FUNCTIONAL MEDICINE
ADULT NEW PATIENT
INTAKE FORMS

THESE FORMS & YOUR MEDICAL RECORDS
MUST BE SUBMITTED TO OUR OFFICE
AT LEAST 7 DAYS PRIOR
TO YOUR FIRST APPOINTMENT
DID YOU REMEMBER TO?
• Read all of the practice documents
• Obtain your medical records and/or test results from previously seen physicians and have them sent at least 7 days prior to your appointment date to:
  
  Austin UltraHealth
  Westlake Medical Center
  5656 Bee Cave Road Suite D-203
  Austin, TX 78746
  Fax #: 512-721-0348

• Provide us with your pharmacy name, address, phone and FAX number.
• Check with your insurance company about Out of Network lab coverage.

FILL OUT AND/OR SIGN THE FOLLOWING FORMS
• Important Patient Information
• Informed Consent Regarding Email or the Internet Use Of Protected Personal Information
• Notice of Medicare Denial
• General Information
• Medical Questionnaire
• 3-Day Diet Diary
• MSQ - Medical Symptom/Toxicity Questionnaire

Thank you,

We are looking forward to working with you to achieve UltraHealth

*PLEASE KEEP PAGES 1 - 9 FOR YOUR RECORDS*
Dear Patient,

Welcome! We look forward to meeting you and working with you to achieve UltraHealth.

**WHAT TO EXPECT DURING YOUR CONSULTATION AT AUSTIN ULTRAHEALTH**

**YOU ARRIVE TO THE OFFICE**
- Update personal forms and sign consent forms if not done previously
- Vital signs taken

PLEASE COME FASTING – WE WILL DRAW BLOOD AT YOUR VISIT. Bring a snack if you’d like.
If you take THYROID MEDICATION please DO NOT take it the morning of your appointment

**FUNCTIONAL MEDICINE INITIAL CONSULTATION:**
- Vitals are taken, picture is taken, HIPPA forms and policies are signed
- Consult with Dr. Myers (70 min)
- Blood draw with on site phlebotomist (please come fasting)
- Consult with Brianne Herman, RD, LD the nutritionist (30 min)
- Pay for consult, labs, and any supplements purchased.

Please plan 3 hours for your initial consultation.
Bring a snack if you’d like.

**Functional Medicine Initial Follow Up Consults:**
- Consult with Dr. Myers to review labs and progress (50 min)
- Consult with our nutritionist, Brianne Herman, RD, LD (50 min)
- Please plan to spend 3 hours for your initial follow up consultation.

**WRAP UP AND CHECK OUT** (with Assistant Practice Manager 10-20 minutes)
- Pay for consult, and labs.
- Schedule follow-up appointments
- Obtain an invoice to send to your insurance company for reimbursement

Any supplements purchased that day will be paid for separately at the front desk.
Our goal is to provide you with the highest level of personalized care possible. We are committed to helping you achieve UltraHealth.

It is important to read all of the enclosed information carefully and return it to our office least 7 days prior to your appointment. You can return it to our office by mail, email or fax. Our system is not interactive, so you will need to print out the documents and then rescan them if you choose to email them to us.

Having these forms 7 days in advance will allow Dr. Myers and Brianne to help solve your problems more efficiently and enhance the quality of your care. If your Intake Form and Medical Records have not been received at least 7 days prior to your initial appointment, it may take Dr. Myers and the nutritionist up to 30 minutes of your appointment time to review your chart.

WEBSITE
Information about Austin UltraHealth and all relevant patient forms are available through the website: www.dramymyers.com and may be found on the new patient page.

MEDICAL RECORDS FROM OTHER DOCTORS/CLINICS/HOSPITALS
Medical records can only be released with your authorization. It is your responsibility to obtain previous medical records from other physicians, or health care providers that you wish Dr. Myers or Brianne to review. Please contact your physician or other health care provider to obtain these records and make sure that we have received them at least 7 days prior to your initial appointment.

Your medical records should be mailed or faxed to:
Austin UltraHealth, 5656 Bee Cave Rd Ste. D-203 Austin, TX 78746
Fax #: 512-721-0348

COPIES OF MEDICAL RECORDS & LABS FROM OUR OFFICE
You will be given a copy of your labs at each visit to keep for your records. [Should you need additional copies of your medical records; a $25 fee will be charged for copies and postage.]

FUNCTIONAL MEDICINE CONSULTATION FEES
Initial Consultation is $500: This includes visits with Dr. Myers and the nutritionist, Brianne.
Initial follow up appointment is $500: This includes visits with Dr. Myers and the nutritionist, Brianne.
All other consultations with Dr. Myers are $325.00 (50 min).
All other consults with Brianne are $85 (50 min), $45 (25 min), $25 (15 min).

LAB TESTS
We have phlebotomist from CPL at our office to draw your blood just after your appointment. PLEASE ARRIVE FASTING. PLEASE CALL YOUR INSURANCE CARRIER PRIOR TO YOUR APPOINTMENT TO KNOW WHAT YOUR COVERAGE IS. Some labs that involve stool, urine or saliva samples are done by you in your home. You will be given all lab kits and step-by-step instructions for at home test at the time of your consult. Once all of the final lab results are received, we will go over them at your follow-up visits.
CPL is at our office Monday – Friday 7:30-12:30. You DO NOT need an appointment to get labs drawn.
SUPPLEMENTS
All of the supplements that are recommended at Austin UltraHealth are available for purchase in our office. You are not obligated to purchase supplements from our office.

Supplements may be purchased in our office or mailed directly to you. Please send orders to supplements@dramymyers.com and allow 24 hours for processing.

RETURNS/REFUNDS
Supplements (except for probiotics and protein powders) and Functional Lab kits may be returned for a refund or exchange if in original condition and unopened or unused within 14 days of purchase. Functional Lab kits must be done within 1 year of purchase. CPL Prepaid Labs will be refunded if labs not drawn and notice is given within 7 days of payment.

CREDIT CARDS
We require a credit card number at the time of scheduling your first appointment. This credit card will be used to hold your appointment and will be kept on file to use for all appointments, labs and supplements unless otherwise specified by you at the time of check out. We do not take American Express.

CANCELLATION AND RESCHEDULING OF APPOINTMENTS
There is a 72 hours (3 business days) cancellation and rescheduling policy. Your appointment must be cancelled or rescheduled at least 72 hours (3 business days) prior to your consultation time or you will be charged a cancellation fee, unless we are able to fill your appointment time. The cancellation fee for a new patient appointment is half the cost of the appointment, the cancellation fee for all other appointments is the full cost of the appointment. You may cancel your appointment by calling the office 512-383-5343 or emailing office@dramymyers.com.

LATE ARRIVAL APPOINTMENTS
We are committed to being on time with patients’ appointments in order to prevent clients from waiting. If you arrive late to the office for your consult your appointment will end at the scheduled time and you will be charged for the length of the originally scheduled visit.

FOLLOW UP APPOINTMENTS
At the time of check out you will be scheduled for a follow up appointment. We will assume you will honor this appointment time unless you notify us otherwise at least 72 hours/ 3 business days prior to your scheduled appointment.

PAYMENT OPTIONS
Cash, checks or credit cards (MasterCard, Visa, Discover) are all accepted methods of payment for services. When you schedule the initial visit, we request a credit card on file to hold the appointment for you. No charges will be applied to your credit card unless you miss or cancel an appointment without proper notice. On the day of your scheduled appointment, all charges for consultations, laboratory testing and nutritional supplements will be itemized and payment is due on the day of service.

