMS QUESTIONNAIRE (MSQ)

### LUNGS

\_\_\_\_\_ Chest congestion  
\_\_\_\_\_ Asthma, bronchitis  
\_\_\_\_\_ Shortness of breath  
\_\_\_\_\_ Difficulty breathing

**Total** \_\_\_\_\_

### DIGESTIVE TRACT

\_\_\_\_\_ Nausea, vomiting  
\_\_\_\_\_ Diarrhea  
\_\_\_\_\_ Constipation  
\_\_\_\_\_ Bloating feeling  
\_\_\_\_\_ Belching, passing gas  
\_\_\_\_\_ Heartburn  
\_\_\_\_\_ Intestinal/stomach pain

**Total** \_\_\_\_\_

### JOINTS/MUSCLE

\_\_\_\_\_ Pain or aches in joints  
\_\_\_\_\_ Arthritis  
\_\_\_\_\_ Stiffness or limitation of movement  
\_\_\_\_\_ Pain or aches in muscles  
\_\_\_\_\_ Feeling of weakness or tiredness

**Total** \_\_\_\_\_

### WEIGHT

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

**Total** \_\_\_\_\_

### ENERGY/ACTIVITY

\_\_\_\_\_ Fatigue, sluggishness  
\_\_\_\_\_ Apathy, lethargy  
\_\_\_\_\_ Hyperactivity  
\_\_\_\_\_ Restlessness

**Total** \_\_\_\_\_

### MIND

\_\_\_\_\_ Poor memory  
\_\_\_\_\_ Confusion, poor comprehension  
\_\_\_\_\_ Poor concentration  
\_\_\_\_\_ Poor physical coordination  
\_\_\_\_\_ Difficulty in making decisions  
\_\_\_\_\_ Stuttering or stammering  
\_\_\_\_\_ Slurred speech  
\_\_\_\_\_ Learning disabilities

**Total** \_\_\_\_\_

### EMOTIONS

\_\_\_\_\_ Mood swings  
\_\_\_\_\_ Anxiety, fear, nervousness  
\_\_\_\_\_ Anger, irritability, aggressiveness  
\_\_\_\_\_ Depression

**Total** \_\_\_\_\_

### OTHER

\_\_\_\_\_ Frequent illness  
\_\_\_\_\_ Frequent or urgent urination  
\_\_\_\_\_ Genital itch or discharge

**Total** \_\_\_\_\_

**Grand Total** \_\_\_\_\_



# Daily Activity Questionnaire

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Please check the one best response for each activity described below:

<p><b>SEDENTARY BEHAVIOR</b></p> <p>Sitting while watching TV, at a computer, driving, talking on the phone, or reading</p>	<p><input type="checkbox"/> 1 Most of the day</p> <p><input type="checkbox"/> 2 Half of the day</p> <p><input type="checkbox"/> 3 Some of the day</p> <p><input type="checkbox"/> 4 Rarely</p> <p style="text-align: right;"><b>Total</b> _____</p>
<p><b>ACTIVITIES OF DAILY LIVING</b></p> <p>Bathing, dressing, feeding self, toilet</p>	<p><input type="checkbox"/> 1 Need some assistance</p> <p><input type="checkbox"/> 2 Slight difficulty</p> <p><input type="checkbox"/> 3 Minimal difficulty</p> <p><input type="checkbox"/> 4 No problem</p> <p style="text-align: right;"><b>Total</b> _____</p>
<p><b>LAUNDRY</b></p>	<p><input type="checkbox"/> 1 Unable</p> <p><input type="checkbox"/> 2 Occasionally</p> <p><input type="checkbox"/> 3 Regularly in small steps or with help</p> <p><input type="checkbox"/> 4 Regularly without help</p> <p style="text-align: right;"><b>Total</b> _____</p>
<p><b>COOKING</b></p>	<p><input type="checkbox"/> 1 Unable</p> <p><input type="checkbox"/> 2 Take-out, breakfast, or simple lunch only</p> <p><input type="checkbox"/> 3 Simple microwave or crockpot meal</p> <p><input type="checkbox"/> 4 Regular meals</p> <p style="text-align: right;"><b>Total</b> _____</p>
<p><b>HOUSEKEEPING</b></p>	<p><input type="checkbox"/> 1 Unable</p> <p><input type="checkbox"/> 2 Light dusting, straighten up</p> <p><input type="checkbox"/> 3 Regular housekeeping in small steps or with help</p> <p><input type="checkbox"/> 4 Fully capable</p> <p style="text-align: right;"><b>Total</b> _____</p>
<p><b>GROCERY SHOPPING</b></p>	<p><input type="checkbox"/> 1 Unable</p> <p><input type="checkbox"/> 2 Occasional (once or twice per month)</p> <p><input type="checkbox"/> 3 Frequent, but with assistance</p> <p><input type="checkbox"/> 4 No problem</p> <p style="text-align: right;"><b>Total</b> _____</p>
<p><b>SOCIAL ACTIVITIES</b></p> <p>Church, temple, family and friends</p>	<p><input type="checkbox"/> 1 Unable</p> <p><input type="checkbox"/> 2 Infrequently</p> <p><input type="checkbox"/> 3 Occasionally (once or twice per month)</p> <p><input type="checkbox"/> 4 Frequently (weekly or more often)</p> <p style="text-align: right;"><b>Total</b> _____</p>
<p><b>DRIVING</b></p>	<p><input type="checkbox"/> 1 Unable</p> <p><input type="checkbox"/> 2 Very limited</p> <p><input type="checkbox"/> 3 Cautious, local trips</p> <p><input type="checkbox"/> 4 Distant trips or traffic</p> <p style="text-align: right;"><b>Total</b> _____</p>
<p><b>ERRANDS OR LIGHT CHORES</b></p> <p>Post office, drop off a child</p>	<p><input type="checkbox"/> 1 None</p> <p><input type="checkbox"/> 2 0-1 per day</p> <p><input type="checkbox"/> 3 2-3 per day</p> <p><input type="checkbox"/> 4 No or few restrictions</p> <p style="text-align: right;"><b>Total</b> _____</p>
<b>Grand Total</b> _____	

