

# **Acupuncture and Chiropractic Center**

## **Introductory Patient Information**

945 Michigan Ave Suite 8 B  
Pensacola Florida 32505

(850) 469 9633

(850) 469 1590

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## PATIENT CHECKLIST

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### **DID YOU REMEMBER TO?**

- Read all of our documents
- Obtain your medical records and/or test results from previously seen physicians and have them sent to **[YOUR ADDRESS]**

### **FILL OUT AND/OR SIGN THE FOLLOWING FORMS**

- Important Patient Information
- Authorization for Release of Medical Information
- General Information
- Health Goals Form
- Functional Diagnostic Medicine Questionnaire
- Nutrition and Lifestyle Questionnaire
- Review of systems
- Environmental Influences Questionnaire
- Patient Readiness Form
- Nutritional Assessment Questionnaire
- Diet Diary

*Thank you*

## FREQUENTLY ASKED QUESTIONS

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

Our clinic uses an innovative approach to assessing and treating your health care concerns. Perhaps you have experienced being examined by 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 anything but normal!. 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.

We use a variety of innovative testing techniques and procedures to help our patients prevent illness and recover from many chronic and difficult to treat conditions. Our clinicians are highly skilled in evaluating, assessing and treating chronic problems such as fibromyalgia, fatigue syndromes, autoimmune diseases, inflammatory disorders, mood and behavior disorders, memory problems and other chronic, complex conditions. We also focus on the prevention and treatment of heart disease, diabetes, dementia, hormonal imbalances and digestive disorders.

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

Most of the testing can be performed at this clinic. Some testing can be done through conventional laboratories and others are only available through specialty laboratories. During your consultation, we will determine which tests are needed and then our office assistants can review the testing recommendations, the instructions (e.g. fasting or non-fasting, etc.) and costs. Some testing can be performed at home with test kits to collect urine, saliva or stool. Others may require you to go to a local laboratory to draw the blood. In all cases, we will assist you in coordinating initial and follow-up testing.

Occasionally, we may recommend certain tests that are not performed at our facility. In those instances, we can provide you with an order that you can take to a facility near your home or we can schedule an appointment to have them done near our office.

### ***Do you take insurance?***

We do not accept insurance or Medicare and we do not file insurance paperwork on your behalf. However, we will provide a detailed receipt for services performed for you to submit to your insurance carriers. Some insurance carriers may partially cover medical services and laboratory tests performed by the physicians. Payment in full by check, cash or credit card is due at the time services are provided.

### ***What credit cards do you accept?***

We accept the following credit cards: MasterCard, Visa and Discover. If you like we can maintain an active credit card on file at the office so we can bill follow-up consultations, laboratory testing, and other services.

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## **Consent Forms**

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## IMPORTANT PATIENT INFORMATION

### Patient Acceptance Policy

In order to best serve you, the *Patient Acceptance Policy* should be carefully reviewed. It is Dr. Cowan's opinion that you should be well informed on our expectations and clinical procedures. To prevent any misunderstandings or confusion on what to expect, Dr. Cowan would appreciate that you read the below steps and provide your signature. This would simply imply that you have read the *Patient Acceptance Policy* and understand what is expected of you.

#### 1. Completion of the following forms:

- The Health Questionnaires**
- The Nutritional Assessment Questionnaire** This 322 question questionnaire was developed to gather important information about your body. It will help Dr. Cowan assist in helping you. The medical questionnaire will allow Dr. Cowan to quickly “zero” in on the probable causes of your health problems.
- The Diet Diary**

It is **VERY** important for you to carefully and thoroughly complete all of these forms and questionnaires prior to your first consultation with Dr. Cowan. Once Dr. Cowan has received your completed forms, our office will schedule your first consultation

2. **Medical Records** from all physicians since you were **first diagnosed** with your health condition **MUST** be obtained prior to scheduling an appointment.
3. Once Dr. Cowan has your completed questionnaires and copies of all your medical records, a one-hour appointment will be scheduled either on a **Tuesday or Thursday** to review your case. Dr. Cowan will provide a **detailed written medical report** at the time of your scheduled appointment. The cost for the one-hour appointment as well as Dr. Cowan's time for reviewing your medical questionnaire, medical records and written report is \$175.00.
4. Based on your scheduled appointment and review of all your medical information, it may be necessary to obtain a **comprehensive blood chemistry**. The blood chemistry test may include the following. Depending on your circumstances, Biomarkers may be added or subtracted from the profile we need for you health related problem.
  - Comprehensive Executive Metabolic Panel**, which includes 24 important disease markers such as SGOT, SGPT, GGT, Bilirubin (Liver), BUN, Creatinine, Uric (Kidney), Alkaline Phosphatase (Bone)
  - Cardiovascular Panel:** Cholesterol, Triglycerides, LDL, HDL, Cholesterol/HDL Ratio, LDL/HDL Ratio, C Reactive Protein (hs-CRP), Homocysteine, Fibrinogen
  - Thyroid Panel:** Total T3, Total T4, Free T3, Free T4, TSH
  - Magnesium**
  - CBC differential:** White Blood Cells and Red Blood Cells, Platelets
  - Inflammatory markers:** Sedimentation Rate, or CRP

5. Based on your medical history, questionnaire, medical records and initial consultation, it may be necessary to order additional medical laboratory tests. You will be presented with detailed information on the **specific tests recommended**. The cost for your initial Laboratory tests will be discussed at that time. **Payment can be made via check and/or credit card**. We accept **Visa, Mastercard, Discover**.
6. If you have not had a physical examination within the last two years or since the start of your most recent health problem, it is required to either schedule an appointment with **Dr. Cowan** or with your primary physician.
7. The results of your lab tests may take approximately **three weeks**, at which point, you will be scheduled for an appointment. This appointment usually takes approximately one to one and half hours. You will be presented with a written report **detailing the results of your tests, the possible causes of your health problem and the recommended treatment protocol**. It is recommended that you have your spouse or a supportive family member attend this appointment.
8. Your treatment may consist of dietary and lifestyle changes as well as prescribed **Natural Pharmaceuticals**, which must be paid at the time of purchase.
9. It is strongly recommended that you have access to a computer with Internet Connection. **A progress medical questionnaire** will be posted to your e-mail one week before your next scheduled appointment. Completion of the progress questionnaire is required every 6-12 weeks to monitor your progress. Correspondence by e-mail is strongly encouraged and is **Free of Charge**. If you do not have access to the internet, then a copy of the progress questionnaire will be mailed or faxed. If you would prefer to schedule an appointment to discuss any questions, you may do so either on [practice day] or [practice day].
10. Follow-up consultations will be scheduled every **3, 6 or 12 weeks** allowing you the opportunity to discuss your progress and any concerns with **Dr. Cowan**. **Dr. Cowan** will at this time determine what direction to take to help you continue your progress. Your cooperation in taking "**personal responsibility**" in your health care will go a long way in getting better. Consultations can be conducted either by phone or in person (at the office). The fee for follow-up consultations is **\$45.00 for 20 minutes**.
11. **Abnormal laboratory tests** will need to be re-evaluated. The success of your treatment will not only be measured on the reduction of elimination of your physical symptoms, but on abnormal laboratory tests returning to a normal status.  
For example: Many physicians will prescribe Lipitor for individuals suffering with high cholesterol. Your physician will also require periodic cholesterol blood tests to monitor the success of the medication. Laboratory fees can vary depending on what needs to be re-tested.

I, \_\_\_\_\_ have read and fully understand the **Patient Acceptance Policy**

---

**Patient Signature**

---

**Dr. Robert Cowan**

# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

## Requesting Records of Doctor:

Name of Facility or Person: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone number ( ) \_\_\_ - \_\_\_\_\_ Fax number ( ) \_\_\_ - \_\_\_\_\_

## THE PURPOSE FOR THIS RELEASE

You are hereby authorized to furnish and release to **Acupuncture and Chiropractic Center / Robert F. Cowan DC, Cap, DACBN** all information from my medical, psychological, and other health records, with no limitation placed on history of illness or diagnostic or therapeutic information, including the furnishing of photocopies of all written documents pertinent thereto.

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

Alcohol or Drug Abuse:  Yes  No

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

Genetic Testing  Yes  No

*Note: With respect to drug and alcohol abuse treatment information, or records regarding communicable disease information, the information is from confidential records which are protected by State and Federal laws that prohibit disclosure with the specific written consent of the person to who they pertain, or as otherwise permitted by law. A general authorization for the release of the protected health information is not sufficient for this purpose.*

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

I hereby release **Acupuncture and Chiropractic Center / Robert F. Cowan DC, Cap, DACBN**; its employees, agents managing members, and the attending physician(s) from legal responsibility or liability for the release of the above information to the extent authorized. A copy of this authorization shall be as valid as the original.

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

Patient's Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

*Please Print*

Signature: \_\_\_\_\_ Date \_\_\_\_\_

**\*PLEASE INCLUDE A COPY OF YOUR DRIVERS LICENSE OR PASSPORT ALONG WITH THE COMPLETED AND SIGNED FORM\***

## Records Requested by:

Doctor's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone number ( ) \_\_\_ - \_\_\_\_\_

Signature: \_\_\_\_\_

# Acupuncture and Chiropractic Center

## Health Questionnaires

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# Acupuncture and Chiropractic Center

## GENERAL INFORMATION

Name \_\_\_\_\_

Preferred Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Place of birth \_\_\_\_\_ Gender: female \_\_\_ male \_\_\_

Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Single \_\_\_\_\_ Partnership \_\_\_\_\_

Right Handed: \_\_\_\_\_ Left Handed: \_\_\_\_\_ Mixed Dominance: \_\_\_\_\_

Number of Sisters: \_\_\_\_\_ (# deceased: \_\_\_\_\_) # of Brothers: \_\_\_\_\_ (# deceased: \_\_\_\_\_) Birth Order: \_\_\_\_\_

Occupation \_\_\_\_\_ Hours per week \_\_\_\_\_ Retired \_\_\_\_\_

Nature of Business \_\_\_\_\_

How did you hear about our clinic? Book \_\_\_\_\_ Website \_\_\_\_\_ Media \_\_\_\_\_ Friend/ family member \_\_\_\_\_

Other \_\_\_\_\_

Has any other family member already been a patient at the clinic? \_\_\_\_\_

Next of Kin or other to reach in an emergency \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Genetic Background: Please check appropriate box(es):

- |   |                                    |  |                                |
|---|------------------------------------|--|--------------------------------|
| <input type="checkbox"/> African American | <input type="checkbox"/> Hispanic  | <input type="checkbox"/> Mediterranean     | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Native American  | <input type="checkbox"/> Caucasian | <input type="checkbox"/> Northern European | <input type="checkbox"/> Other |

Who is your primary medical physician? \_\_\_\_\_

Primary medical physician address & office phone # \_\_\_\_\_

## PERSONAL DESCRIPTIVE INFORMATION

**Marital status:**

- Single
  Married
  Divorced  
 Widow
  Long Term Partnership

**List Children:**

Child's Name	Age	Gender

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

\_\_\_\_\_

\_\_\_\_\_

Do you have any pets or farm animals? Yes \_\_\_ No \_\_\_

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

Have you ever lived or travelled outside the United States? Yes \_\_\_ No \_\_\_

If so, when and where? \_\_\_\_\_

\_\_\_\_\_

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

If yes, please comment: \_\_\_\_\_

\_\_\_\_\_

Have you experienced any major losses in life? Yes \_\_\_ No \_\_\_

If so, please comment: \_\_\_\_\_

\_\_\_\_\_

How much time have you lost from work or school in the past year?

- a. \_\_\_ 0-2 days                      b. \_\_\_ 3 –14 days                      c. \_\_\_ > 15 days

Previous jobs: \_\_\_\_\_

\_\_\_\_\_

Please list your highest level of education:

- High School  
 College \_\_\_\_\_ Major: \_\_\_\_\_ Year: \_\_\_\_\_  
 Graduate School \_\_\_\_\_ Field: \_\_\_\_\_ Year: \_\_\_\_\_  
 Professional School \_\_\_\_\_ Field: \_\_\_\_\_ Year: \_\_\_\_\_  
 Did you have learning problems? \_\_\_\_\_

# Functional Diagnostic Medicine Questionnaire

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

Note that we are interested in so-called minor symptoms as well as major problems. We know that in many doctor's offices there is some tendency not to mention too many symptoms for fear that the doctor will take you for a hypochondriac. The rules in our office are different. We are interested in any odd or unusual message you are getting from your body, even though it may be considered irrelevant to "making a diagnosis" or it may seem to you to be of no consequence to your health. Some such symptoms are useful clues in the kind of "medical detective work" we do. Please include as much information as you can on this form.