Follow-up phone, or in person consultations will be billed to your credit card on file unless you provide other payment information and instructions prior to your appointment. Credit card on file will also be used for supplements mailed unless otherwise specified.
INSURANCE INFORMATION
Medical insurance is not accepted and our office cannot assist you with claim resolution. In addition, Dr. Myers and Brianne are not Medicare providers. You will be provided with a billing summary that you can submit to your insurance carrier. Neither Dr. Myers nor Brianne submit their medical notes to insurance companies.

DISABILITY FORMS
Neither Dr. Myers nor Brianne fills out medical disability forms for patients. On very rare occasions Dr. Myers will write a letter to detail the medical necessity of testing. Under such circumstances, Dr. Myers bills at her hourly rate to write such letters. Dr. Myers does not submit her medical notes to support disability claims.

OFFICE HOURS
Our office hours are Monday – Friday, 9 am to 5 pm CST.

If you are going to stop by the office to pick up supplements we ask that you kindly email your order to us at supplements@dramymyers.com prior to your visit. If you need lab kits or anything of that nature please call us at (512) 383-5343 or email office@dramymyers.com.

PHONE CALLS AND MESSAGES
• Phone messages left will be responded to within 24 hours (during business hours).
  • To reach the office, please call (512) 383-5343
  • If you call after hours, the office staff will return your call on the next business day.
• If you have a medical emergency, call 911 or go directly to the nearest ER.
• When leaving a message, please be brief and include the following information:
  ✓ Full name, spell your last name, and date of birth
  ✓ Reason for call
  ✓ Phone number(s)
  ✓ E-mail address (if desired)

PRESCRIPTION REFILL REQUESTS
For prescription refills, we ask that you contact your pharmacy and have them fax over the medication refill request. Our fax number is (512) 721-0348. It may take up to 72 business hours to process a prescription refill. Please note that Dr. Myers is generally not in the office on Fridays to authorize refills. Please plan ahead to avoid any interruptions in your medications.

EMAIL
If you would like to schedule an appointment or cancel an appointment, have lab kit questions or administrative questions, please email office@dramymyers.com.

If you have a medical question for Dr. Myers please email her at dramy@dramymyers.com. Please note that it can take Dr. Myers up to 48 hours to respond to emails.

If you have a nutrition, Elimination Diet or supplement question please email our nutritionist, Brianne Herman, RD, LD, at nutritionist@dramymyers.com.

If you would like to order supplements from us, or would like us to have a supplement order ready for you to pick up at the office, please send an email to: supplements@dramymyers.com.

If you need immediate assistance please call the office. If you have a medical emergency please call 911.
MISCELLANEOUS
Please refrain from wearing any perfumes, colognes or heavily scented lotions to the office, as Dr. Myers is very sensitive to these products.

Dr. Myers brings Bella, her very sweet 12 year old yellow lab mix to the office. Bella sleeps all day under Dr. Myers’ desk and generally goes unnoticed by patients. If you are allergic to dogs or wish not to have Bella at the office – please let us know prior to your appointment so that Dr. Myers may leave Bella at home.

Wishing you UltraHealth,

The Austin UltraHealth Team
FREQUENTLY ASKED QUESTIONS

What is your website address?
Information about the practice can be found at www.dramymyers.com.

How may I purchase supplements?
Dr. Myers has extensively researched supplements and recommends only the highest quality of nutritional supplements. All of the supplements that are recommended at Austin UltraHealth are available for purchase in our office. You may purchase supplements after each visit or if you need something in the interim you are welcome to come by the office. We do ask that you please email us your order (supplements@dramymyers.com) prior to coming to pick up supplements.

If you live out of town, you may email supplements@dramymyers.com and we will fill your order and mail it to you within 48 hours.

Do you think you can help me with my health problem?
Dr. Myers and her team use an innovative systems approach to assessing and treating your health care concerns. Perhaps you have experienced being examined by your doctor, having blood tests done, x-rays or other diagnostic tests taken, only for your doctor to report back that “all your tests are normal”. Yet, both you and your doctor know that you are sick. Unfortunately, this experience is all too common.

Most physicians are trained to look only in specific places for the answers, using the same familiar labs or diagnostic tests. Yet, many causes of illness cannot be found in these places. The usual tests do not look for food allergies, hidden infections, environmental toxins, mold exposures, nutritional deficiencies and metabolic imbalances. New gene testing can uncover underlying genetic predispositions that can be modified through diet, lifestyle, supplements or medications.

At Austin UltraHealth, on the other hand, we use innovative testing to help patients prevent illness and recover from many chronic and difficult-to-treat conditions. Dr. Myers is skilled in evaluating, assessing and treating chronic problems such as fibromyalgia, fatigue syndromes, autoimmune diseases, inflammatory disorders, mood and behavior disorders, Irritable Bowel Syndrome (IBS), seasonal allergies, and other chronic, complex conditions. Dr. Myers also focuses on the prevention and treatment of heart disease, diabetes, dementia, hormonal imbalances and digestive disorders.

How will lab tests be performed at Austin UltraHealth?
Some testing can be done through conventional laboratories and others are only available through functional medicine laboratories. During your medical consultation, Dr. Myers and Brianne will determine which tests are needed and review with you testing recommendations, instructions (ex. fasting or non-fasting, etc.) and costs. Some testing requires collecting urine, saliva or stool at home. Others may require you to go to a local laboratory to have blood drawn. In all cases, we will assist you in coordinating initial and follow-up testing.

Do you take insurance?
Austin UltraHealth does not accept insurance or Medicare; we do not file insurance claims on your behalf; nor do we assist with claim resolution. However, we will provide a detailed receipt of services performed and you can submit this to your insurance carrier. For assistance with your reimbursement you may want to contact your insurance provider. We expect payment in full by check, cash or credit card due at the time services are provided.
What credit cards do you accept?
We accept the following credit cards: MasterCard, Visa and Discover. We do not accept American Express. It is important to maintain an active credit card on file with our office for billing of follow-up consultations, laboratory testing, and supplement orders.

Is Dr. Amy Myers a primary care physician?
Dr. Myers is trained as an emergency physician and can handle many of your primary care needs, however she requests that you maintain a primary care doctor for an annual physical exam, Pap smear, prostate exam, etc. Dr. Myers also does not provide acute care services. She is happy to work with you closely as a consultant and coach in preventive, nutritional and functional medicine to help you address the roots of chronic health problems. Dr. Myers is also happy to confer with your primary care doctor if desired.

Do I have to see the physician in person for my medical consultation?
Yes, Texas requires that Dr. Myers meet a patient in person in the state of Texas to provide an initial medical consultation. Follow-up appointments can be arranged by telephone or in person.

Whom do I contact?
The office phone number is: (512) 383-5343.

Assistant Practice Manager (appointment scheduling, lab questions): office@dramymyers.com

Practice Manager (all office, insurance, administrative, logistical questions): admin@dramymyers.com

Dr. Myers (medical Questions only): dramymyers@dramymyers.com

Brianne Herman RD, LD, our nutritionist (nutritional, elimination diet and basic supplement questions): nutritionist@dramymyers.com

Supplement Orders: supplements@dramymyers.com
IMPORTANT PATIENT INFORMATION

APPOINTMENTS
- Initial consult and first follow up are $500 each. The first appointment consists of 70 minutes with Dr. Myers and 30 minutes with our nutritionist, Brianne Herman, RD, LD. The first follow up consists of 50 minutes with Dr. Myers and 50 minutes with our nutritionist, Brianne Herman, RD, LD.
- Please allow 2.5 to 3 hours for these appointments
- Each additional follow up is priced as follows
  - Dr. Myers- $325/hr
  - Brianne Herman, RD, LD - $85/50min
- There is a 72 hour/3 business day cancellation policy (please see cancellation policy in Practice Policies for Patients).
  We reserve the right to charge your credit card on file for the full amount of the missed visit for a follow up appointment and half the amount for a new patient appointment if it is not canceled or rescheduled 72 hours (3 business days) prior to your appointment. By signing below you agree to our cancelation policy and authorize Amy Myers MD, PA to charge your credit card on file for any missed visits.