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Sleep is important for musculoskeletal healing and for healthy immune function, mood, cognitive and brain function, and for many physiological functions.

Please answer the following questions as accurately and fully as possible. For Yes / No questions, please check the correct answer and provide an explanation if one is requested. The information will help to determine whether you are getting the sleep you need and to identify possible strategies to help you sleep better.

### Sleep Problems:

1 Do you have a sleep problem that has been diagnosed?  Yes  No  
If yes, what? \_\_\_\_\_

2 Do you feel that you have a sleep problem?  Yes  No  
If yes, how would you describe it? \_\_\_\_\_

### Sleepiness Questions:

3 Do you feel well rested in the morning?  Yes  No  
Please explain \_\_\_\_\_

4 Are there times during the day or evening that you feel sleepy?  Yes  No  
If yes, what times are these? \_\_\_\_\_

5 What do you do to wake up when you feel sleepy? \_\_\_\_\_

6 Have you ever had an accident at work, at home or on your job because you were sleepy?  Yes  No  
If yes, please explain \_\_\_\_\_

7 Do you take naps?  Yes  No  
If yes, for how many minutes and at what time of day? \_\_\_\_\_

8 Do you feel well rested after a nap?  Yes  No

### Insomnia Questions:

9 Can you usually fall asleep within 20 minutes of lying in bed?  Yes  No

10 How long does it usually take you to fall asleep? \_\_\_\_\_

11 Do you ever feel so wired at night that it is difficult to fall asleep?  Yes  No

12 Have you had a saliva cortisol test?  Yes  No  
If yes, what was your night time level? \_\_\_\_\_

**Insomnia Questions:**

- 13** Do you currently take, or have you tried, any of the following sleep aids to fall asleep?  Yes  No  
 If yes, how many times per week do you take them? Please answer with an **E** for effective or an **N** for not effective in helping you to sleep:

Sleep Aids	Tried in the past?	Taking now?	Dosage?	E or N?
Ambien (zolpidem)				
Sonata (zaleplon)				
Valium (diazepam)				
Ativan (lorazepam)				
Restoril (temazepam)				
Tylenol PM				
Benadryl				
Calcium/Magnesium				
Valerian				
Kava				
Melatonin				
L-Tryptophan				
Other? <i>(Please specify)</i> _____				

- 14** Do you wake up in the middle of the night?  Yes  No  
 If yes, how many times times and for what reasons? \_\_\_\_\_
- 15** Do you have any trouble falling back asleep when you wake up?  Yes  No  
 If yes, how long does it usually take you? \_\_\_\_\_
- 16** Does feeling the need to move your feet or legs at night keep you awake or have you been diagnosed with Restless Legs Syndrome?  Yes  No
- 17** Do you have disturbing dreams at night?  Yes  No

### Caffeine and Other Stimulants:

18 If you drink or eat any of the following, please indicate how much (number of ounces, cups, glasses, etc.), how often per day, and at what times per day?