**Please print or write legibly.**

## COMPLAINTS/CONCERNS

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

Problem	Onset	Frequency	Severity
1. e.g. Headaches	June 2007	4 times per week	Mild / moderate / severe
2.			
3.			
4.			
5.			
6.			
7.			

What diagnosis or explanation have been given to you? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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 all physicians you have seen for the above health conditions:

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

Please check all the Alternative Treatments you have tried for your condition(s)

- |                                       |                                      |  |   |
|---------------------------------------|--------------------------------------|--|---|
| <input type="checkbox"/> None         | <input type="checkbox"/> Massage     | <input type="checkbox"/> Yoga          | <input type="checkbox"/> Environmental medicine |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Rolfing     | <input type="checkbox"/> Hypnosis      | <input type="checkbox"/> Nutritional Therapy    |
| <input type="checkbox"/> Acupuncture  | <input type="checkbox"/> Reiki       | <input type="checkbox"/> Ayurveda      | <input type="checkbox"/> Biological Dentistry   |
| <input type="checkbox"/> Iridology    | <input type="checkbox"/> Homeopathy  | <input type="checkbox"/> Light therapy | <input type="checkbox"/> IV (chelation) therapy |
| <input type="checkbox"/> Colonics     | <input type="checkbox"/> Biofeedback | <input type="checkbox"/> Meditation    | <input type="checkbox"/> Naturopathic medicine  |

**PAST MEDICAL & SURGICAL HISTORY**

ILLNESSES	Date	Date	Date	Comments
Chicken Pox		X	X	
German Measles		X	X	
Measles		X	X	
Mononucleosis		X	X	
Mumps		X	X	
Whooping cough		X	X	
Anemia				
Arthritis				
Asthma				
Bronchitis				
Cancer				
Chronic Fatigue Syndrome				
Crohn's Disease or Ulcerative Colitis				
Diabetes				
Emphysema				
Epilepsy, convulsions				
Gallstones				
Gout				
Heart attack/Angina				
Heart failure				
Hepatitis				
Hugh blood pressure				
Irritable bowel				
Kidney stones				
Mononucleosis				
Pneumonia				
Rheumatic fever				
Sinusitis				

<b>ILLNESSES</b>	<b>Date</b>	<b>Date</b>	<b>Date</b>	<b>Comments</b>
Sleep apnea				
Stroke				
Thyroid disease				
Other (describe)				
<b>INJURIES</b>	<b>Date</b>	<b>Date</b>	<b>Date</b>	<b>Comments</b>
Head Injury				
Neck Injury				
Back Injury				
Fracture				
Other (describe)				
<b>DIAGNOSTIC STUDIES</b>	<b>Date</b>	<b>Date</b>	<b>Date</b>	<b>Comments</b>
Chest X-ray				
Mammogram				
EKG				
Sigmoidoscopy				
Colonoscopy				
Upper GI Series				
Barium Enema				
CAT scan of Abdomen				
CAT scan of brain				
CAT scan of spine				
Liver scan				
Bone scan				
Neck X-rays				
Back X-rays				
MRI				
Bone Density Test				
Carotid Artery Ultrasound				
Blood Tests				
Other (describe)				
<b>OPERATIONS</b>	<b>Date</b>	<b>Date</b>	<b>Date</b>	<b>Comments</b>
Tonsillectomy		X	X	
Tubes in Ears				
Appendectomy		X	X	
Gall Bladder		X	X	
Hernia				
Hysterectomy		X	X	
Dental Surgery				
Other (describe)				
Other (describe)				

## HOSPITALIZATIONS

Where Hospitalized	When	For What Reason

## PATIENT BIRTH HISTORY

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

## CHILDHOOD HEALTH HISTORY

Question	Yes	No	Don't Know	Comment
Did you live in an area with soft water?				
Hard water?				
As a child, did you consume a lot of the following:				
Sugar?				
Candy?				
Sweet foods?				
Soda?				
Diet soda?				

Question	Yes	No	Don't Know	Comment
White bread?				
Cookies?				
Ice Cream?				
Meat, vegetable & potato/rice/pasta diet?				
Vegetarian & grain based diet with little meat?				
Vegetarian diet with milk & eggs?				
Vegetarian diet without milk & eggs?				

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

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

Food	Symptom	Other comments

### AGE OF ONSET OF ILLNESSES

Please indicate which, if any, of the following problems/conditions developed when you were a child (ages birth to age12) by indicating the approximate age of onset.

- |  |   |
|--|---|
| <input type="checkbox"/> Frequent colds or flu                           | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Bronchitis                                      | <input type="checkbox"/> Ear Infections             |
| <input type="checkbox"/> Measles   | <input type="checkbox"/> Mumps                      |
| <input type="checkbox"/> Chicken Pox                                     | <input type="checkbox"/> Whooping Cough             |
| <input type="checkbox"/> Strep Infections                                | <input type="checkbox"/> Seasonal allergies         |
| <input type="checkbox"/> Significant dental work                         | <input type="checkbox"/> Behavior problems          |
| <input type="checkbox"/> ADD   | <input type="checkbox"/> Hyperactivity              |
| <input type="checkbox"/> Difficulty learning:                            | <input type="checkbox"/> Frequent headaches         |
| <input type="checkbox"/> High # of absences from school                  | <input type="checkbox"/> Upset stomach, indigestion |
| <input type="checkbox"/> Jaundice  | <input type="checkbox"/> Colic                      |
| <input type="checkbox"/> Ear infections                                  | <input type="checkbox"/> Congenital abnormalities   |
| <input type="checkbox"/> Premature at birth                              | <input type="checkbox"/> Pneumonia                  |
| <input type="checkbox"/> Fever blisters                                  | <input type="checkbox"/> Parent (s) smoked          |
| <input type="checkbox"/> Abusive or alcoholic parent (s)                 | <input type="checkbox"/> Skin disorders (eczema)    |
| <input type="checkbox"/> Major illness(s) that required hospitalization. |   |

If yes, please explain your illness:

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## IMMUNIZATION HISTORY

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

- |  |   |
|--|---|
| <input type="checkbox"/> Smallpox          | <input type="checkbox"/> Mumps                    |
| <input type="checkbox"/> Tetanus           | <input type="checkbox"/> Measles                  |
| <input type="checkbox"/> Diphtheria        | <input type="checkbox"/> Rubella (German measles) |
| <input type="checkbox"/> Pertussis         | <input type="checkbox"/> Typhoid                  |
| <input type="checkbox"/> Polio (oral)      | <input type="checkbox"/> Cholera                  |
| <input type="checkbox"/> Polio (Injection) |   |

## FEMALE MEDICAL HISTORY (for women only)

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

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Pregnancies _____      | <input type="checkbox"/> Caesarean _____                    | <input type="checkbox"/> Vaginal deliveries _____ |
| <input type="checkbox"/> Miscarriage _____      | <input type="checkbox"/> Abortion _____                     | <input type="checkbox"/> Living Children _____    |
| <input type="checkbox"/> Post partum depression | <input type="checkbox"/> Toxemia                            | <input type="checkbox"/> Gestational diabetes     |
| <input type="checkbox"/> Baby over 8 pounds     | <input type="checkbox"/> Breast feeding For how long? _____ |   |

### GYNECOLOGICAL HISTORY

Age at 1<sup>st</sup> period: \_\_\_\_\_ Menses Frequency: \_\_\_\_\_ Length: \_\_\_\_\_ Pain: Yes \_\_\_ No \_\_\_

Clotting: Yes \_\_\_ No \_\_\_ Has your period skipped? \_\_\_\_\_ For how long? \_\_\_\_\_

Last Menstrual Period: \_\_\_\_\_

Do you currently use contraception? Yes \_\_\_ No \_\_\_ If yes, what type do you use?

- Condom       Diaphragm       IUD       Partner vasectomy

Have you ever used hormonal contraception? Yes \_\_\_ No \_\_\_ If yes, when \_\_\_\_\_

Use of hormonal contraception:       Birth control pills       Patch       Nuva Ring How long? \_\_\_\_\_

Are you using the pill now? Yes \_\_\_ No \_\_\_ Did taking the pill agree with you? Yes \_\_\_ No \_\_\_

In the 2<sup>nd</sup> half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)?       Yes       No

Last Mammogram \_\_\_\_\_ Breast Biopsy/Date \_\_\_\_\_

Last PAP Test: \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal \_\_\_\_\_

Date of last Bone Density: \_\_\_\_\_ Results:       High       Low       Within normal range

Are you in menopause? Yes \_\_\_ No \_\_\_ Age at Menopause \_\_\_\_\_

Do you take:       Estrogen       Ogen       Estrace       Premarin      Other \_\_\_\_\_  
                     Progesterone       Provera      Other \_\_\_\_\_

How long have you been on hormone replacement? \_\_\_\_\_

# FAMILY HISTORY

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

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age (if still alive)												
Age at death (if deceased)												
Heart Attack												
Stroke												
Uterine Cancer												
Colon Cancer												
Breast Cancer												
Ovarian Cancer												
Prostate Cancer												
Skin Cancer												
ADD/ADHD												
ALS or other Motor Neuron Diseases												
Alzheimer's												
Anemia												
Anxiety												
Arthritis												
Asthma												
Autism												
Autoimmune Diseases (such as Lupus)												
Bipolar Disease												
Bladder disease												
Blood clotting problems												
Celiac disease												
Dementia												
Depression												
Diabetes												
Eczema												
Emphysema												
Environmental Sensitivities												
Epilepsy												
Flu												
Food Allergies, Sensitivities, Intolerances												
Genetic disorders												
Glaucoma												
Headache												
Heart Disease												
High Blood Pressure												
High Cholesterol												

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
<b>Inflammatory Arthritis</b> (Rheumatoid, Psoriatic, Ankylosing spondylitis)												
<b>Inflammatory Bowel Disease</b>												
<b>Insomnia</b>												
<b>Irritable Bowel Syndrome</b>												
<b>Kidney disease</b>												
<b>Multiple Sclerosis</b>												
<b>Nervous breakdown</b>												
<b>Obesity</b>												
<b>Osteoporosis</b>												
<b>Other</b>												
<b>Parkinson's</b>												
<b>Pneumonia/Bronchitis</b>												
<b>Psoriasis</b>												
<b>Psychiatric disorders</b>												
<b>Schizophrenia</b>												
<b>Sleep Apnea</b>												
<b>Smoking addiction</b>												
<b>Stroke</b>												
<b>Substance abuse</b> (such as alcoholism)												
<b>Ulcers</b>												

Any other family history we should know about? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please comment: \_\_\_\_\_

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

## ESTABLISHING HEALTH GOALS

### Personal Message

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

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

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

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

\_\_\_\_\_

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

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**Have you made the decision to change? To do what it takes to get well?**

Yes \_\_\_\_\_

No \_\_\_\_\_

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

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

When you have made a decision to make a change and you know your reasons, you create an internal power that can propel you to achieving health and wellness. So now I ask:

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_





**HAVE YOU COMPLETED THE LAST SECTION?**

**IF NOT, PLEASE GO BACK AND ANSWER ALL THE QUESTIONS!**

**PLEASE DO NOT SKIP THIS SECTION!!**

**GIVE CAREFUL THOUGHT TO WHY YOU WANT TO GET BETTER AND  
HOW IT WOULD AFFECT YOUR LIFE!**

## REVIEW OF SYSTEMS

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

### GENERAL

- Fever
- Chills/Cold all over
- Aches/Pains
- General Weakness
- Difficulty sweating
- Excessive Sweating
- Swollen Glands
- Cold hands & Feet
- Fatigue
- Difficulty falling asleep
- Night Walker
- Nightmares
- No dream recall
- Early waking
- Daytime sleepiness
- Distorted Vision

### SKIN:

- Cuts Heal slowly
- Bruise Easily
- Rash
- Pigmentation
- Changing Moles
- Calluses
- Eczema
- Psoriasis
- Dryness
- Oiliness
- Itching
- Acne
- Boils
- Hives
- Fungus on Nails
- Peeling Skin
- Cracking skin
- Shingles
- Nails Split
- White Spots/Lines on Nails
- Crawling Sensation
- Burning on Bottom of Feet
- Athletes Foot
- Cellulite
- Bugs love to bite you
- Have bumps on the back of arms and front of thighs
- Skin Cancer
- Strong body odor