LAB TESTS
- All lab results will be reviewed with you at the time of your follow up appointment. We do not email lab results to patients. The exception to this is if you have a follow up appointment by phone – we will email you your lab results prior to your appointment.

RETURNS/REFUNDS
- Supplements (except probiotics and protein powders) and Functional Lab kits may be returned for a refund or exchange if in original condition and unopened or unused within 14 days of purchase.
- Functional Lab kits must be completed within 1 year of purchase.
- CPL Prepaid Labs will be refunded if labs not drawn and notice is given within 7 days of payment.

RETURN CHECK FEE
- A $35 fee will be assessed for all checks returned for insufficient funds

BILLING/INSURANCE
- You will receive an invoice at the completion of your visit that you may submit to your insurance for reimbursement. We do not help with insurance claim resolution.
- Payment for the office visit, phone consultation, or lab tests is expected at time of service. All credit card payment will be processed the same day of the visit, or phone call.
- If test kits or supplements are sent to you, you will be charged the day they are mailed.
- Austin UltraHealth does not accept insurance; however, you can submit your patient statement to your insurance carrier.
- We will give you instructions for insurance filing, a copy of your bill and all codes necessary for insurance filing. We do not, however aid you in insurance claim resolution or respond to insurance carrier requests for more information.

PRIMARY CARE PHYSICIAN
- Please note that neither Dr. Amy Myers nor Brianne Herman, RD, LD is your primary care physician. We recommend that you have a primary care physician.

Patient Signature  ___________________________  Date  ___________________________
NOTICE OF POSSIBLE MEDICARE DENIAL
Medicare will only pay for services determined to be reasonable and necessary under Section 1862 (a) (1) of Medicare Law. If a particular service is considered not acceptable and unnecessary under Medicare standards, Medicare will deny payment for those excluded services.

MEDICARE NOTICE
Neither Dr. Amy Myers nor Brianne Herman, RD, LD is a Medicare provider; therefore, your payment is due at the time services are provided. Any claims submitted will have to be sent by the patient; payment reimbursement is not guaranteed and is subject to Medicare eligibility/reimbursement rules and regulations.

PATIENT ACKNOWLEDGEMENT
My physician, and/or staff have informed me, that he or she believes services provided will likely be denied by Medicare for reasons stated above.

__________________________
Signature

__________________________
Print name

__________________________
Date
INFORMED CONSENT REGARDING E-MAIL OR THE INTERNET USE OF PROTECTED PERSONAL INFORMATION

Austin UltraHealth provides patients the opportunity to communicate with them by e-mail. Transmitting confidential health information by e-mail, however, has a number of risks, both general and specific, that should be considered before using e-mail.

1. Risks:
   a. General e-mail risks are the following: e-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward e-mail to other recipients without the original sender(s) permission, or knowledge; users can easily misaddress an e-mail; e-mail is easier to falsify than handwritten, or signed documents; backup copies of e-mail may exist even after the sender, or recipient has deleted his/her history.
   b. Specific e-mail risks are the following: e-mail containing information pertaining to diagnosis and/or treatment must be included in the protected personal health information; all individuals who have access to the protected personal health information will have access to the e-mail messages; patients who send, or receive e-mail from their place of employment risk having their employer read their e-mail.

2. It is the policy of Austin UltraHealth that all e-mail messages sent or received, which concern the diagnosis, or treatment, of the patient will be a part of that patient’s protected personal health information and we will treat such e-mail messages, or internet communications, with the same degree of confidentiality as afforded other portions of the protected personal health information. Austin UltraHealth will use reasonable means to protect the security and confidentiality of e-mail, or internet communication. Because of the risks outlined above, we cannot, however, guarantee the security and confidentiality of e-mail, or internet communications.

3. Patients must consent to the use of e-mail for confidential medical information after having been informed of the above risks. Consent to the use of e-mail includes agreement with the following conditions:
   a. All e-mail to, or from, patients concerning diagnosis and/or treatment will be made a part of the protected personal health information. As a part of the protected personal health information, other individuals, Dr. Amy Myers, Brianne Herman, RD, LD, physicians, nurses, other healthcare practitioners, insurance coordinators, and upon written authorization other healthcare providers and insurers will have access to e-mail messages contained in protected personal health information.
   b. Austin UltraHealth practitioners may forward e-mail messages within the practice as necessary for diagnosis and treatment. We will not, however, forward the e-mail outside the practice without the consent of the patient as required by law.
   c. We at Austin UltraHealth will endeavor to read e-mail promptly, but can provide no assurance that the recipient of the particular e-mail will read the e-mail message promptly. Therefore, e-mail must not be used in a medical emergency.
   d. It is the responsibility of the sender to determine whether the intended recipient received the e-mail and when the recipient will respond.
   e. Because some medical information is so sensitive that unauthorized disclosure can be very damaging, e-mail should not be used for communications concerning diagnosis, or treatment of AIDS/HIV infection; other sexually transmissible, or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; Behavioral health, Mental health, or developmental disability; or alcohol and drug abuse.
f. Austin UltraHealth cannot guarantee that electronic communications will be private. However, we will take reasonable steps to protect the confidentiality of the e-mail, or internet communication. However, Dr. Amy Myers and Brianne Herman RD, LD are not liable for improper disclosure of confidential information not caused by its employee’s gross negligence, or wanton misconduct.

g. If consent is given for the use of e-mail, it is the responsibility of the patient to inform Austin UltraHealth staff of any type of information you do not want to be sent by e-mail.

h. It is the responsibility of the patient to protect their password or other means of access to e-mail sent, or received, from Austin UltraHealth, to protect confidentiality. Austin UltraHealth is not liable for breaches of confidentiality caused by the patient.

Any further use of e-mail initiated by the patient that discusses diagnosis, or treatment, constitutes informed consent to the foregoing.

I understand that my consent to the use of e-mail may be withdrawn at any time by e-mail, or written communication, to Austin UltraHealth at admin@dramymyers.com

I have read this form carefully and understand the risks and responsibilities associated with the use of e-mail. I agree to assume all risks associated with the use of e-mail.

Name Printed: ________________________________

Signature: _________________________________

Date: ________________________________
# GENERAL INFORMATION

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<th>Name: First</th>
<th>Middle</th>
<th>Last</th>
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**Preferred Name:**

**Date of Birth:**

**Age:**

**Gender:**

- Male
- Female

**Genetic Background:**

- African
- European
- Native American
- Mediterranean
- Asian
- Ashkenazi
- Middle Eastern

**Highest Education Level:**

- High School
- Under-Graduate
- Post-Graduate

**Job Title:**

**Nature of Business:**

**Primary Address:**

- Number, Street:
- Apt. No.
- City
- State
- Zip

**Primary Address:**

- Number, Street:
- Apt. No.
- City
- State
- Zip

**Home Phone 1:**

**Home Phone 2:**

**Work Phone:**

**Cell Phone:**

**Fax:**

**E-mail:**

**Emergency Contact:**

- Name
- Phone Number:
- Address
- Apt. No.
- City
- State
- Zip

**Physician’s Name:**

- Phone Number
- Fax

**Referred by:**

- Google (which words)
- Media
- Family Member
- Friend
- Other
### PHARMACY INFORMATION

**Primary Pharmacy:**

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<th>Phone Number</th>
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<th>City</th>
<th>State</th>
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<th>E-mail</th>
<th>Fax*</th>
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*It is extremely important that you list the pharmacy's fax number.*

**Compounding/Supplement Pharmacy:**

<table>
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<tr>
<th>Name</th>
<th>Phone Number</th>
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<th>City</th>
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*It is extremely important that you list the pharmacy's fax number.*
AUSTIN ULTRAHEALTH MEDICAL QUESTIONNAIRE

ALLERGIES
Medication/ Supplement/Food:

__________________________________________________________

Reaction:

__________________________________________________________

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

__________________________________________________________

If you had a magic wand and could erase three problems, what would they be?
1.