Do you use...	How much?	How often per day?	When during the day?
Coffee			
Caffeinated sodas (Coke, Pepsi, Mountain Dew, etc.)			
Caffeinated water			
Green tea			
Black tea			
Other tea			
Chocolate			
Coffee or espresso ice creams			
Sudafed or other OTC cold medications			
Alcohol			

19 What medications are you on and what time do you take them?

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### Stress and Stress Reduction:

20 What kind of stress have you been under in the past few months? \_\_\_\_\_

21 What do you do for stress management? \_\_\_\_\_

22 Do you have a journal to write in that is near your bed?  Yes  No

23 Do you exercise aerobically?  Yes  No  
If yes, what do you do, how often do you exercise, and at what time of day? \_\_\_\_\_

### Sleep Hygiene:

24 What time do you usually go to bed? \_\_\_\_\_

25 What time do you usually wake up? \_\_\_\_\_

26 Do you feel that you go to bed too late?  Yes  No  
If yes, what time would you like to go to bed? \_\_\_\_\_

27 Do you watch TV in the evenings  Yes  No  
If yes, what hours do you watch it? \_\_\_\_\_

28 Is the TV in your bedroom or in a family room? \_\_\_\_\_

29 On the weekend or days off do you vary your sleep schedule?  Yes  No

30 How many hours are you physically in your bed? \_\_\_\_\_

### Sleep Hygiene:

- 31 How many hours of the time spent in bed are you actually asleep? \_\_\_\_\_
- 32 Do you have much light coming into your bedroom?  Yes  No
- 33 What can you see at night without any lights on? \_\_\_\_\_
- 34 Do you have little children who wake you up?  Yes  No

### Bedroom, Breathing and Environment:

- 35 Is the air in your bedroom clean or dirty? \_\_\_\_\_
- 36 Are there any unusual smells in your bedroom?  Yes  No  
If yes, please describe \_\_\_\_\_
- 37 Do you snore, stop breathing, or have trouble breathing at night?  Yes  No
- 38 Do you use Breathe-Easy strips on your nose?  Yes  No If yes, do they help you to breath?  Yes  No
- 39 Do you have carpets or hardwood floors in your bed room? \_\_\_\_\_
- 40 How many rooms in your home have carpets and how old are the carpets? \_\_\_\_\_
- 41 What type of heat is in your home: forced air or radiant? \_\_\_\_\_
- 42 How often do you change the furnace filter in your home? \_\_\_\_\_
- 43 Have you seen any black mold in your window sills or in a basement?  Yes  No
- 44 Do you have a HEPA air filter for your bedroom?  Yes  No  
If yes, what brand is it and how long do you run it each day? \_\_\_\_\_
- 45 What type of vacuum cleaner do you use and does it have a HEPA filter in it? \_\_\_\_\_
- 46 How often do you clean the dust in your bedroom? \_\_\_\_\_
- 47 Do you sleep with an animal that snores or moves around and disturbs you?  Yes  No
- 48 Do you sleep with a bed partner who snores, moves around at night or disturbs you when you are trying to sleep?  
 Yes  No
- 49 Do noises wake you up?  Yes  No  
If yes, what are they? \_\_\_\_\_
- 50 Do you live on a noisy street?  Yes  No
- 51 Do you feel safe in your bed at night?  Yes  No  
If not, explain \_\_\_\_\_

### Bed, Pillows, and Pain:

- 52 What type of bed do you have and what size is it? \_\_\_\_\_
- 53 Do you wake up because of pain?  Yes  No  
If yes, at what time and where is the pain? \_\_\_\_\_
- 54 What type of pillow is most comfortable for you and what type have you tried that did not work?  
\_\_\_\_\_
- 55 Do you use body pillows?  Yes  No  
If yes, how many and how do you use them? \_\_\_\_\_



# Depression Anxiety Stress Scales

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Please read each statement and circle a number 0, 1, 2 or 3 that indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

**The rating scale is as follows:**

- 0 – *Did not apply* to me at all  
 1 – *Applied to me to some degree*, or some of the time  
 2 – *Applied to me to a considerable degree*, or a good part of time  
 3 – *Applied to me very much*, or most of the time

SYMPTOMS	Rating Scale			
1 I found myself getting upset by quite trivial things	0	1	2	3
2 I was aware of dryness of my mouth	0	1	2	3
3 I couldn't seem to experience any positive feeling at all	0	1	2	3
4 I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5 I just couldn't seem to get going	0	1	2	3
6 I tended to over-react to situations	0	1	2	3
7 I had a feeling of shakiness (e.g., legs going to give way)	0	1	2	3
8 I found it difficult to relax	0	1	2	3
9 I found myself in situations that made me so anxious I was most relieved when they ended	0	1	2	3
10 I felt that I had nothing to look forward to	0	1	2	3
11 I found myself getting upset rather easily	0	1	2	3
12 I felt that I was using a lot of nervous energy	0	1	2	3
13 I felt sad and depressed	0	1	2	3
14 I found myself getting impatient when I was delayed in any way (e.g., elevators, traffic lights, being kept waiting)	0	1	2	3
15 I had a feeling of faintness	0	1	2	3
16 I felt that I had lost interest in just about everything	0	1	2	3
17 I felt I wasn't worth much as a person	0	1	2	3
18 I felt that I was rather touchy	0	1	2	3
19 I perspired noticeably (e.g., hands sweaty) in the absence of high temperatures or physical exertion	0	1	2	3
20 I felt scared without any good reason	0	1	2	3
21 I felt that life wasn't worthwhile	0	1	2	3