### Is your skin sensitive to the:

- Sun
- Fabrics \_\_\_\_\_
- Detergents \_\_\_\_\_

### HEAD:

- Poor Concentration
- Confusion
- Headaches:

- After Meals
- Severe
- Migraine
- Frontal
- Afternoon
- Occipital
- Afternoon
- Daytime
- Relieved by:
- Eating Sweets
- Concussion/Whiplash
- Mental Sluggishness
- Forgetfulness
- Indecisive
- Face Twitch
- Poor Memory
- Hair Loss

### EYES:

- Sand in Eyes
- Double Vision
- Blurred Vision
- Poor Night Vision
- Bright Flashes
- Halo around Lights
- Eye Pains
- Dark Circles under Eyes
- Strong Light Irritates
- Cataracts
- Floaters in Eyes
- Visual hallucinations

### EARS:

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

### NOSE/SINUSES

- Stuffy
- Bleeding
- Running
- Discharge
- Watery Nose
- Congested
- Infection
- Polyps
- Acute smell
- Drainage

- Sneezing spells
- Post nasal drip
- No sense of smell
- Do the change of seasons tend to make your symptoms worse? Yes/No

**If yes, is it worse in the:**

- Spring
- Summer
- Fall
- Winter

***MOUTH:***

- Coated Tongue
- Sore Tongue
- Teeth Problems
- Bleeding Gums
- Canker Sores
- TMJ
- Cracked lips/ corners
- Chapped lips
- Fever blisters
- Wear dentures
- Grind teeth when sleeping
- Bad breath
- Dry mouth

***THROAT:***

- Mucus
- Difficulty Swallowing
- Frequent Hoarseness
- Tonsillitis
- Enlarged Glands
- Constant clearing of throat
- Throat closes up

***NECK:***

- Stiffness
- Swelling
- Lumps
- Neck glands swell

***CIRCULATION/RESPIRATION:***

- Swollen Ankles
- Sensitive to Hot
- Sensitive to Cold
- Extremities Cold or Clammy
- Hands/Feet go to sleep/numb
- High Blood Pressure
- Chest Pain
- Pain between shoulders
- Dizziness upon standing
- Fainting Spells
- High Cholesterol
- High Triglycerides
- Wheezing
- Irregular Heartbeat
- Palpitations
- Low exercise tolerance
- Frequent coughs
- Breathing heavily
- Frequently Sighing
- Shortness of breath

- Night Sweats
- Varicose Veins
- Mitral valve prolapse
- Murmurs
- Skipped heartbeat
- Heart enlargement
- Angina pain
- Bronchitis/Pneumonia
- Emphysema
- Croup
- Frequent colds
- Heavy/tight chest
- Past Heart Attack ?? When \_\_\_\_\_
- Phlebitis
- Spider Veins

***GASTROINTESTINAL/DIGESTION***

- Peptic/Duodenal Ulcer
- Poor Appetite
- Excessive Appetite
- Gallstones
- Gallbladder pain
- Nervous Stomach
- Full Feeling after meal
- Indigestion
- Heartburn
- Acid Reflux
- Hiatal Hernia
- Nausea
- Vomiting
- Vomiting Blood
- Abdominal Pains/Cramps
- Gas
- Diarrhea
- Constipation
- Changes in Bowels
- Rectal Bleeding
- Tarry Stools
- Rectal Itching
- Use laxatives
- Bloating
- Belch frequently
- Anal itching
- Anal fissures
- Bloody stools
- Undigested food in stools

***KIDNEY/URINARY TRACT:***

- Burning
- Frequent Urination
- Blood in Urine
- Night time Urination
- Problem Passing Urine
- Kidney Pain
- Kidney Stones
- Painful Urination
- Bladder infections
- Kidney infections
- Syphilis
- Bedwetting
- Have trichomonas

### **WOMEN'S HISTORY (for women only)**

- Fibrocystic Breasts
- Lumps in breast
- Fibroid Tumors/Breast
- Spotting
- Heavy Periods
- Fibroid Tumors/Uterus
- Painful periods
- Change in period
- Breast soreness before period
- Endometriosis
- Non-period bleeding
- Breast soreness during period
- Vaginal Dryness
- Vaginal discharge
- Had partial/total hysterectomy
- Hot Flashes
- Mood Swings
- Concentration/Memory Problems
- Breast cancer
- Ovarian cysts
- Pregnant
- Infertility
- Decreased Libido
- Heavy Bleeding
- Joint Pains
- Headaches
- Weight Gain
- Loss of Control of Urine
- Palpitations

### **MEN'S HISTORY (for men only)**

Have you had a PSA done?

Yes \_\_\_\_\_ No \_\_\_\_\_

PSA Level:

- 0 – 2
- 2 – 4
- 4 – 10
- >10
- Prostate enlargement
- Prostate infection
- Change in libido
- Impotence
- Diminished libido
- Poor libido
- Infertility
- Lumps in testicles
- Sore on penis
- Genital pain
- Hernia
- Prostate cancer
- Low sperm count
- Difficulty Obtaining Erection
- Difficulty Maintaining an Erection
- Nocturia (urination at night)
- How many times at night? \_\_\_\_\_
- Urgency/Hesitancy/Change in Urinary Stream
- Loss of Control of Urine

### **JOINT/MUSCLES/TENDONS**

- Pain wakes me up
- Weakness in Legs and arms
- Balance problems
- Muscle cramping
- Head injury
- Muscle Stiffness in Morning
- Damp weather bothers you

### **EMOTIONAL:**

- Convulsions
- Dizziness
- Fainting Spells
- Blackouts
- Amnesia
- Had shock therapy
- Frequently keyed up and jittery
- Shaky
- Startled by sudden noises
- Often feel suddenly scared
- Go to pieces easily
- Forgetful
- Listless
- Withdrawn feeling
- Feel "lost" in time
- Had nervous breakdown
- Had "burnout"
- Feel groggy
- Unable to concentrate
- Short attention span
- Vision changes
- Unable to reason
- Considered a nervous person
- Worried over little things
- Anxiety
- Unusual tension
- Frustration
- Numbness
- Often break out in cold sweats
- Profuse sweating
- Depressed
- Been admitted for psychiatric care
- Often awakened by frightening dreams
- Family member had nervous breakdown
- Use tranquilizers
- Aggressive
- Misunderstood by others
- Irritable
- Easily flare in anger
- Feeling of hostility
- Fatigue
- Hyperactive
- Restless leg syndrome
- Considered clumsy
- Unable to coordinate muscles
- Have difficulty falling asleep
- Have difficulty staying asleep
- Daytime sleepiness
- Am a workaholic
- Have had hallucinations
- Have considered suicide

- Have overused alcohol
- Family history of overused alcohol
- Cry often
- Feel insecure
- Have overused drugs
- Been addicted to drugs
- Extremely shy

**DENTAL HISTORY**

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

Has ringing in the ears (tinnitus) been present? Yes \_\_\_\_ No \_\_\_\_

Have TMJ (temporal mandibular joint) problems been a concern? Yes \_\_\_\_ No \_\_\_\_

Do you often have a 'metallic' taste in your mouth? Yes \_\_\_\_ No \_\_\_\_

Do you have a lot of bad breath (halitosis) or white tongue (thrush)? Yes \_\_\_\_ No \_\_\_\_

Have you worn or do you presently wear braces? Yes \_\_\_\_ No \_\_\_\_

Do you have problems chewing? Yes \_\_\_\_ No \_\_\_\_

Do you floss regularly? Yes \_\_\_\_ No \_\_\_\_

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

Did you have fillings as a child? Yes \_\_\_\_ No \_\_\_\_

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

Did you have dental fillings as an adult? Yes \_\_\_\_ No \_\_\_\_

If yes, about how many fillings did you have after to 18 yrs? \_\_\_\_\_

How many amalgam fillings do you have now? \_\_\_\_\_

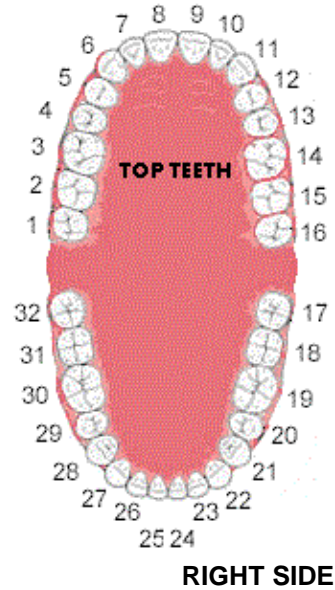
Did you play with mercury as a child or adult? Yes \_\_\_\_ No \_\_\_\_

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

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

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

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



**RECORD ANSWERS:**

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## MEDICATIONS & SUPPLEMENTS

### ANTIBIOTIC USE

**Antibiotics: How often have you taken antibiotics?**

	<b>&lt; 5 times</b>	<b>&gt; 5 times</b>
Infancy/Childhood		
Teen		
Adulthood		

### STEROID USE

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

	<b>&lt; 5 times</b>	<b>&gt; 5 times</b>
Infancy/Childhood		
Teen		
Adulthood		

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

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Acid Blocking Drugs</li> <li><input type="checkbox"/> Anti-anxiety medications</li> <li><input type="checkbox"/> Antibiotics</li> <li><input type="checkbox"/> Anticonvulsants</li> <li><input type="checkbox"/> Antidepressants</li> <li><input type="checkbox"/> Anti-fungals</li> <li><input type="checkbox"/> Aspirin/Ibuprofen</li> <li><input type="checkbox"/> Asthma inhalers</li> <li><input type="checkbox"/> Beta blockers</li> <li><input type="checkbox"/> Birth control pills/implant contraceptives</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Diuretics</li> <li><input type="checkbox"/> Estrogen or progesterone (pharmaceutical, prescription)</li> <li><input type="checkbox"/> Estrogen or progesterone (natural)</li> <li><input type="checkbox"/> Heart medications</li> <li><input type="checkbox"/> High blood pressure medications</li> <li><input type="checkbox"/> Laxatives</li> <li><input type="checkbox"/> Relaxants/Sleeping pills</li> <li><input type="checkbox"/> Testosterone (natural or prescription)</li> <li><input type="checkbox"/> Thyroid medication</li> </ul> |
|---|--|



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

Yes \_\_\_\_ No \_\_\_\_ If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<b>ALLERGIES</b>	
<b>Medication/Supplement/Food</b>	<b>Reaction</b>
_____	_____
_____	_____
_____	_____
_____	_____

## NUTRITION & LIFESTYLE HISTORY

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

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

*Check all that apply:*

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Low fat   | <input type="checkbox"/> Gluten restricted       | <input type="checkbox"/> The Zone Diet             |
| <input type="checkbox"/> Mixed food diet (animal and vegetable sources)          | <input type="checkbox"/> Low sodium              | <input type="checkbox"/> Total calorie restriction |
| <input type="checkbox"/> High protein  | <input type="checkbox"/> Fat restriction         | <input type="checkbox"/> Ovo-lacto diet            |
| <input type="checkbox"/> Vegetarian  | <input type="checkbox"/> Low starch/carbohydrate | <input type="checkbox"/> Diabetic                  |
| <input type="checkbox"/> Vegan   | <input type="checkbox"/> The Blood type Diet     | <input type="checkbox"/> No dairy                  |
| <input type="checkbox"/> Specific Program for Weight Loss/Maintenance Type:_____ | <input type="checkbox"/> Metabolic Typing Diet   | <input type="checkbox"/> No wheat                  |

**Please check any specific food restrictions you have:**

- |                                      |                                |                                     |
|--------------------------------------|--------------------------------|-------------------------------------|
| <input type="checkbox"/> Dairy       | <input type="checkbox"/> Wheat | <input type="checkbox"/> Eggs       |
| <input type="checkbox"/> Soy         | <input type="checkbox"/> Corn  | <input type="checkbox"/> All gluten |
| <input type="checkbox"/> Other _____ |                                |                                     |

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

\_\_\_\_\_

\_\_\_\_\_

Height (feet/inches)\_\_\_\_\_ Current Weight\_\_\_\_\_

Usual weight range +/- 5 lbs\_\_\_\_\_ Desired Weight range +/- 5 lbs\_\_\_\_\_

Highest adult weight \_\_\_\_\_ Lowest adult weight \_\_\_\_\_

Weight fluctuations (>10lbs) Yes\_\_\_\_ No \_\_\_\_ Body Fat % \_\_\_\_\_

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

Are there any foods that you avoid because they give you symptoms? Yes\_\_\_\_ No\_\_\_\_

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

Food	Symptom	Other comments

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

\_\_\_\_\_

\_\_\_\_\_

Do you grocery Shop? Yes \_\_\_\_ No \_\_\_\_ If no, who does the shopping? \_\_\_\_\_

When you shop do you purchase the following?