__________________________________________________________

2.

__________________________________________________________

3.

__________________________________________________________

When was the last time you felt well?

__________________________________________________________

Did something trigger your change in health?

__________________________________________________________

What makes you feel worse?

__________________________________________________________

What makes you feel better?

__________________________________________________________

Please list current and ongoing problems in order of priority:

<table>
<thead>
<tr>
<th>Describe Problem:</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
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<tbody>
<tr>
<td>Example: Post Nasal Drip</td>
<td></td>
<td>X</td>
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<tr>
<th>Prior Treatment/Approach</th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
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</thead>
<tbody>
<tr>
<td>Example: Elimination Diet</td>
<td>X</td>
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</table>
# Medical History Diseases/Diagnosis/Conditions

*Check appropriate box and provide date of onset*

## Gastrointestinal
- [ ] Irritable Bowel Syndrome ________________
- [ ] Inflammatory Bowel Disease ________________
- [ ] Crohn’s ________________
- [ ] Ulcerative Colitis ________________
- [ ] Gastritis or Peptic Ulcer Disease ________________
- [ ] GERD (reflux) ________________
- [ ] Celiac Disease ________________
- [ ] Other ________________

## Cardiovascular
- [ ] Heart Attack ________________
- [ ] Other Heart Disease ________________
- [ ] Stroke ________________
- [ ] Elevated Cholesterol ________________
- [ ] Arrythmia (irregular heart rate) ________________
- [ ] Hypertension (high blood pressure) ________________
- [ ] Rheumatic Fever ________________
- [ ] Mitral Valve Prolapse ________________
- [ ] Other ________________

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

## Cancer
- [ ] Lung Cancer ________________
- [ ] Breast Cancer ________________
- [ ] Colon Cancer ________________
- [ ] Ovarian Cancer ________________
- [ ] Prostate Cancer ________________
- [ ] Skin Cancer ________________

## Genital and Urinary Systems
- [ ] Kidney Stones ________________
- [ ] Gout ________________
- [ ] Interstitial Cystitis ________________
- [ ] Frequent Urinary Tract Infections ________________
- [ ] Frequent Yeast Infections ________________
- [ ] Erectile Dysfunction or Sexual Dysfunction ________________
- [ ] Other ________________

## Musculoskeletal/Pain
- [ ] Osteoarthritis ________________
- [ ] Fibromyalgia ________________
- [ ] Chronic Pain ________________
- [ ] Other ________________

## Inflammatory/Autoimmune
- [ ] Chronic Fatigue Syndrome ________________
- [ ] Autoimmune Disease ________________
- [ ] Rheumatoid Arthritis ________________
- [ ] Lupus SLE ________________
- [ ] Immune Deficiency Disease ________________
- [ ] Herpes-Genital ________________
- [ ] Severe Infectious Disease ________________
- [ ] Poor Immune Function ________________
- [ ] (frequent infections) ________________
- [ ] Food Allergies ________________
- [ ] Environmental Allergies ________________
- [ ] Multiple Chemical Sensitivities ________________
- [ ] Latex Allergy ________________
- [ ] Other ________________
## MEDICAL HISTORY (CONTINUED)

### DISEASES/DIAGNOSIS/CONDITIONS

*Check appropriate box and provide date of onset*

#### RESPIRATORY DISEASES
- □ Asthma
- □ Chronic Sinusitis
- □ Bronchitis
- □ Emphysema
- □ Pneumonia
- □ Tuberculosis
- □ Sleep Apnea
- □ Other

#### SKIN DISEASES
- □ Eczema
- □ Psoriasis
- □ Acne
- □ Melanoma
- □ Skin Cancer
- □ Other

#### NEUROLOGIC/MOOD
- □ Depression
- □ Anxiety
- □ Bipolar Disorder
- □ Schizophrenia
- □ Headaches
- □ Migraines
- □ ADD/ADHD
- □ Autism
- □ Mild Cognitive Impairment
- □ Memory Problems
- □ Parkinson’s Disease
- □ Multiple Sclerosis
- □ ALS
- □ Seizures
- □ Other Neurological Problems

#### PREVENTIVE TESTS AND DATE OF LAST TEST

*Check box if yes and provide date*
- □ Full Physical Exam
- □ Bone Density
- □ Colonoscopy
- □ Cardiac Stress Test
- □ EBT Heart Scan
- □ EKG
- □ Hemoccult Test
- □ MRI
- □ CT Scan
- □ Upper Endoscopy
- □ Upper GI Series
- □ Ultrasound

#### INJURIES

*Check box if yes: □ Back Injury □ Head Injury □ Neck Injury □ Broken Bones*

#### SURGERIES

*Check box if yes and provide date of surgery*
- □ Appendectomy
- □ Hysterectomy +/− Ovaries
- □ Gall Bladder
- □ Hernia
- □ Tonsillectomy
- □ Dental Surgery
- □ Joint Replacement – Knee/Hip
- □ Heart Surgery – Bypass Valve
- □ Angioplasty or Stent
- □ Pacemaker
- □ Other
- □ None

#### BLOOD TYPE:
- □ A
- □ B
- □ AB
- □ O
- □ Rh+
- □ Unknown

### HOSPITALIZATIONS

- □ None

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GYNECOLOGIC HISTORY (FOR WOMEN ONLY)

OBSTETRIC HISTORY (Check box if yes and provide number)
☐ Pregnancies_________ ☐ Caesarean_________ ☐ Vaginal deliveries_________
☐ Miscarriage_________ ☐ Abortion_________ ☐ Living Children_________
☐ Post PartumDepression ☐ Toxemia ☐ Gestational Diabetes Baby Over 8 Pounds
☐ Breast Feeding For how long?_________

MENSTRUAL HISTORY
Age at First Period:______ Menses Frequency:_____ Length:______ Pain: ○ Yes ○ No Clotting: ○ Yes ○ No
Has your period ever skipped?______ For how long?______
Last Menstrual Period:_________
Use of hormonal contraception such as: ☐ Birth Control Pills ☐ Patch ☐ Nuva Ring
How long?______
Do you use contraception? ○ Yes ○ No
☐ Condome ☐ Diaphragm ☐ IUD ☐ Partner Vasectomy

WOMEN’S DISORDERS/HORMONAL IMBALANCES
☐ Fibrocystic Breasts ☐ Endometriosis ☐ Fibroids ☐ Infertility
☐ Painful Periods ☐ Heavy periods ☐ PMS
Last Mammogram:_________ Breast Biopsy/Date:_________
Last PAP Test:_________ ☐ Normal ☐ Abnormal
Last Bone Density:_________ Results: ☐ High ☐ Low ☐ Within Normal Range
Are you in menopause? ☐ Yes ☐ No
Age at Menopause_________
☐ Hot Flashes ☐ Mood Swings ☐ Concentration/Memory Problems
☐ Vaginal Dryness ☐ Decreased Libido

WOMEN’S DISORDERS/HORMONAL IMBALANCES (CONTINUED)
☐ Heavy Bleeding ☐ Joint Pains ☐ Headaches ☐ Weight Gain
☐ Loss of Control of Urine ☐ Palpitations
☐ Use of hormone replacement therapy For how long?__________________
MEN’S HISTORY (FOR MEN ONLY)

Have you had a PSA done?  ○ Yes  ○ No
PSA Level: □ 0-2  □ 2-4  □ 4-10  □ >10
☐ Prostate Enlargement  ☐ Prostate infection  ☐ Change in Libido  ☐ Impotence
☐ Difficulty Obtaining an Erection  ☐ Difficulty Maintaining an Erection
☐ Nocturia (urination at night)  How many times at night? ________
☐ Urgency/Hesitancy/Change in Urinary Stream  ☐ Loss of Control of Urine

GI HISTORY

Foreign Travel?  ○ Yes  ○ No  Where? ________________________________
Wilderness Camping?  ○ Yes  ○ No  Where? ________________________________
Have you ever had severe:  ○ Gastroenteritis  ○ Diarrhea
Do you feel like you digest your food well?  ○ Yes  ○ No
Do you feel bloated after meals?  ○ Yes  ○ No

PATIENT BIRTH HISTORY

○ Term  ○ Premature
Pregnancy Complications: ____________________________________________
Birth Complications: ________________________________________________
☐ Breast Fed. How long? ________  ☐ Bottle-fed
Age at introduction of:  Solid Foods:_________  Dairy:_________  Wheat:_________
Did you eat a lot of candy or sugar as a child?  ○ Yes  ○ No

DENTAL HISTORY

☐ Silver Mercury Fillings  How many? ________
☐ Gold Fillings
☐ Root Canals  How many? ________
☐ Implants
☐ Tooth Pain
☐ Bleeding Gums
☐ Gingivitis
☐ Problems with Chewing

Do you floss regularly?  ○ Yes  ○ No
## MEDICATIONS

### CURRENT MEDICATIONS

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<tr>
<th>MEDICATION</th>
<th>DOSE</th>
<th>FREQUENCY</th>
<th>START DATE (MONTH/YEAR)</th>
<th>REASON FOR USE</th>
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### PREVIOUS MEDICATIONS: Last 10 years

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### NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

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<th>SUPPLEMENT AND BRAND</th>
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<th>START DATE (MONTH/YEAR)</th>
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Have your medications or supplements ever caused you unusual side effects or problems? ○ Yes ○ No
Describe: ________________________________________________________________

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ○ Yes ○ No
Have you had prolonged or regular use of Tylenol? ○ Yes ○ No
Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.) ○ Yes ○ No
Frequent antibiotics > 3 times/year ○ Yes ○ No
Long term antibiotics ○ Yes ○ No
Use of steroids (prednisone, nasal allergy inhalers) in the past ○ Yes ○ No
Use of oral contraceptives ○ Yes ○ No
**FAMILY HISTORY**

*Check family members that apply.*

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<th>MOTHER</th>
<th>FATHER</th>
<th>BROTHER(S)</th>
<th>SISTERS</th>
<th>CHILDREN</th>
<th>MATERNAL GRANDMOTHER</th>
<th>PATERNAL GRANDMOTHER</th>
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SOCIAL HISTORY

NUTRITION HISTORY

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

Have you made any changes in your eating habits because of your health?  ○ Yes  ○ No

Describe: __________________________________________________________

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

Check all that apply:

☐ Low Fat  ☐ Low Carbohydrate  ☐ High Protein  ☐ Low Sodium  ☐ Diabetic  ☐ No Dairy
☐ No Wheat  ☐ Gluten Restricted  ☐ Vegetarian  ☐ Vegan
☐ Specific Program for Weight Loss/Maintenance Type: _____________________________

☐ Other _____________________________________________________________________

Height (feet/inches)__________ Current Weight __________

Usual Weight Range +/- 5 lbs __________ Desired Weight Range +/- 5 lbs __________

Highest adult weight __________ Lowest adult weight __________

Weight Fluctuations (> 10 lbs.)  ○ Yes  ○ No

Body Fat % __________

How often do you weigh yourself?  ○ Daily  ○ Weekly  ○ Monthly  ○ Rarely  ○ Never

Have you ever had your metabolism (resting metabolic rate) checked?  ○ Yes  ○ No

If yes, what was it? __________

Do you avoid any particular foods?  ○ Yes  ○ No

If yes, types and reason __________________________________________________

______________________________________________________________________________

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

______________________________________________________________________________

Do you grocery shop?  ○ Yes  ○ No

If no, who does the shopping?___________________________________________________

Do you read food labels?  ○ Yes  ○ No

Do you cook?  ○ Yes  ○ No  If no, who does the cooking?___________________________

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

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

☐ Fast eater  ☐ Erratic eating pattern

☐ Eat too much  ☐ Late night eating

☐ Dislike healthy food  ☐ Time constraints

☐ Eat more than 50% meals away from home  ☐ Travel frequently

☐ Non-availability of healthy foods  ☐ Do not plan meals or menus

☐ Reliance on convenience items  ☐ Poor snack choices

☐ Significant other or family members don't like healthy foods  ☐ Significant other or family members have special dietary needs or food preferences

☐ Love to eat  ☐ Eat because I have to

☐ Have a negative relationship to food  ☐ Struggle with eating issues

☐ Emotional eater (eat when sad, lonely depressed, bored)  ☐ Eat too much under stress

☐ Eat too little under stress  ☐ Don't care to cook

☐ Eating in the middle of the night  ☐ Confused about nutrition advice

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

______________________________________________________________________________
SMOKING
Currently Smoking? ◯ Yes ◯ No
How many years? __________ Packs per day: __________ Attempts to quit: __________
Previous Smoking: How many years? __________ Packs per day? __________
Second Hand Smoke Exposure? __________

ALCOHOL INTAKE
How many drinks currently per week? 1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits
☐ None ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ 11-10 If “None,” skip to Other Substances
Previous alcohol intake? ◯ Yes (☐ Mild ☐ Moderate ☐ High) ☐ None
Have you ever been told you should cut down your alcohol intake? ◯ Yes ◯ No
Do you get annoyed when people ask you about your drinking? ◯ Yes ◯ No
Do you ever feel guilty about your alcohol consumption? ◯ Yes ◯ No
Do you ever take an eye-opener? ◯ Yes ◯ No
Do you notice a tolerance to alcohol (can you “hold” more than others)? ◯ Yes ◯ No
Have you ever been unable to remember what you did during a drinking episode? ◯ Yes ◯ No
Do you get into arguments or physical fights when you have been drinking? ◯ Yes ◯ No
Have you ever been arrested or hospitalized because of drinking? ◯ Yes ◯ No
Have you ever thought about getting help to control or stop your drinking? ◯ Yes ◯ No

OTHER SUBSTANCES
Caffeine Intake: ◯ Yes ◯ No
Coffee cups/day: ☐ 1-2-3 ☐ 4-6 ☐ 7-10 ☐ 11-10 Tea cups/day: ☐ 1-2-3 ☐ 4-6
Caffeinated Sodas or Diet Sodas Intake: ◯ Yes ◯ No
12-ounce can/bottle ☐ 1-2-3 ☐ 4-6 ☐ 7-10 per day
List favorite type (Ex. Diet Coke, Pepsi, etc.): __________________________________________
Are you currently using any recreational drugs? ◯ Yes ◯ No
Type________________________________________________________________________________
Have you ever used IV or inhaled recreational drugs? ◯ Yes ◯ No