- |  |  |
|--|--|
| <input type="checkbox"/> Organic Foods | <input type="checkbox"/> Hormone free and antibiotic free meat |
|--|--|

Do you read food labels? Yes \_\_\_\_ No \_\_\_\_

Do you Cook? Yes \_\_\_\_ No \_\_\_\_ If no, who does the cooking? \_\_\_\_\_

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

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

- |  |   |
|--|---|
| <input type="checkbox"/> Fast eater            | <input type="checkbox"/> Significant other or family members have special dietary needs of food preferences |
| <input type="checkbox"/> Erratic eating habits |   |

- Eat too much
- Late night eater
- Dislike health food
- Time constraints
- Eat more than 50% of meals away from home
- Travel frequently
- Non-availability of 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
- Love to eat
- Eat because I have to
- Have a negative relationship to food
- Struggle with eating issues
- Emotional eater (eat when sad, lonely, depressed, bored)
- Eat too much under stress
- Eat too little under stress
- Don't care to cook
- Eating in the middle of the night
- Confused about nutritional advise
- Diet often for weight control

## FOOD DIARY

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

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

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

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Almonds                 | <input type="checkbox"/> Coconut              | <input type="checkbox"/> Milk, Soy            | <input type="checkbox"/> Soybean            |
| <input type="checkbox"/> Almond Butter           | <input type="checkbox"/> Cod                  | <input type="checkbox"/> Mexican Food         | <input type="checkbox"/> Spinach            |
| <input type="checkbox"/> Alcohol                 | <input type="checkbox"/> Coffee               | <input type="checkbox"/> Malt                 | <input type="checkbox"/> Strawberry         |
| <input type="checkbox"/> Apples                  | <input type="checkbox"/> Corn                 | <input type="checkbox"/> Nutmeg               | <input type="checkbox"/> Sucralose          |
| <input type="checkbox"/> Avocado                 | <input type="checkbox"/> Crab                 | <input type="checkbox"/> NutriSweet           | <input type="checkbox"/> Sugar              |
| <input type="checkbox"/> Asparagus               | <input type="checkbox"/> Cranberry            | <input type="checkbox"/> Oatmeal, Regular     | <input type="checkbox"/> Sunflower          |
| <input type="checkbox"/> Bagels                  | <input type="checkbox"/> Cashew               | <input type="checkbox"/> Oatmeal, Instant     | <input type="checkbox"/> Salad Bar          |
| <input type="checkbox"/> Barley                  | <input type="checkbox"/> Cheese               | <input type="checkbox"/> Olive                | <input type="checkbox"/> Sardines           |
| <input type="checkbox"/> Banana                  | <input type="checkbox"/> Cucumber             | <input type="checkbox"/> Onion                | <input type="checkbox"/> Squash             |
| <input type="checkbox"/> Burger King             | <input type="checkbox"/> Deli Meats           | <input type="checkbox"/> Orange Juice         | <input type="checkbox"/> Taco bell food     |
| <input type="checkbox"/> Bacon                   | <input type="checkbox"/> Desserts             | <input type="checkbox"/> Oregano              | <input type="checkbox"/> Tea, Black         |
| <input type="checkbox"/> Bean, Lima              | <input type="checkbox"/> Deli Sandwich        | <input type="checkbox"/> Oyster               | <input type="checkbox"/> Tea, Decaffeinated |
| <input type="checkbox"/> Bread, White            | <input type="checkbox"/> Eggplant             | <input type="checkbox"/> Orange               | <input type="checkbox"/> Thai food          |
| <input type="checkbox"/> Bread, Wheat            | <input type="checkbox"/> Ensure               | <input type="checkbox"/> Papaya               | <input type="checkbox"/> Tomato             |
| <input type="checkbox"/> Bread, Rye              | <input type="checkbox"/> Flounder             | <input type="checkbox"/> Parsley              | <input type="checkbox"/> Trout              |
| <input type="checkbox"/> Bagels                  | <input type="checkbox"/> Fried Foods          | <input type="checkbox"/> PopTarts             | <input type="checkbox"/> Tuna               |
| <input type="checkbox"/> Biscuits                | <input type="checkbox"/> French Fries         | <input type="checkbox"/> Peanuts              | <input type="checkbox"/> Turkey             |
| <input type="checkbox"/> Bean, Pinto             | <input type="checkbox"/> French Toast         | <input type="checkbox"/> Peanut butter        | <input type="checkbox"/> Tangerine          |
| <input type="checkbox"/> Bean, String            | <input type="checkbox"/> Garlic               | <input type="checkbox"/> Peas                 | <input type="checkbox"/> Vinegar            |
| <input type="checkbox"/> Broccoli                | <input type="checkbox"/> Ginger               | <input type="checkbox"/> Peach                | <input type="checkbox"/> Walnut             |
| <input type="checkbox"/> Brazil Nuts             | <input type="checkbox"/> Grape                | <input type="checkbox"/> Pecan                | <input type="checkbox"/> Waffles            |
| <input type="checkbox"/> Brussels Sprouts        | <input type="checkbox"/> Grits                | <input type="checkbox"/> Pepper               | <input type="checkbox"/> Whitefish          |
| <input type="checkbox"/> Blueberries             | <input type="checkbox"/> Greek Food           | <input type="checkbox"/> Pepper, Green        | <input type="checkbox"/> Wheat              |
| <input type="checkbox"/> Butter                  | <input type="checkbox"/> Grapefruit           | <input type="checkbox"/> Perch                | <input type="checkbox"/> Wendy's food       |
| <input type="checkbox"/> Cabbage                 | <input type="checkbox"/> Grape nuts           | <input type="checkbox"/> Pineapple            | <input type="checkbox"/> Yeast, Bakers      |
| <input type="checkbox"/> Cereal, Special K       | <input type="checkbox"/> Haddock              | <input type="checkbox"/> Pancakes             | <input type="checkbox"/> Yeast, Brewers     |
| <input type="checkbox"/> Cereal, Bran flakes     | <input type="checkbox"/> Ham                  | <input type="checkbox"/> Protein Shakes, Soy  | <input type="checkbox"/> Yogurt             |
| <input type="checkbox"/> Cereal, Cornflakes      | <input type="checkbox"/> Halibut              | <input type="checkbox"/> Protein Shakes, Milk | <input type="checkbox"/> Yam                |
| <input type="checkbox"/> Cereal,                 | <input type="checkbox"/> Herring              | <input type="checkbox"/> Protein Shakes, Whey | <input type="checkbox"/> Zucchini           |
| <input type="checkbox"/> Cereal,                 | <input type="checkbox"/> Hot Dogs, Pork       | <input type="checkbox"/> Protein Shakes,      |   |
| <input type="checkbox"/> Celery                  | <input type="checkbox"/> Hot Dogs, Beef       | <input type="checkbox"/> Protein Shakes,      |   |
| <input type="checkbox"/> Cantaloupe              | <input type="checkbox"/> Hamburgers           | <input type="checkbox"/> Protein Shakes,      |   |
| <input type="checkbox"/> Candy                   | <input type="checkbox"/> Hardies Food         | <input type="checkbox"/> Protein Shakes,      |   |
| <input type="checkbox"/> Chinese Food            | <input type="checkbox"/> Honey                | <input type="checkbox"/> Protein Shakes,      |   |
| <input type="checkbox"/> Cream Cheese            | <input type="checkbox"/> Italian Food         | <input type="checkbox"/> Plum                 |   |
| <input type="checkbox"/> Carrot                  | <input type="checkbox"/> Ice Cream            | <input type="checkbox"/> Pork                 |   |
| <input type="checkbox"/> Chicken                 | <input type="checkbox"/> Indian Food          | <input type="checkbox"/> Peanut               |   |
| <input type="checkbox"/> Chili Pepper            | <input type="checkbox"/> Jack in the box food | <input type="checkbox"/> Potato, sweet        |   |
| <input type="checkbox"/> Cinnamon                | <input type="checkbox"/> Japanese Food        | <input type="checkbox"/> Potato, White        |   |
| <input type="checkbox"/> Clam                    | <input type="checkbox"/> Jelly                | <input type="checkbox"/> Pumpkin              |   |
| <input type="checkbox"/> Cloves                  | <input type="checkbox"/> Ketchup              | <input type="checkbox"/> Quinoa               |   |
| <input type="checkbox"/> Cocoa-Chocolate         | <input type="checkbox"/> Lamb                 | <input type="checkbox"/> Radish               |   |
| <input type="checkbox"/> Carnation Drink         | <input type="checkbox"/> Lemon                | <input type="checkbox"/> Rye                  |   |
| <input type="checkbox"/> Chewing gum, sweetened  | <input type="checkbox"/> Lentil               | <input type="checkbox"/> Safflower            |   |
| <input type="checkbox"/> Chewing gum, sugar free | <input type="checkbox"/> Lettuce              | <input type="checkbox"/> Sage                 |   |
|  | <input type="checkbox"/> Lime                 | <input type="checkbox"/> Salt                 |   |
|  | <input type="checkbox"/> Lobster              | <input type="checkbox"/> Salmon               |   |
|  | <input type="checkbox"/> Mackerel             | <input type="checkbox"/> Scallops             |   |
|  | <input type="checkbox"/> Margarine            | <input type="checkbox"/> Sausage              |   |
|  | <input type="checkbox"/> McDonalds Food       | <input type="checkbox"/> Slim Fast            |   |
|  | <input type="checkbox"/> Millet               | <input type="checkbox"/> Sweet & Low          |   |
|  | <input type="checkbox"/> Mung Bean            | <input type="checkbox"/> Sesame               |   |
|  | <input type="checkbox"/> Mushroom             | <input type="checkbox"/> Shrimp               |   |
|  | <input type="checkbox"/> Mustard              | <input type="checkbox"/> Snapper              |   |
|  | <input type="checkbox"/> Milk, Cow            | <input type="checkbox"/> Soft Drinks          |   |
|  | <input type="checkbox"/> Milk, Goat           | <input type="checkbox"/> Sole                 |   |
|  | <input type="checkbox"/> Milk, Rice           | <input type="checkbox"/> Sour cream           |   |
|  | <input type="checkbox"/> Milk, Almond         |   |   |

**What snacks do you eat or drink between:**

Breakfast & Lunch: \_\_\_\_\_

Lunch & Dinner: \_\_\_\_\_

After Dinner: \_\_\_\_\_

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

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

**Water:** Glasses/day\_\_\_ **Type:** Tap:\_\_\_ Distilled:\_\_\_ Spring:\_\_\_ Well:\_\_\_ Reverse Osmosis:\_\_\_

Do you have symptoms **immediately after** eating, such as belching, bloating, sneezing, hives, etc.?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

If yes, are these symptoms associated with a particular food or supplement(s)? Yes \_\_\_\_\_ No \_\_\_\_\_

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

Food	Symptom	Other comments

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

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

- |  |  |
|--|--|
| <input type="checkbox"/> High fat foods                                    | <input type="checkbox"/> Refined sugar (junk food) |
| <input type="checkbox"/> High protein foods                                | <input type="checkbox"/> Fried foods               |
| <input type="checkbox"/> High carbohydrate foods (breads, pasta, potatoes) | <input type="checkbox"/> 1 or 2 alcoholic drinks   |
|  | <input type="checkbox"/> Other _____               |

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

- |  |  |
|--|--|
| <input type="checkbox"/> High fat foods                                    | <input type="checkbox"/> Refined sugar (junk food) |
| <input type="checkbox"/> High protein foods                                | <input type="checkbox"/> Fried foods               |
| <input type="checkbox"/> High carbohydrate foods (breads, pasta, potatoes) | <input type="checkbox"/> 1 or 2 alcoholic drinks   |
|  | <input type="checkbox"/> Other _____               |

Does skipping meals greatly affect your symptoms? Yes \_\_\_\_\_ No \_\_\_\_\_

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

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what food(s) \_\_\_\_\_

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Do you have an aversion to certain foods? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what food(s) \_\_\_\_\_

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

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### TOBACCO HISTORY

Currently using tobacco? Yes \_\_\_\_\_ No \_\_\_\_\_ How many years? \_\_\_\_\_ Packs per day: \_\_\_\_\_

If yes, what type? Cigarette \_\_\_\_\_ Smokeless \_\_\_\_\_ Cigar \_\_\_\_\_ Pipe \_\_\_\_\_ Patch/Gum \_\_\_\_\_

Attempts to quit: \_\_\_\_\_

Previous smoking: How many years? \_\_\_\_\_ Packs per day: \_\_\_\_\_

Are you exposed to 2<sup>nd</sup> hand smoke? If yes, please explain: \_\_\_\_\_

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### ALCOHOL INTAKE

How many drinks currently per week? *1 drink = 5 ounces wine, 12 oz. beer, 1.5 ounces spirits*

None \_\_\_\_\_ 1-3 \_\_\_\_\_ 4-6 \_\_\_\_\_ 7-10 \_\_\_\_\_ >10 \_\_\_\_\_ *If none skip to “Other Substances”*

Previous alcohol intake? Yes \_\_\_\_\_ (Mild \_\_\_\_\_ Moderate \_\_\_\_\_ High \_\_\_\_\_)

Have you ever been told to cut down your alcohol intake? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you get annoyed when people ask you about your drinking? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you ever feel guilty about your alcohol consumption? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you ever take an eye-opener? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you notice a tolerance to alcohol (can you “hold” more than others?) Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever been unable to remember what you did during a drinking episode? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you get into arguments or physical fights when you have been drinking? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever been arrested or hospitalized because of drinking? Yes \_\_\_\_\_ No \_\_\_\_\_

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

Was your mother an alcoholic? \_\_\_\_\_ Father? \_\_\_\_\_ Other family member? \_\_\_\_\_

## OTHER SUBSTANCES

Are you currently using recreational drugs? Yes\_\_\_\_ No\_\_\_\_

If yes, what types?: \_\_\_\_\_

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

If yes, what types?: \_\_\_\_\_

## EXERCISE

Current Exercise program: *Activity (list type, number of sessions/week, and duration of activity)*

Activity	Type	Frequency per week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength Training			
Other (Pilates, yoga, etc.)			
Sports or Leisure Activities (golf, tennis, rollerblading etc.)			

Rate your level of motivation for including exercise in your life?  Low  Medium  High

List problems that limit activity: \_\_\_\_\_

\_\_\_\_\_

Do you feel unusually fatigued after exercise? Yes \_\_\_\_ No \_\_\_\_

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

Do you usually sweat when exercising? Yes \_\_\_\_ No \_\_\_\_

## SOCIAL HISTORY

### PSYCHOSOCIAL

Do you feel significantly less vital than you did a year ago? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you happy? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you feel your life has meaning and purpose? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you believe stress is presently reducing the quality of your life? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you like the work you do? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you experienced major losses in your life? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you spend 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

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

Please do your best to answer the following questions:

Did you feel safe growing up? Yes \_\_\_\_\_ No \_\_\_\_\_

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

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

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

Have you ever sought counseling? Yes \_\_\_\_\_ No \_\_\_\_\_

Currently? Yes \_\_\_\_\_ No \_\_\_\_\_ Previously? Yes \_\_\_\_\_ No \_\_\_\_\_ If previously from \_\_\_\_\_ to \_\_\_\_\_

What kind? \_\_\_\_\_

Comments: \_\_\_\_\_

Do you feel you have an excessive amount of stress in your life? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you feel you can easily handle the stress in your life? Yes \_\_\_\_\_ No \_\_\_\_\_

Daily stressors: *Rate on a scale of 1 – 10 (1 not stressful - 10 very stressful)*

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

Hobbies and leisure activities: \_\_\_\_\_

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

a. \_\_\_\_\_ not at all important      b. \_\_\_\_\_ somewhat important      c. \_\_\_\_\_ extremely important

Have you ever been abused, a victim of a crime, or experienced a significant trauma?

Yes \_\_\_\_\_ No \_\_\_\_\_

How well have things been going for you?

	Very well	Fine	Poorly	Very poorly	Does not apply
At school					
In your job					
In your social life					
With close friends					
With sex					
With your attitude					
With your boyfriend/girlfriend					
With your children					
With your parents					
With your spouse					

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

- Spouse    Family    Friends    Religious/Spiritual    Pets    Other \_\_\_\_\_

## STRESS EVALUATION

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

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

Do you have chronic pain?       Yes     No

Do you have chronic inflammation?     Yes     No

## SOCIAL READJUSTMENT RATING SCALE\*

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

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

Revision of personal habits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	24
Trouble with boss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	23
Change in work hours, conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	20
Change in residence	<input type="checkbox"/> Yes	<input type="checkbox"/> No	20
Change in schools	<input type="checkbox"/> Yes	<input type="checkbox"/> No	20
Change in recreational habits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	19
Mortgage or loan under \$10,000	<input type="checkbox"/> Yes	<input type="checkbox"/> No	18
Change in sleeping habits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	16
Change in eating habits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	15
Vacation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	13
<b>TOTAL SCORE</b>			_____

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

## TOXIC STRESS TRIGGERS

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

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

### DO YOU WORRY OVER?

- Home life
- Marriage
- Children
- Job
- Income

### IS YOUR LIFE:

- Satisfactory
- Boring
- Demanding
- Unsatisfactory
- Money Problems

## SLEEP/REST

Average number of hours you sleep  >10  8 – 10  6 – 8  <6

Do you have trouble falling asleep? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you feel rested upon awakening? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have problems with insomnia? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you snore? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you use sleeping aids? Yes \_\_\_\_\_ No \_\_\_\_\_ Explain: \_\_\_\_\_

## ENVIRONMENTAL INFLUENCES

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

### Electromagnetic Factors

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

#### Position of your head of your bed is facing:

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

What is your occupation?

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### Toxin Exposure

#### Trichloroethylene/TCE

- Work close to a copy machine
- Worked in a printing shop
- Drink decaffeinated coffee
- Use typewriter correction fluid

- Use rug cleaners
- Use disinfectants
- Use carbonless paper
- Use spot removers
- Use cleaning supplies
- Use metal degreasers
- Do recreational painting

#### Formaldehyde

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

## Pesticides & Herbicides

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

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

## Volatile Organic Compounds

### (Paradichlorobenzenes, toluene, ethers, ketones, propane, polymers, tetrachloroethylene)

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

## Phenols

Do you use the following?

- Household cleaners
- Nasal Sprays
- Styrofoam cups
- Cough Syrup
- Decongestants
- Hair sprays
- Scented deodorants

- Scotch tape
- Newsprint
- Lysol
- Epoxy
- Listerine
- Chloraseptic throat sprays
- Noxema
- Mildew cleaners
- Perfumes
- Air Fresheners
- Disinfectants
- Polishes
- Glues
- Waxes
- Mouthwash
- Hard saucepan handles
- Smoke in the house
- Have you been exposed to chemicals?  
When? \_\_\_\_\_
- Have you had your home treated for termites  
When? \_\_\_\_\_
- Wash own vehicle by hand.  
What type of cleaners do you use? \_\_\_\_\_

## Carbon Monoxide/Nitrogen Oxide/Sulfur Dioxide

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

## Ozone

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

## Carbon Dioxide

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

## Asbestos

- Live in an old home

- Have old ceiling tiles, plaster, insulation board and heating duct tape
- Lived in a large city with many trucks, buses etc.
- Lived near a building which was torn down
- Mother exposed to any unusual chemicals or drugs during pregnancy (DES)
- Do you have your nails treated? Acrylic Adhesives

**Please note the “brand” of product you use**

**For example: Toothpaste: Crest**

Shampoo: \_\_\_\_\_

Toothpaste: \_\_\_\_\_

Hair Conditioner: \_\_\_\_\_

Makeup: \_\_\_\_\_

Lipstick: \_\_\_\_\_

Make-up Foundation: \_\_\_\_\_

Deodorant: \_\_\_\_\_

Perfume: \_\_\_\_\_

Hairspray: \_\_\_\_\_

Shaving Cream: \_\_\_\_\_

Cologne: \_\_\_\_\_

Facial Creams: \_\_\_\_\_

Body Creams: \_\_\_\_\_

Do you have hair permanents? O Yes O No  
If yes, how often? \_\_\_\_\_

Do you have hair colorings? O Yes O No  
If yes, was it permanent or temporary?

**Do you use Latex products?**

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

**General Miscellaneous**

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

- Use black hair dye (Nitrosamines)
- Worked in beauty shop.  
When? \_\_\_\_\_
- Take any illicit drugs as an adolescent/young adult?  
What type? \_\_\_\_\_
- Open your windows at home
- Work in a machine shop
- Work in a garden?
- Work or have you worked on a farm  
When? \_\_\_\_\_
- Have mercury fillings
- Had mercury fillings removed?  
When? \_\_\_\_\_
- Been exposed to radiation  
When? \_\_\_\_\_
- Have a hot tub
- Use chlorine or bromine
- Have a well
- Work around PVC pipe (Vinyl chloride)
- Home well ventilated
- Moved to a new office in the last two years
- Live in an apartment?  
How old? \_\_\_\_\_
- Eat at salad bars
- Eat raw fish (Sushi)
- Buy food from street vendors
- For Women:** Have breast implants. The implant was made of saline \_\_\_ silicone\_\_\_
- Has any type of metal been used in implants or joint replacements in your body?  
What type? \_\_\_\_\_  
Where \_\_\_\_\_
- Notice more symptoms at work than at home or vice versa?
- Symptoms worse going into a mall
- Have you ever worked in a mall?  
When? \_\_\_\_\_
- Have live plants in your home
- Have pets in your home
- Owned a new vehicle since your symptoms began
- Furniture been put in storage or possibly fumigated
- Stained furniture in the last 2 years
- Have a tool shop in your garage
- Live on or near a golf course
- Live in or near an industrial area

- Lived or traveled outside the US.  
Where? \_\_\_\_\_
- Bought new furniture?  
What type of material? \_\_\_\_\_
- Installed drop ceilings
- Painted indoors
- Sided your home
- Changed your heating system, stove, clothes dryer  
or water heater
- Lived in a brand new home
- Lived in a new office
- Noticed changes of your health since you moved into  
your home?
- Have a water purification system?
- Live near a landfill?
- Have a water filter on your shower?

**Describe the contents of your bedroom**

- What type of mattress? \_\_\_\_\_
- Have hardwood floors
- Have carpeting
- Have blinds
- Have draperies
- Use a foam pillow
- Use a feather pillow
- Use a Dacron pillow
- Use wool blankets
- Use cotton blankets
- Use quilts
- Use synthetic blankets
- Use an electric blanket
- Have a ceiling fan
- Have material under your bed
- Have real plants in your bedroom

- Have artificial plants in your bedroom
- Use aromatherapy in your bedroom
- Burn scented candles in your bedroom
- Have central heat
- Have a fireplace in your room
- Have an electric baseboard
- Use gas heat
- Use an air filter in your bedroom  
What type? \_\_\_\_\_
- When was the last time you changed your filter in  
your room? \_\_\_\_\_
- Have central air conditioning
- Sleep with your windows open
- Live close to a high traffic road
- Smoke in bed
- Allow any pets in your room  
What type? \_\_\_\_\_
- Have plugged in air fresheners

**Art and Leisure Activities**

- Silk-screening
- Make stained glass
- Make pottery & ceramic products
- Make jewelry
- Buy art and craft supplies
- Use airbrush and spray paints
- Do quilting and weaving
- Gardening
- Make soapstone carvings
- Use acrylic paint

**What hobbies do you have? Please list:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Please indicate the occupation of your parents during your childhood:**

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## 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 – 5 \_\_\_\_\_ 4 \_\_\_\_\_ 3 \_\_\_\_\_ 2 \_\_\_\_\_ 1 \_\_\_\_\_

Take several nutritional supplements each day– 5 \_\_\_\_\_ 4 \_\_\_\_\_ 3 \_\_\_\_\_ 2 \_\_\_\_\_ 1 \_\_\_\_\_

Keep a record of everything you eat each day – 5 \_\_\_\_\_ 4 \_\_\_\_\_ 3 \_\_\_\_\_ 2 \_\_\_\_\_ 1 \_\_\_\_\_

Modify your lifestyle (e.g. work demands, sleep habits) – 5 \_\_\_\_\_ 4 \_\_\_\_\_ 3 \_\_\_\_\_ 2 \_\_\_\_\_ 1 \_\_\_\_\_

Practice relaxation techniques – 5 \_\_\_\_\_ 4 \_\_\_\_\_ 3 \_\_\_\_\_ 2 \_\_\_\_\_ 1 \_\_\_\_\_

Engage in regular exercise – 5 \_\_\_\_\_ 4 \_\_\_\_\_ 3 \_\_\_\_\_ 2 \_\_\_\_\_ 1 \_\_\_\_\_

Have periodic lab tests to assess progress – 5 \_\_\_\_\_ 4 \_\_\_\_\_ 3 \_\_\_\_\_ 2 \_\_\_\_\_ 1 \_\_\_\_\_

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

How confident are you of your ability to organize and follow through on the 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 fully engage in the above activities? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Rate on a scale of: 5 (very supportive) to 1 (not supportive at all).