EXERCISE
Current Exercise Program: (List type of activity, number of sessions/week, and duration)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Type</th>
<th>Frequency per Week</th>
<th>Duration in Minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stretching</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardio/Aerobics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strength</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (yoga, pilates, gyrotonics, etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sports or Leisure Activities (golf, tennis, rollerblading, etc.)</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Rate your level of motivation for including exercise in your life? ◯ Low ◯ Medium ◯ High
List problems that limit activity:
__________________________________________________________________________________
__________________________________________________________________________________
Do you feel unusually fatigued after exercise? ◯ Yes ◯ No
If yes, please describe:
__________________________________________________________________________________
__________________________________________________________________________________
Do you usually sweat when exercising? ◯ Yes ◯ No
### PSYCHOSOCIAL

Do you feel significantly less vital than you did a year ago?  ○ Yes  ○ No
Are you happy?  ○ Yes  ○ No
Do you feel your life has meaning and purpose?  ○ Yes  ○ No
Do you believe stress is presently reducing the quality of your life?  ○ Yes  ○ No
Do you like the work you do?  ○ Yes  ○ No
Have you ever experienced major losses in your life?  ○ Yes  ○ No
Do you spend the majority of your time and money to fulfill responsibilities and obligations?  ○ Yes  ○ No
Would you describe your experience as a child in your family as happy and secure?  ○ Yes  ○ No

### STRESS/COPING

Have you ever sought counseling?  ○ Yes  ○ No
Are you currently in therapy?  ○ Yes  ○ No
Describe: ____________________________________________________________
Do you feel you have an excessive amount of stress in your life?  ○ Yes  ○ No
Do you feel you can easily handle the stress in your life?  ○ Yes  ○ No
Daily Stressors: Rate on scale of 1-10
Work _____ Family _____ Social _____ Finances_____ Health_____ Other_____
Do you practice meditation or relaxation techniques?  ○ Yes  ○ No
How often? __________
Check all that apply: □ Yoga □ Meditation □ Imagery □ Breathing □ Tai Chi □ Prayer
□ Other: __________________________________________________________________
Have you ever been abused, a victim of a crime, or experienced a significant trauma?
○ Yes  ○ No

### SLEEP/REST

Average number of hours you sleep per night: □ >10 □ 8-10 □ 6-8 □ < 6
Do you feel rested upon awakening?  ○ Yes  ○ No
Do you have problems with insomnia?  ○ Yes  ○ No
Do you snore?  ○ Yes  ○ No
Do you use sleeping aids?  ○ Yes  ○ No
Explain: ____________________________________________________________________
ROLES/RELATIONSHIP

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

List Children:

<table>
<thead>
<tr>
<th>Child’s Name</th>
<th>Age</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

Who is Living in Household? Number: ________

Names:____________________________________________________________________________

Their employment/Occupations:__________________________________________________________

Resources for emotional support?

Check all that apply:
- Spouse
- Family
- Friends
- Religious/Spiritual
- Pets
- Other: _______________

Are you satisfied with your sex life? ○ Yes ○ No

How well have things been going for you?

<table>
<thead>
<tr>
<th>Overall</th>
<th>Very Well</th>
<th>Fine</th>
<th>Poorly</th>
<th>Does Not Apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>At School</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In your job</td>
<td></td>
<td></td>
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<tr>
<td>In your social life</td>
<td></td>
<td></td>
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<tr>
<td>With your friends</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>With sex</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>With your attitude</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With your boyfriend/girlfriend</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With your children</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>With your parents</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>With your spouse</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

Do you have known adverse food reactions or sensitivities? ○ Yes ○ No

If yes, describe symptoms:____________________________________________________________________

Do you have any food allergies or sensitivities? ○ Yes ○ No

If yes, list all:__________________________________________________________________________

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

When you drink caffeine do you feel: ○ Irritable or wired ○ Aches & Pains

Do you adversely react to (Check all that apply):
- Monosodium glutamate (MSG)
- Aspartame (Nutrasweet)
- Caffeine
- Bananas
- Garlic
- Onion
- Cheese
- Citrus Foods
- Chocolate
- Alcohol
- Red Wine
- Sulfite Containing Foods (wine, dried fruit, salad bars)
- Preservatives (ex. sodium benzoate)
- Other: ___________________________________________________________________________
Which of these significantly affect you? Check all that apply:
- Cigarette Smoke
- Perfumes/Colognes
- Auto Exhaust Fumes
- Other: __________________

In your work or home environment, are you exposed to:
- Chemicals
- Electromagnetic Radiation
- Mold

Have you ever turned yellow (jaundiced)?  ○ Yes  ○ No
Have you ever been told you have Gilbert’s syndrome or a liver disorder?  ○ Yes  ○ No
Explain: ____________________________________________

Do you have a known history of significant exposure to any harmful chemicals such as the following:
- Herbicides
- Insecticides (frequent visits of exterminator)
- Pesticides
- Organic Solvents
- Heavy Metals
- Other: __________________
Chemical Name, Date, Length of Exposure: ____________________________

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

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

Do you have any pets or farm animals?  ○ Yes  ○ No
SYMPTOM REVIEW

Please check all current symptoms or those present during the past 6 months.

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

HEAD, EYES & EARS
☐ Conjunctivitis
☐ Distorted Sense of Smell
☐ Distorted Taste
☐ Ear Fullness
☐ Ear Pain
☐ Ear Ringing/Buzzing
☐ Lid Margin Redness
☐ Eye Crusting
☐ Eye Pain
☐ Hearing Loss
☐ Hearing Problems
☐ Headache
☐ Migraine
☐ Sensitivity to Loud Noises
☐ Vision problems
☐ Macular Degeneration
☐ Vitreous Detachment
☐ Retinal Detachment

MUSCULOSKELETAL
☐ Back Muscle Spasm
☐ Calf Cramps
☐ Chest Tightness
☐ Foot Cramps
☐ Joint Deformity
☐ Joint Pain
☐ Joint Redness
☐ Joint Stiffness
☐ Muscle Pain
☐ Muscle Spasms
☐ Muscle Stiffness

Muscle Twitches:
☐ Around Eyes
☐ Arms or Legs
☐ Muscle Weakness
☐ Neck Muscle Spasm
☐ Tendonitis
☐ Tension Headache
☐ TMJ Problems

MOOD/NERVES
☐ Agoraphobia
☐ Anxiety
☐ Auditory Hallucinations
☐ Black-out
☐ Depression

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

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

DIGESTION
☐ Anal Spasms
☐ Bad Teeth
☐ Bleeding Gums

Bloating of:
☐ Lower Abdomen
☐ Whole Abdomen
☐ Bloating After Meals
☐ Blood in Stools
☐ Burping
☐ Canker Sores
☐ Cold Sores
☐ Constipation
☐ Cracking at Corner of Lips
☐ Cramps
☐ Dentures w/Poor Chewing
☐ Diarrhea
☐ Alternating Diarrhea and Constipation
☐ Difficulty Swallowing
☐ Dry Mouth
☐ Excess Flatulence/Gas
☐ Fissures
☐ Foods “Repeat” (Reflex)
☐ Gas
☐ Heartburn
☐ Hemorrhoids
☐ Indigestion
☐ Nausea
☐ Upper Abdominal Pain
☐ Vomiting

Intolerance to:
☐ Lactose
☐ All Dairy Products
☐ Wheat
☐ Gluten (Wheat, Rye, Barley)
☐ Corn
☐ Eggs
☐ Fatty Foods
☐ Yeast
☐ Liver Disease/Jaundice
☐ (Yellow Eyes or Skin)
☐ Abnormal Liver Function Tests
☐ Lower Abdominal Pain
☐ Mucus in Stools
☐ Periodontal Disease
☐ Sore Tongue
☐ Strong Stool Odor
☐ Undigested Food in St
<table>
<thead>
<tr>
<th>SKIN PROBLEMS</th>
<th>SKIN, DRYNESS OF</th>
<th>CARDIOVASCULAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Acne on Back</td>
<td>□ Eyes</td>
<td>□ Angina/chest pain</td>
</tr>
<tr>
<td>□ Acne on Chest</td>
<td>□ Feet</td>
<td>□ Breathlessness</td>
</tr>
<tr>
<td>□ Acne on Face</td>
<td></td>
<td>□ Heart Murmur</td>
</tr>
<tr>
<td>□ Acne on Shoulders</td>
<td>□ Cracking?</td>
<td>□ Irregular Pulse</td>
</tr>
<tr>
<td>□ Athlete’s Foot</td>
<td>□ Peeling?</td>
<td>□ Palpitations</td>
</tr>
<tr>
<td>□ Bumps on Back of Upper Arms</td>
<td>□ Hair □ Unmanageable?</td>
<td>□ Phlebitis</td>
</tr>
<tr>
<td>□ Cellulite</td>
<td>□ Hands</td>
<td>□ Swollen Ankles/Feet</td>
</tr>
<tr>
<td>□ Dark Circles Under Eyes</td>
<td></td>
<td>□ Varicose Veins</td>
</tr>
<tr>
<td>□ Ears Get Red</td>
<td>□ Cracking?</td>
<td></td>
</tr>
<tr>
<td>□ Easy Bruising</td>
<td>□ Peeling?</td>
<td></td>
</tr>
<tr>
<td>□ Lack Of Sweating</td>
<td>□ Mouth/Throat</td>
<td></td>
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<tr>
<td>□ Eczema</td>
<td>□ Scalp</td>
<td></td>
</tr>
<tr>
<td>□ Hives</td>
<td>□ Dandruff?</td>
<td></td>
</tr>
<tr>
<td>□ Jock Itch</td>
<td>□ Skin In General</td>
<td></td>
</tr>
<tr>
<td>□ Lackluster Skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Moles w/Color/Size Change</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Oily Skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Pale Skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Patchy Dullness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Rash</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Red Face</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Sensitivity to Bites</td>
<td></td>
<td></td>
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<tr>
<td>□ Sensitivity to Poison Ivy/Oak</td>
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<td></td>
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<tr>
<td>□ Shingles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Skin Darkening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Strong Body Odor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Hair Loss</td>
<td></td>
<td></td>
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<tr>
<td>□ Vitiligo</td>
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<td></td>
</tr>
<tr>
<td>ITCHING SKIN</td>
<td></td>
<td></td>
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<tr>
<td>□ Skin in General</td>
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<td></td>
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<tr>
<td>□ Anus</td>
<td></td>
<td></td>
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<tr>
<td>□ Arms</td>
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</tr>
<tr>
<td>□ Ear Canals</td>
<td></td>
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<tr>
<td>□ Eyes</td>
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<tr>
<td>□ Feet</td>
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<tr>
<td>□ Hands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Legs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Nipples</td>
<td></td>
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<tr>
<td>□ Nose</td>
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<td></td>
</tr>
<tr>
<td>□ Penis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Roof of Mouth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Scalp</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Rash</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Sensitivity to Bites</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Sensitivity to Poison Ivy/Oak</td>
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<tr>
<td>□ Shingles</td>
<td></td>
<td></td>
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<tr>
<td>□ Skin Darkening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Strong Body Odor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Hair Loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Vitiligo</td>
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</tbody>
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<table>
<thead>
<tr>
<th>LYMPH NODES</th>
<th>NAILS</th>
<th>URINARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Enlarged/neck</td>
<td>□ Bitten</td>
<td>□ Bed Wetting</td>
</tr>
<tr>
<td>□ Tender/neck</td>
<td>□ Brittle</td>
<td>□ Hesitancy</td>
</tr>
<tr>
<td>□ Other Enlarged/Tender</td>
<td>□ Curve Up</td>
<td>(trouble getting started)</td>
</tr>
<tr>
<td>□ Lymph Nodes</td>
<td>□ Frayed</td>
<td>□ Infection</td>
</tr>
<tr>
<td></td>
<td>□ Fungus-Fingers</td>
<td>□ Kidney Disease</td>
</tr>
<tr>
<td></td>
<td>□ Fungus-Toes</td>
<td>□ Leaking/Incontinence</td>
</tr>
<tr>
<td></td>
<td>□ Pitting</td>
<td>□ Pain/Burning</td>
</tr>
<tr>
<td></td>
<td>□ Ragged Cuticles</td>
<td>□ Prostate Infection</td>
</tr>
<tr>
<td></td>
<td>□ Ridges</td>
<td>□ Urgency</td>
</tr>
<tr>
<td></td>
<td>□ Soft</td>
<td></td>
</tr>
<tr>
<td>Thickening of:</td>
<td>□ Fingernails</td>
<td></td>
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<tr>
<td></td>
<td>□ Toenails</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ White Spots/Lines</td>
<td></td>
</tr>
<tr>
<td>RESPIRATORY</td>
<td>□ Nasal Stuffiness</td>
<td></td>
</tr>
<tr>
<td>□ Bad Breath</td>
<td>□ Loose</td>
<td></td>
</tr>
<tr>
<td>□ Bad Odor in Nose</td>
<td>□ Nose Bleeds</td>
<td></td>
</tr>
<tr>
<td>□ Cough-Dry</td>
<td>□ Post Nasal Drip</td>
<td></td>
</tr>
<tr>
<td>□ Cough-Productive</td>
<td>□ Sinus Fullness</td>
<td></td>
</tr>
<tr>
<td>□ Hoarseness</td>
<td>□ Sinus Infection</td>
<td></td>
</tr>
<tr>
<td>□ Sore Throat</td>
<td>□ Snoring</td>
<td></td>
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<tr>
<td>Hay Fever:</td>
<td>□ Wheezing</td>
<td></td>
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<tr>
<td></td>
<td>□ Winter Stiffness</td>
<td></td>
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<tr>
<td></td>
<td>□ Spring</td>
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<td></td>
<td>□ Summer</td>
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<tr>
<td></td>
<td>□ Fall</td>
<td></td>
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<tr>
<td></td>
<td>□ Change Of Season</td>
<td></td>
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<tr>
<td></td>
<td>□ Nasal Stuffiness</td>
<td></td>
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<td></td>
<td>□ Loose</td>
<td></td>
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<tr>
<td></td>
<td>□ Post Nasal Drip</td>
<td></td>
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<tr>
<td></td>
<td>□ Sinus Fullness</td>
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<tr>
<td></td>
<td>□ Sinus Infection</td>
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<tr>
<td></td>
<td>□ Snoring</td>
<td></td>
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<tr>
<td></td>
<td>□ Wheezing</td>
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<table>
<thead>
<tr>
<th>FEMALE REPRODUCTIVE</th>
<th>PREMENSTRUAL:</th>
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<tbody>
<tr>
<td>□ Breast Cysts</td>
<td>□ Bloating Breast Tenderness</td>
<td></td>
</tr>
<tr>
<td>□ Breast Lumps</td>
<td>□ Carbohydrate Cravings</td>
<td></td>
</tr>
<tr>
<td>□ Breast Tenderness</td>
<td>□ Chocolate Cravings</td>
<td></td>
</tr>
<tr>
<td>□ Ovarian Cyst</td>
<td>□ Constipation</td>
<td></td>
</tr>
<tr>
<td>□ Poor Libido (Sex Drive)</td>
<td>□ Decreased Sleep</td>
<td></td>
</tr>
<tr>
<td>□ Ovarian Cyst</td>
<td>□ Diarrhea</td>
<td></td>
</tr>
<tr>
<td>□ Poor Libido (Sex Drive)</td>
<td>□ Fatigue</td>
<td></td>
</tr>
<tr>
<td>□ Vaginal Discharge</td>
<td>□ Increased Sleep</td>
<td></td>
</tr>
<tr>
<td>□ Vaginal Odor</td>
<td>□ Irritability</td>
<td></td>
</tr>
<tr>
<td>□ Vaginal Itch</td>
<td></td>
<td></td>
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<tr>
<td>□ Vaginal Pain with Sex</td>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th>MALE REPRODUCTIVE</th>
<th>PREGNENTRUAL:</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>□ Discharge From Penis</td>
<td>□ Cramps</td>
<td></td>
</tr>
<tr>
<td>□ Ejaculation Problem</td>
<td>□ Heavy Periods</td>
<td></td>
</tr>
<tr>
<td>□ Genital Pain</td>
<td>□ Irregular Periods</td>
<td></td>
</tr>
<tr>
<td>□ Impotence</td>
<td>□ No Periods</td>
<td></td>
</tr>
<tr>
<td>□ Prostate or Urinary Infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Lumps In Testicles</td>
<td>□ Scanty Periods</td>
<td></td>
</tr>
<tr>
<td>□ Poor Libido (Sex Drive)</td>
<td>□ Spotting Between</td>
<td></td>
</tr>
</tbody>
</table>
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......................................................... O 5 O 4 O 3 O 2 O 1
Take several nutritional supplements each day................................. O 5 O 4 O 3 O 2 O 1
Keep a record of everything you eat each day................................... O 5 O 4 O 3 O 2 O 1
Modify your lifestyle (e.g., work demands, sleep habits).................... O 5 O 4 O 3 O 2 O 1
Practice a relaxation technique ..................................................... O 5 O 4 O 3 O 2 O 1
Engage in regular exercise ............................................................. O 5 O 4 O 3 O 2 O 1
Have periodic lab tests to assess your progress............................... O 5 O 4 O 3 O 2 O 1