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? – 5 \_\_\_\_\_ 4 \_\_\_\_\_ 3 \_\_\_\_\_ 2 \_\_\_\_\_ 1 \_\_\_\_\_

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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

5 \_\_\_\_\_ 4 \_\_\_\_\_ 3 \_\_\_\_\_ 2 \_\_\_\_\_ 1 \_\_\_\_\_

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Thank you for taking the time to complete this health history medical questionnaire.

The information derived from all of these medical forms will provide invaluable data.

Each section builds upon the other, allowing me and other physicians the opportunity to discover the “**missing key**” that will solve your health problem.

Once all the sections of this form and the questionnaires have been filled out please return them to our office and we'll make an appointment for our initial consultation.

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

Sincerely,

Robert F. Cowan DC CAP DACBN



**Section 2**

68

- |             |  |             |  |
|-------------|--|-------------|--|
| 71. 0 1 2 3 | Pain between shoulder blades   | 85. 0 1     | Easily hung over if you were to drink wine (0=no, 1=yes)       |
| 72. 0 1 2 3 | Stomach upset by greasy foods  | 86. 0 1 2 3 | Alcohol per week (0=<3, 1=<7, 2 =<14, 3=>14)                   |
| 73. 0 1 2 3 | Greasy or shiny stools   | 87. 0 1     | Recovering alcoholic (0=no, 1=yes)                             |
| 74. 0 1 2 3 | Nausea   | 88. 0 1     | History of drug or alcohol abuse (0=no, 1=yes)                 |
| 75. 0 1 2 3 | Sea, car, airplane or motion sickness  | 89. 0 1     | History of hepatitis (0=no, 1=yes)                             |
| 76. 0 1     | History of morning sickness (0 = no, 1 = yes)  | 90. 0 1     | Long term use of prescription/recreational drugs (0=no, 1=yes) |
| 77. 0 1 2 3 | Light or clay colored stools   | 91. 0 1 2 3 | Sensitive to chemicals (perfume, cleaning agents, etc.)        |
| 78. 0 1 2 3 | Dry skin, itchy feet or skin peels on feet   | 92. 0 1 2 3 | Sensitive to tobacco smoke                                     |
| 79. 0 1 2 3 | Headache over eyes   | 93. 0 1 2 3 | Exposure to diesel fumes                                       |
| 80. 0 1 2 3 | Gallbladder attacks (0=never, 1=years ago, 2=within last year, 3=within past 3 months) | 94. 0 1 2 3 | Pain under right side of rib cage                              |
| 81. 0 1     | Gallbladder removed (0=no, 1=yes)  | 95. 0 1 2 3 | Hemorrhoids or varicose veins                                  |
| 82. 0 1 2 3 | Bitter taste in mouth, especially after meals  | 96. 0 1 2 3 | Nutrasweet (aspartame) consumption                             |
| 83. 0 1     | Become sick if you were to drink wine (0=no, 1=yes)                                    | 97. 0 1 2 3 | Sensitive to Nutrasweet (aspartame)                            |
| 84. 0 1     | Easily intoxicated if you were to drink wine (0=no, 1=yes)                             | 98. 0 1 2 3 | Chronic fatigue or Fibromyalgia                                |

**Section 3**

47

- |              |  |              |   |
|--------------|--|--------------|---|
| 99. 0 1 2 3  | Food allergies   | 108. 0 1 2 3 | Crohn's disease (0 =no, 1=yes in the past, 2=currenty mild condition, 3=severe) |
| 100. 0 1 2 3 | Abdominal bloating 1 to 2 hours after eating           | 109. 0 1 2 3 | Wheat or grain sensitivity  |
| 101. 0 1     | Specific foods make you tired or bloated (0=no, 1=yes) | 110. 0 1 2 3 | Dairy sensitivity   |
| 102. 0 1 2 3 | Pulse speeds after eating                              | 111. 0 1     | Are there foods you could not give up (0=no, 1=yes)                             |
| 103. 0 1 2 3 | Airborne allergies                                     | 112. 0 1 2 3 | Asthma, sinus infections, stuffy nose   |
| 104. 0 1 2 3 | Experience hives                                       | 113. 0 1 2 3 | Bizarre vivid dreams, nightmares  |
| 105. 0 1 2 3 | Sinus congestion, "stuffy head"                        | 114. 0 1 2 3 | Use over-the-counter pain medications   |
| 106. 0 1 2 3 | Crave bread or noodles                                 | 115. 0 1 2 3 | Feel spacey or unreal   |
| 107. 0 1 2 3 | Alternating constipation and diarrhea                  |              |   |

**Section 4**

58

- |              |   |              |  |
|--------------|---|--------------|--|
| 116. 0 1 2 3 | Anus itches   | 126. 0 1 2 3 | Stools have corners or edges, are flat or ribbon shaped        |
| 117. 0 1 2 3 | Coated tongue   | 127. 0 1 2 3 | Stools are not well formed (loose)                             |
| 118. 0 1 2 3 | Feel worse in moldy or musty place  | 128. 0 1 2 3 | Irritable bowel or mucus colitis                               |
| 119. 0 1 2 3 | Taken antibiotic for a total accumulated time of (0=never, 1= <1 month, 2= <3 months, 3= >3 months) | 129. 0 1 2 3 | Blood in stool   |
| 120. 0 1 2 3 | Fungus or yeast infections  | 130. 0 1 2 3 | Mucus in stool   |
| 121. 0 1 2 3 | Ring worm, "jock itch", "athletes foot", nail fungus  | 131. 0 1 2 3 | Excessive foul smelling lower bowel gas                        |
| 122. 0 1 2 3 | Yeast symptoms increase with sugar, starch or alcohol   | 132. 0 1 2 3 | Bad breath or strong body odors                                |
| 123. 0 1 2 3 | Stools hard or difficult to pass  | 133. 0 1 2 3 | Painful to press along outer sides of thighs (Iliotibial Band) |
| 124. 0 1     | History of parasites (0=no, 1=yes)  | 134. 0 1 2 3 | Cramping in lower abdominal region                             |
| 125. 0 1 2 3 | Less than one bowel movement per day  | 135. 0 1 2 3 | Dark circles under eyes  |

**Section 5**

75

- |              |  |              |                                     |
|--------------|--|--------------|-------------------------------------|
| 136. 0 1     | History of carpal tunnel syndrome (0=no, 1=yes)                                  | 150. 0 1     | History of bone spurs (0=no, 1=yes) |
| 137. 0 1     | History of lower right abdominal pains or ileocecal valve problems (0=no, 1=yes) | 151. 0 1 2 3 | Morning stiffness                   |
| 138. 0 1     | History of stress fracture (0=no, 1=yes)   | 152. 0 1 2 3 | Nausea with vomiting                |
| 139. 0 1 2 3 | Bone loss (reduced density on bone scan)   | 153. 0 1 2 3 | Crave chocolate                     |
| 140. 0 1     | Are you shorter than you used to be? (0=no, 1=yes)                               | 154. 0 1 2 3 | Feet have a strong odor             |
| 141. 0 1 2 3 | Calf, foot or toe cramps at rest   | 155. 0 1 2 3 | History of anemia                   |
| 142. 0 1 2 3 | Cold sores, fever blisters or herpes lesions                                     | 156. 0 1 2 3 | Whites of eyes (sclera) blue tinted |
| 143. 0 1 2 3 | Frequent fevers  | 157. 0 1 2 3 | Hoarseness                          |
| 144. 0 1 2 3 | Frequent skin rashes and/or hives  | 158. 0 1 2 3 | Difficulty swallowing               |
| 145. 0 1     | Herniated disc (0=no, 1=yes)   | 159. 0 1 2 3 | Lump in throat                      |
| 146. 0 1 2 3 | Excessively flexible joints, "double jointed"                                    | 160. 0 1 2 3 | Dry mouth, eyes and/or nose         |
| 147. 0 1 2 3 | Joints pop or click  | 161. 0 1 2 3 | Gag easily                          |
| 148. 0 1 2 3 | Pain or swelling in joints   | 162. 0 1 2 3 | White spots on fingernails          |
| 149. 0 1 2 3 | Bursitis or tendonitis   | 163. 0 1 2 3 | Cuts heal slowly and/or scar easily |
|              |  | 164. 0 1 2 3 | Decreased sense of taste or smell   |

KEY: 0=No, symptom does not occur	2=Moderate symptom, occurs occasionally (weekly)
1=Yes, minor or mild symptom, rarely occurs (monthly)	3=Severe symptom, occurs frequently (daily)

**Section 6**

22

- |              |  |              |  |
|--------------|--|--------------|--|
| 165. 0 1     | Experience pain relief with aspirin (0=no, 1=yes)                                | 169. 0 1 2 3 | Headaches when out in the hot sun      |
| 166. 0 1 2 3 | Crave fatty or greasy foods  | 170. 0 1 2 3 | Sunburn easily or suffer sun poisoning |
| 167. 0 1 2 3 | Low- or reduced-fat diet (0=never, 1=years ago, 2=within past year, 3=currently) | 171. 0 1 2 3 | Muscles easily fatigued                |
| 168. 0 1 2 3 | Tension headaches at base of skull   | 172. 0 1 2 3 | Dry flaky skin or dandruff             |

**Section 7**

39

- |              |  |              |  |
|--------------|--|--------------|--|
| 173. 0 1 2 3 | Awaken a few hours after falling asleep, hard to get back to sleep | 180. 0 1 2 3 | Headache if meals are skipped or delayed                                 |
| 174. 0 1 2 3 | Crave sweets   | 181. 0 1 2 3 | Irritable before meals   |
| 175. 0 1 2 3 | Binge or uncontrolled eating                                       | 182. 0 1 2 3 | Shaky if meals delayed   |
| 176. 0 1 2 3 | Excessive appetite   | 183. 0 1 2 3 | Family members with diabetes (0=none, 1=1 or 2, 2=3 or 4, 3=more than 4) |
| 177. 0 1 2 3 | Crave coffee or sugar in the afternoon                             | 184. 0 1 2 3 | Frequent thirst  |
| 178. 0 1 2 3 | Sleepy in afternoon  | 185. 0 1 2 3 | Frequent urination   |
| 179. 0 1 2 3 | Fatigue that is relieved by eating                                 |              |  |