Comments ____________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

Rate on a scale of 5 (very confident) to 1 (not confident at all):
How confident are you of your ability to organize and follow through on the above health related activities? O 5 O 4 O 3 O 2 O 1
If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities?
__________________________________________________________________________________
__________________________________________________________________________________

Rate on a scale of 5 (very supportive) to 1 (very unsupportive):
At the present time, how supportive do you think the people in your household will be to your implementing the above changes? O 5 O 4 O 3 O 2 O 1
Comments: __________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact):
How much on-going support and contact (e.g., telephone consults, e-mail correspondence) from our professional staff would be helpful to you as you implement your personal health program? O 5 O 4 O 3 O 2 O 1
Comments: __________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
**3-DAY DIET DIARY INSTRUCTIONS**

PLEASE SUBMIT WITH THE ENTIRE INTAKE FORM. DO NOT WAIT AND BRING WITH YOU TO THE APPOINTMENT. WE NEED TO REVIEW PRIOR TO YOUR APPOINTMENT.

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

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

- Do not change your eating behavior at this time, as the purpose of this food record is to analyze your present eating habits.
- Record information as soon as possible after the food has been consumed
- Describe the food or beverage as accurately as possible e.g., milk - what kind? (whole, 2%, nonfat); toast (whole wheat, white, buttered); chicken (fried, baked, breaded); coffee (decaffeinated with sugar and ½ & ½).
- Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, ½ cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.
- Record all beverages, including water, coffee, tea, sports drinks, sodas/diet sodas, etc.
- Include any additional comments about your eating habits on this form (ex. craving sweet, skipped meal and why, when the meal was at a restaurant, etc).
- Please note all bowel movements and their consistency (regular, loose, firm, etc.)

**DIET DIARY**

Name: ___________________________ Date: ________________

**DAY 1**

<table>
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<tr>
<th>TIME</th>
<th>FOOD/BEVERAGE/AMOUNT</th>
<th>COMMENTS</th>
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Bowel Movements (#, form,color): ____________________________________________
### Stress/Mood/Emotions

### Other Comments

### DAY 2

<table>
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<tr>
<th>TIME</th>
<th>FOOD/BEVERAGE/AMOUNT</th>
<th>COMMENTS</th>
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Bowel Movements (#, form, color): ____________________________________________
Stress/Mood/Emotions: ________________________________________________________
Other Comments: ___________________________________________________________

### DAY 3

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<th>TIME</th>
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Bowel Movements (#, form, color): ____________________________________________
Stress/Mood/Emotions: ________________________________________________________
Other Comments: ___________________________________________________________
The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are completing this after your first time, then record your symptoms for **ONLY** the last 48 hours.

### POINT SCALE

<table>
<thead>
<tr>
<th>Scale</th>
<th>Description</th>
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<tbody>
<tr>
<td>0</td>
<td>Never or almost never have the symptom</td>
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<tr>
<td>1</td>
<td>Occasionally have it, effect is not severe</td>
</tr>
<tr>
<td>2</td>
<td>Occasionally have, effect is severe</td>
</tr>
<tr>
<td>3</td>
<td>Frequently have it, effect is not severe</td>
</tr>
<tr>
<td>4</td>
<td>Frequently have it, effect is severe</td>
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### KEY TO QUESTIONNAIRE

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

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

<table>
<thead>
<tr>
<th>Section</th>
<th>Symptoms</th>
<th>Score</th>
</tr>
</thead>
</table>
| **DIGESTIVE TRACT** | ___ Nausea or vomiting  
 ___ Diarrhea  
 ___ Constipation  
 ___ Bloating feeling  
 ___ Belching or passing gas  
 ___ Heartburn  
 ___ Intestinal/Stomach pain |       |
| **HEAD**         | ___ Headaches  
 ___ Fainting  
 ___ Dizziness  
 ___ Insomnia |       |
| **HEART**        | ___ Irregular or skipped heartbeat  
 ___ Rapid or pounding heartbeat  
 ___ Chest pain |       |
| **JOINTS/MUSCLES** | ___ Pain or aches in joints  
 ___ Arthritis  
 ___ Stiffness or limitation of movement  
 ___ Pain or aches in muscles  
 ___ Feeling of weakness or tiredness |       |
| **LUNGS**        | ___ Chest congestion  
 ___ Asthma, bronchitis  
 ___ Shortness of breath  
 ___ Difficult breathing |       |
| **MIND**         | ___ Poor memory  
 ___ Confusion, poor comprehension  
 ___ Poor concentration  
 ___ Poor physical coordination  
 ___ Difficulty in making decisions  
 ___ Stuttering or stammering  
 ___ Slurred speech  
 ___ Learning disabilities |       |
| **MOUTH/THROAT** | ___ Chronic coughing  
 ___ Gagging, frequent need to clear throat  
 ___ Sore throat, hoarseness, loss of voice  
 ___ Swollen/discoled tongue, gum, lips  
 ___ Canker sores |       |
| **NOSE**         | ___ Stuffy nose  
 ___ Sinus problems  
 ___ Hay fever  
 ___ Sneezing attacks  
 ___ Excessive mucus formation |       |
| **SKIN**         | ___ Acne  
 ___ Hives, rashes or dry skin  
 ___ Hair loss  
 ___ Flushing or hot flushes  
 ___ Excessive sweating |       |
| **WEIGHT**       | ___ Binge eating/drinking  
 ___ Craving certain foods  
 ___ Excessive weight  
 ___ Compulsive eating  
 ___ Water retention  
 ___ Underweight |       |
| **OTHER**        | ___ Frequent illness  
 ___ Frequent or urgent urination  
 ___ Genital itch or discharge |       |

**GRAND TOTAL:** _____