**Section 8**

81

- |              |   |              |  |
|--------------|---|--------------|--|
| 186. 0 1 2 3 | Muscles become easily fatigued                  | 200. 0 1 2 3 | Can hear heart beat on pillow at night       |
| 187. 0 1 2 3 | Feel exhausted or sore after moderate exercise  | 201. 0 1 2 3 | Whole body or limb jerk as falling asleep    |
| 188. 0 1 2 3 | Vulnerable to insect bites                      | 202. 0 1 2 3 | Night sweats                                 |
| 189. 0 1 2 3 | Loss of muscle tone, heaviness in arms/legs     | 203. 0 1 2 3 | Restless leg syndrome                        |
| 190. 0 1 2 3 | Enlarged heart or congestive heart failure      | 204. 0 1 2 3 | Cracks at corner of mouth (Cheilosis)        |
| 191. 0 1 2 3 | Pulse below 65 per minute (0=no, 1=yes)         | 205. 0 1 2 3 | Fragile skin, easily chaffed, as in shaving  |
| 192. 0 1 2 3 | Ringing in the ears (Tinnitus)                  | 206. 0 1 2 3 | Polyps or warts                              |
| 193. 0 1 2 3 | Numbness, tingling or itching in hands and feet | 207. 0 1 2 3 | MSG sensitivity                              |
| 194. 0 1 2 3 | Depressed                                       | 208. 0 1 2 3 | Wake up without remembering dreams           |
| 195. 0 1 2 3 | Fear of impending doom                          | 209. 0 1 2 3 | Small bumps on back of arms                  |
| 196. 0 1 2 3 | Worrier, apprehensive, anxious                  | 210. 0 1 2 3 | Strong light at night irritates eyes         |
| 197. 0 1 2 3 | Nervous or agitated                             | 211. 0 1 2 3 | Nose bleeds and/or tend to bruise easily     |
| 198. 0 1 2 3 | Feelings of insecurity                          | 212. 0 1 2 3 | Bleeding gums especially when brushing teeth |
| 199. 0 1 2 3 | Heart races                                     |              |  |

**Section 9**

78

- |              |  |              |  |
|--------------|--|--------------|--|
| 213. 0 1 2 3 | Tend to be a "night person"                    | 226. 0 1 2 3 | Arthritic tendencies                         |
| 214. 0 1 2 3 | Difficulty falling asleep                      | 227. 0 1 2 3 | Crave salty foods                            |
| 215. 0 1 2 3 | Slow starter in the morning                    | 228. 0 1 2 3 | Salt foods before tasting                    |
| 216. 0 1 2 3 | Tend to be keyed up, trouble calming down      | 229. 0 1 2 3 | Perspire easily                              |
| 217. 0 1 2 3 | Blood pressure above 120/80                    | 230. 0 1 2 3 | Chronic fatigue, or get drowsy often         |
| 218. 0 1 2 3 | Headache after exercising                      | 231. 0 1 2 3 | Afternoon yawning                            |
| 219. 0 1 2 3 | Feeling wired or jittery after drinking coffee | 232. 0 1 2 3 | Afternoon headache                           |
| 220. 0 1 2 3 | Clench or grind teeth                          | 233. 0 1 2 3 | Asthma, wheezing or difficulty breathing     |
| 221. 0 1 2 3 | Calm on the outside, troubled on the inside    | 234. 0 1 2 3 | Pain on the medial or inner side of the knee |
| 222. 0 1 2 3 | Chronic low back pain, worse with fatigue      | 235. 0 1 2 3 | Tendency to sprain ankles or "shin splints"  |
| 223. 0 1 2 3 | Become dizzy when standing up suddenly         | 236. 0 1 2 3 | Tendency to need sunglasses                  |
| 224. 0 1 2 3 | Difficulty maintaining manipulative correction | 237. 0 1 2 3 | Allergies and/or hives                       |
| 225. 0 1 2 3 | Pain after manipulative correction             | 238. 0 1 2 3 | Weakness, dizziness                          |

**Section 10**

29

- |              |   |              |   |
|--------------|---|--------------|---|
| 239. 0 1     | Height over 6' 6" (0=no, 1=yes)                           | 245. 0 1     | Height under 4' 10" (0=no, 1=yes)                       |
| 240. 0 1     | Early sexual development (before age 10) (0=no, 1=yes)    | 246. 0 1 2 3 | Decreased libido  |
| 241. 0 1 2 3 | Increased libido  | 247. 0 1 2 3 | Excessive thirst  |
| 242. 0 1 2 3 | Splinting type headache                                   | 248. 0 1 2 3 | Weight gain around hips or waist                        |
| 243. 0 1 2 3 | Memory failing  | 249. 0 1 2 3 | Menstrual disorders                                     |
| 244. 0 1     | Tolerate sugar, feel fine when eating sugar (0=no, 1=yes) | 250. 0 1     | Delayed sexual development (after age 13) (0=no, 1=yes) |
|              |   | 251. 0 1 2 3 | Tendency to ulcers or colitis                           |

KEY: 0=No, symptom does not occur	2=Moderate symptom, occurs occasionally (weekly)
1=Yes, minor or mild symptom, rarely occurs (monthly)	3=Severe symptom, occurs frequently (daily)

**Section 11**

48

- |      |         |   |      |         |   |
|------|---------|---|------|---------|---|
| 252. | 0 1 2 3 | Sensitive/allergic to iodine                        | 260. | 0 1 2 3 | Mentally sluggish, reduced initiative                     |
| 253. | 0 1 2 3 | Difficulty gaining weight, even with large appetite | 261. | 0 1 2 3 | Easily fatigued, sleepy during the day                    |
| 254. | 0 1 2 3 | Nervous, emotional, can't work under pressure       | 262. | 0 1 2 3 | Sensitive to cold, poor circulation (cold hands and feet) |
| 255. | 0 1 2 3 | Inward trembling                                    | 263. | 0 1 2 3 | Constipation, chronic                                     |
| 256. | 0 1 2 3 | Flush easily  | 264. | 0 1 2 3 | Excessive hair loss and/or coarse hair                    |
| 257. | 0 1 2 3 | Fast pulse at rest                                  | 265. | 0 1 2 3 | Morning headaches, wear off during the day                |
| 258. | 0 1 2 3 | Intolerance to high temperatures                    | 266. | 0 1 2 3 | Loss of lateral 1/3 of eyebrow                            |
| 259. | 0 1 2 3 | Difficulty losing weight                            | 267. | 0 1 2 3 | Seasonal sadness  |

**Section 12 – Men Only**

27

- |      |         |  |      |         |   |
|------|---------|--|------|---------|---|
| 268. | 0 1 2 3 | Prostate problems                        | 272. | 0 1 2 3 | Waking to urinate at night              |
| 269. | 0 1 2 3 | Difficulty with urination, dribbling     | 273. | 0 1 2 3 | Interruption of stream during urination |
| 270. | 0 1 2 3 | Difficult to start and stop urine stream | 274. | 0 1 2 3 | Pain on inside of legs or heels         |
| 271. | 0 1 2 3 | Pain or burning with urination           | 275. | 0 1 2 3 | Feeling of incomplete bowel evacuation  |
|      |         |  | 276. | 0 1 2 3 | Decreased sexual function               |

**Section 13 – Women Only**

60

- |      |         |   |      |         |  |
|------|---------|---|------|---------|--|
| 277. | 0 1 2 3 | Depression during periods                 | 287. | 0 1 2 3 | Breast fibroids, benign masses               |
| 278. | 0 1 2 3 | Mood swings associated with periods (PMS) | 288. | 0 1 2 3 | Painful intercourse (dysparenia)             |
| 279. | 0 1 2 3 | Crave chocolate around periods            | 289. | 0 1 2 3 | Vaginal discharge                            |
| 280. | 0 1 2 3 | Breast tenderness associated with cycle   | 290. | 0 1 2 3 | Vaginal dryness                              |
| 281. | 0 1 2 3 | Excessive menstrual flow                  | 291. | 0 1 2 3 | Vaginal itchiness                            |
| 282. | 0 1 2 3 | Scanty blood flow during periods          | 292. | 0 1 2 3 | Gain weight around hips, thighs and buttocks |
| 283. | 0 1 2 3 | Occasional skipped periods                | 293. | 0 1 2 3 | Excess facial or body hair                   |
| 284. | 0 1 2 3 | Variations in menstrual cycles            | 294. | 0 1 2 3 | Hot flashes                                  |
| 285. | 0 1 2 3 | Endometriosis                             | 295. | 0 1 2 3 | Night sweats (in menopausal females)         |
| 286. | 0 1 2 3 | Uterine fibroids                          | 296. | 0 1 2 3 | Thinning skin                                |

**Section 14**

30

- |      |         |  |      |         |  |
|------|---------|--|------|---------|--|
| 297. | 0 1 2 3 | Aware of heavy and/or irregular breathing  | 302. | 0 1 2 3 | Ankles swell, especially at end of day   |
| 298. | 0 1 2 3 | Discomfort at high altitudes               | 303. | 0 1 2 3 | Cough at night   |
| 299. | 0 1 2 3 | "Air hunger" or sigh frequently            | 304. | 0 1 2 3 | Blush or face turns red for no reason  |
| 300. | 0 1 2 3 | Compelled to open windows in a closed room | 305. | 0 1 2 3 | Dull pain or tightness in chest and/or radiate into right arm, worse with exertion |
| 301. | 0 1 2 3 | Shortness of breath with moderate exertion | 306. | 0 1 2 3 | Muscle cramps with exertion  |

**Section 15**

13

- |      |         |  |      |         |                                  |
|------|---------|--|------|---------|----------------------------------|
| 307. | 0 1 2 3 | Pain in mid-back region                        | 310. | 0 1 2 3 | Cloudy, bloody or darkened urine |
| 308. | 0 1 2 3 | Puffy around the eyes, dark circles under eyes | 311. | 0 1 2 3 | Urine has a strong odor          |
| 309. | 0 1     | History of kidney stones (0=no, 1=yes)         |      |         |                                  |

**Section 16**

30

- |      |         |   |      |         |  |
|------|---------|---|------|---------|--|
| 312. | 0 1 2 3 | Runny or drippy nose  | 317. | 0 1 2 3 | Never get sick (0 = sick only 1 or 2 times in last 2 years, 1 = not sick in last 2 years, 2 = not sick in last 4 years, 3 = not sick in last 7 years)  |
| 313. | 0 1 2 3 | Catch colds at the beginning of winter  | 318. | 0 1 2 3 | Acne (adult)   |
| 314. | 0 1 2 3 | Mucus producing cough   | 319. | 0 1 2 3 | Itchy skin (Dermatitis)  |
| 315. | 0 1 2 3 | Frequent colds or flu (0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year)  | 320. | 0 1 2 3 | Cysts, boils, rashes   |
| 316. | 0 1 2 3 | Other infections (sinus, ear, lung, skin, bladder, kidney, etc.) (0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year) | 321. | 0 1 2 3 | History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue Syndrome, Hepatitis or other chronic viral condition (0 = no, 1 = yes in the past, 2 = currently mild condition, 3 = severe) |

KEY: 0=No, symptom does not occur	2=Moderate symptom, occurs occasionally (weekly)
1=Yes, minor or mild symptom, rarely occurs (monthly)	3=Severe symptom, occurs frequently (daily)

# Health Questionnaire (NTAF)

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date: \_\_\_\_\_

\* Please circle the appropriate number "0 - 3" on all questions below. 0 as the least/never to 3 as the most/always.

## SECTION A

- Is your memory noticeably declining? 0 1 2 3
- Are you having a hard time remembering names and phone numbers? 0 1 2 3
- Is your ability to focus noticeably declining? 0 1 2 3
- Has it become harder for you to learn things? 0 1 2 3
- How often do you have a hard time remembering your appointments? 0 1 2 3
- Is your temperament getting worse in general? 0 1 2 3
- Are you losing your attention span endurance? 0 1 2 3
- How often do you find yourself down or sad? 0 1 2 3
- How often do you fatigue when driving compared to the past? 0 1 2 3
- How often do you fatigue when reading compared to the past? 0 1 2 3
- How often do you walk into rooms and forget why? 0 1 2 3
- How often do you pick up your cell phone and forget why? 0 1 2 3

## SECTION B

- How high is your stress level? 0 1 2 3
- How often do you feel that you have something that must be done? 0 1 2 3
- Do you feel you never have time for yourself? 0 1 2 3
- How often do you feel you are not getting enough sleep or rest? 0 1 2 3
- Do you have the time to get regular exercise? 0 1 2 3
- How often do you **not** feel cared about by the people in your life? 0 1 2 3
- How often do you **not** feel you are accomplishing your life purpose? 0 1 2 3
- How often do you share your problems with someone? 0 1 2 3

## SECTION C

### SECTION C1

- How often do you get irritable, shaky, or have lightheadedness between meals? 0 1 2 3
- How often do you feel energized after eating? 0 1 2 3
- How often do you have difficulty eating large meals in the morning? 0 1 2 3
- How often does your energy level drop in the afternoon? 0 1 2 3
- How often do you crave sugar and sweets in the afternoon? 0 1 2 3
- How often do you wake up in the middle of the night? 0 1 2 3
- How often do you have difficulty concentrating before eating? 0 1 2 3
- How often do you depend on coffee to keep yourself going? 0 1 2 3
- How often do you feel agitated, easily upset, and nervous between meals? 0 1 2 3

### SECTION C2

- Do you get fatigued after meals? 0 1 2 3
- Do you crave sugar and sweets after meals? 0 1 2 3
- Do you feel you need stimulants such as coffee after meals? 0 1 2 3
- Do you have difficulty losing weight? 0 1 2 3
- How much larger is your waist girth compared to your hip girth? 0 1 2 3
- How often do you urinate? 0 1 2 3
- Have your thirst and appetite been increased? 0 1 2 3
- Do you have weight gain when under stress? 0 1 2 3
- Do you have difficulty falling asleep? 0 1 2 3

## SECTION 1 - S

- Are you losing your pleasure in hobbies and interests? 0 1 2 3
- How often do you feel overwhelmed with ideas to manage? 0 1 2 3
- How often do you have feelings of inner rage (anger)? 0 1 2 3
- How often do you have feelings of paranoia? 0 1 2 3
- How often do you feel sad or down for no reason? 0 1 2 3

- How often do you feel like you are **not** enjoying life? 0 1 2 3
- How often do you feel you lack artistic appreciation? 0 1 2 3
- How often do you feel depressed in overcast weather? 0 1 2 3
- How much are you losing your enthusiasm for your favorite activities? 0 1 2 3
- How much are you losing enjoyment for your favorite foods? 0 1 2 3
- How much are you losing your enjoyment of friendships and relationships? 0 1 2 3
- How often do you have difficulty falling into deep restful sleep? 0 1 2 3
- How often do you have feelings of dependency on others? 0 1 2 3
- How often do you feel more susceptible to pain? 0 1 2 3
- How often do you have feelings of unprovoked anger? 0 1 2 3
- How much are you losing interest in life? 0 1 2 3

## SECTION 2 - D

- How often do you have feelings of hopelessness? 0 1 2 3
- How often do you have self-destructive thoughts? 0 1 2 3
- How often do you have an inability to handle stress? 0 1 2 3
- How often do you have anger and aggression while under stress? 0 1 2 3
- How often do you feel you are not rested even after long hours of sleep? 0 1 2 3
- How often do you prefer to isolate yourself from others? 0 1 2 3
- How often do you have unexplained lack of concern for family and friends? 0 1 2 3
- How easily are you distracted from your tasks? 0 1 2 3
- How often do you have an inability to finish tasks? 0 1 2 3
- How often do you feel the need to consume caffeine to stay alert? 0 1 2 3
- How often do you feel your libido has been decreased? 0 1 2 3
- How often do you lose your temper for minor reasons? 0 1 2 3
- How often do you have feelings of worthlessness? 0 1 2 3

## SECTION 3 - G

- How often do you feel anxious or panic for no reason? 0 1 2 3
- How often do you have feelings of dread or impending doom? 0 1 2 3
- How often do you feel knots in your stomach? 0 1 2 3
- How often do you have feelings of being overwhelmed for no reason? 0 1 2 3
- How often do you have feelings of guilt about everyday decisions? 0 1 2 3
- How often does your mind feel restless? 0 1 2 3
- How difficult is it to turn your mind off when you want to relax? 0 1 2 3
- How often do you have disorganized attention? 0 1 2 3
- How often do you worry about things you were not worried about before? 0 1 2 3
- How often do you have feelings of inner tension and inner excitability? 0 1 2 3

## SECTION 4 - ACH

- Do you feel your visual memory (shapes & images) is decreased? 0 1 2 3
- Do you feel your verbal memory is decreased? 0 1 2 3
- Do you have memory lapses? 0 1 2 3
- Has your creativity been decreased? 0 1 2 3
- Has your comprehension been diminished? 0 1 2 3
- Do you have difficulty calculating numbers? 0 1 2 3
- Do you have difficulty recognizing objects & faces? 0 1 2 3
- Do you feel like your opinion about yourself has changed? 0 1 2 3
- Are you experiencing excessive urination? 0 1 2 3
- Are you experiencing slower mental response? 0 1 2 3

Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition.  
For nutritional purposes only.

# Daily Record of Food Intake

Each day, record all the items you eat and drink. Be sure to include the approximate amount of each item.

Patient: \_\_\_\_\_

When you have completed this form, return it to your health care professional for evaluation.

Address: \_\_\_\_\_

*Your diet may be the key to better health.*



Health Care Professional: \_\_\_\_\_

L1400 10/06

## Day 1 - Date:

<b>BREAKFAST</b> (TIME:        ) )	<b>LUNCH</b> (TIME:        ) )	<b>DINNER</b> (TIME:        ) )
Meat & Dairy	Meat & Dairy	Meat & Dairy:
Vegetables & Fruits	Vegetables & Fruits:	Vegetables & Fruits
Breads, Cereals, & Grains:	Breads, Cereals, & Grains:	Breads, Cereals, & Grains:
Fats (butter, margarine, oils, etc.):	Fats (butter, margarine, oils, etc.):	Fats (butter, margarine, oils, etc.):
Candy, Sweets, & Junk Food:	Candy, Sweets, & Junk Food:	Candy, Sweets, & Junk Food:
Water Intake (11 oz)	Water Intake (11 oz)	Water Intake (11 oz.)
Other Drinks	Other Drinks	Other Drinks:
<b>MID-MORNING SNACK</b> (TIME:        ) )	<b>MID-DAY SNACK</b> (TIME:        ) )	<b>NIGHTTIME SNACK</b> (TIME:        ) )
Number and Consistency of Bowel Movements:	Number of Sleep Hours:	Quality of Sleep: (good) 1    2    3    4    5 (poor)

## Day 2 - Date:

<b>BREAKFAST</b> (TIME:        ) )	<b>LUNCH</b> (TIME:        ) )	<b>DINNER</b> (TIME:        ) )
Meat & Dairy	Meat & Dairy	Meat & Dairy:
Vegetables & Fruits	Vegetables & Fruits:	Vegetables & Fruits
Breads, Cereals, & Grains:	Breads, Cereals, & Grains:	Breads, Cereals, & Grains:
Fats (butter, margarine, oils, etc.):	Fats (butter, margarine, oils, etc.):	Fats (butter, margarine, oils, etc.):
Candy, Sweets, & Junk Food:	Candy, Sweets, & Junk Food:	Candy, Sweets, & Junk Food:
Water Intake (11 oz)	Water Intake (11 oz)	Water Intake (11 oz.)
Other Drinks	Other Drinks	Other Drinks:
<b>MID-MORNING SNACK</b> (TIME:        ) )	<b>MID-DAY SNACK</b> (TIME:        ) )	<b>NIGHTTIME SNACK</b> (TIME:        ) )
Number and Consistency of Bowel Movements:	Number of Sleep Hours:	Quality of Sleep: (good) 1    2    3    4    5 (poor)

**Day 3 - Date:****BREAKFAST**(TIME: )

Meat &amp; Dairy

Vegetables &amp; Fruits

Breads, Cereals, &amp; Grains:

Fats (butter, margarine, oils, etc.):

Candy, Sweets, &amp; Junk Food:

Water Intake (II oz)

Other Drinks

**MID-MORNING SNACK**(TIME: )

Number and Consistency of Bowel Movements:

**LUNCH**(TIME: )

Meat &amp; Dairy

Vegetables &amp; Fruits:

Breads, Cereals, &amp; Grains:

Fats (butter, margarine, oils, etc.):

Candy, Sweets, &amp; Junk Food:

Water Intake (II oz)

Other Drinks

**MID-DAY SNACK**(TIME: )

Number of Sleep Hours:

**DINNER**(TIME:

Meat &amp; Dairy:

Vegetables &amp; Fruits

Breads, Cereals, &amp; Grains:

Fats (butter, margarine, oils, etc.):

Candy, Sweets, &amp; Junk Food:

Water Intake (II oz.)

Other Drinks:

**NIGHTTIME SNACK**(TIME:

Quality of Sleep: (good) 1 2 3 4 5 (poor)

**Day 4 - Date:****BREAKFAST**(TIME: )

Meat &amp; Dairy

Vegetables &amp; Fruits

Breads, Cereals, &amp; Grains:

Fats (butter, margarine, oils, etc.):

Candy, Sweets, &amp; Junk Food:

Water Intake (II oz)

Other Drinks

**MID-MORNING SNACK**(TIME: )

Number and Consistency of Bowel Movements:

**LUNCH**(TIME: )

Meat &amp; Dairy

Vegetables &amp; Fruits:

Breads, Cereals, &amp; Grains:

Fats (butter, margarine, oils, etc.):

Candy, Sweets, &amp; Junk Food:

Water Intake (II oz)

Other Drinks

**MID-DAY SNACK**(TIME: )

Number of Sleep Hours:

**DINNER**(TIME:

Meat &amp; Dairy:

Vegetables &amp; Fruits

Breads, Cereals, &amp; Grains:

Fats (butter, margarine, oils, etc.):

Candy, Sweets, &amp; Junk Food:

Water Intake (II oz.)

Other Drinks:

**NIGHTTIME SNACK**(TIME:

Quality of Sleep: (good) 1 2 3 4 5 (poor)

**Day 5 - Date:****BREAKFAST**(TIME: )

Meat &amp; Dairy

Vegetables &amp; Fruits

Breads, Cereals, &amp; Grains:

Fats (butter, margarine, oils, etc.):

Candy, Sweets, &amp; Junk Food:

Water Intake (II oz)

Other Drinks

**MID-MORNING SNACK**(TIME: )

Number and Consistency of Bowel Movements:

**LUNCH**(TIME: )

Meat &amp; Dairy

Vegetables &amp; Fruits:

Breads, Cereals, &amp; Grains:

Fats (butter, margarine, oils, etc.):

Candy, Sweets, &amp; Junk Food:

Water Intake (II oz)

Other Drinks

**MID-DAY SNACK**(TIME: )

Number of Sleep Hours:

**DINNER**(TIME:

Meat &amp; Dairy:

Vegetables &amp; Fruits

Breads, Cereals, &amp; Grains:

Fats (butter, margarine, oils, etc.):

Candy, Sweets, &amp; Junk Food:

Water Intake (II oz.)

Other Drinks:

**NIGHTTIME SNACK**(TIME:

Quality of Sleep: (good) 1 2 3 4 5 (poor)

**Day 6 - Date:**

**BREAKFAST**(TIME: )

Meat & Dairy

Vegetables & Fruits

Breads, Cereals, & Grains:

Fats (butter, margarine, oils, etc.):

Candy, Sweets, & Junk Food:

Water Intake (II oz)

Other Drinks

**MID-MORNING SNACK**(TIME: )

Number and Consistency of Bowel Movements:

**LUNCH**(TIME: )

Meat & Dairy

Vegetables & Fruits:

Breads, Cereals, & Grains:

Fats (butter, margarine, oils, etc.):

Candy, Sweets, & Junk Food:

Water Intake (II oz)

Other Drinks

**MID-DAY SNACK**(TIME: )

Number of Sleep Hours:

**DINNER**(TIME:

Meat & Dairy:

Vegetables & Fruits

Breads, Cereals, & Grains:

Fats (butter, margarine, oils, etc.)

Candy, Sweets, & Junk Food:

Water Intake (II oz.)

Other Drinks:

**NIGHTTIME SNACK**(TIME:

Quality of Sleep: (good) 1 2 3 4 5 (poor)

**Day 7 - Date:**

**BREAKFAST**(TIME: )

Meat & Dairy

Vegetables & Fruits

Breads, Cereals, & Grains:

Fats (butter, margarine, oils, etc.):

Candy, Sweets, & Junk Food:

Water Intake (II oz)

Other Drinks

**MID-MORNING SNACK**(TIME: )

Number and Consistency of Bowel Movements:

**LUNCH**(TIME: )

Meat & Dairy

Vegetables & Fruits:

Breads, Cereals, & Grains:

Fats (butter, margarine, oils, etc.):

Candy, Sweets, & Junk Food:

Water Intake (II oz)

Other Drinks

**MID-DAY SNACK**(TIME: )

Number of Sleep Hours:

**DINNER**(TIME:

Meat & Dairy:

Vegetables & Fruits

Breads, Cereals, & Grains:

Fats (butter, margarine, oils, etc.)

Candy, Sweets, & Junk Food:

Water Intake (II oz.)

Other Drinks:

**NIGHTTIME SNACK**(TIME:

Quality of Sleep: (good) 1 2 3 4 5 (poor)