Your Health
Solutions
Functional & Lifestyle Medicine

Intake Form

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yourhealthsolutions.net

General Information

Date: **Name:**

Name _____
First *Middle* *Last*

Preferred Name _____

Date of Birth *(dd/mm/yyyy)* _____ Place of Birth _____

Age _____

Gender ◯ Male ◯ Female

Primary Address _____
Number, Street *Apt #*

_____
City *State/Province* *Zip Code/Postal*

Genetic Background
◯ African ◯ European ◯ Native American ◯ Mediterranean
◯ Asian ◯ Ashkenazi ◯ Middle Eastern ◯ Caucasian
◯ Other: _____

Highest Education Level ◯ High School ◯ Under-Graduate ◯ Post Graduate

Job Title _____ Hours per week _____

Nature of Business _____

Marital Status ◯ Single ◯ Married ◯ Divorce ◯ Widowed
◯ Long Term Partnership

Home Phone _____

Work Phone _____

Cell Phone _____

Email _____

Emergency Contact _____
Name *Phone Number*

_____
Number, Street *Apt #*

_____
City *State* *Zip*

Physician _____
Name *Phone Number* *Fax Number*

How did you hear about our office? _____

Story Page

Name: Age: Sex: ◯ Male ◯ Female Date:

Please tell us your story about your health:

Medical Questionnaire

Allergies

Medication/Supplement/Food	Reaction

Complaints/Concerns

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

_____

If you could permanently eliminate three problems, what would they be?

1. _____
2. _____
3. _____

When was the last time you felt well? _____

_____

Did something trigger change in health/symptoms? _____

_____

What makes you feel worse? _____

_____

What makes you feel better? _____

_____

Current Health Status/Concerns

Please provide us with current and ongoing problems

PROBLEM	DATE OF ONSET	SEVERITY/FREQUENCY	TREATMENT APPROACH	SUCCESS
EX. Headaches	*May 2006*	*2 times per week*	*Acupuncture/Aspirin*	*Mild Improvement*

What diagnosis or explanation(s), if any, have been given to you for these concerns?

What physician or other health care provider (including alternative or complimentary practitioners) have you seen for these conditions?

How much time have you lost from work or school in the past year due to these conditions?

Medical History

Diseases/Diagnosis/Conditions *Check appropriate box and provide date of onset (mm/yyyy)*

Past	Ongoing	GASTROINTESTINAL
☐	☐	Irritable Bowel Syndrome
☐	☐	Inflammatory Bowel Disease
☐	☐	Crohn's
☐	☐	Ulcerative Colitis
☐	☐	Gastritis or Peptic Ulcer Disease
☐	☐	GERD(reflux)
☐	☐	Celiac Disease
☐	☐	Gallstones
☐	☐	Other

Past	Ongoing	CARDIOVASCULAR
☐	☐	Heart Attack
☐	☐	Other Heart Disease
☐	☐	Stroke
☐	☐	Elevated Cholesterol
☐	☐	Arrhythmia (irregular heartbeat)
☐	☐	Hypertension (high blood pressure)
☐	☐	Celiac Disease (Rheumatic Fever)
☐	☐	Mitral Valve Prolapse
☐	☐	Other

Past	Ongoing	METABOLIC/ENDOCRINE
☐	☐	Type 1 Diabetes
☐	☐	Type 2 Diabetes
☐	☐	Hypoglycemia
☐	☐	Metabolic Syndrome Insulin Resistance or Pre-Diabetes
☐	☐	Hypothyroidism (low thyroid)
☐	☐	Hypothyroidism (overactive thyroid)
☐	☐	Endocrine Problems
☐	☐	Polycystic Ovarian Syndrome (PCOS)
☐	☐	Infertility
☐	☐	Weight Gain
☐	☐	Weight Loss
☐	☐	Frequent Weight Fluctuations
☐	☐	Bulimia
☐	☐	Anorexia
☐	☐	Binge Eating Disorder
☐	☐	Night Eating Disorder
☐	☐	Eating Disorder (non-specific)
☐	☐	Other

Past	Ongoing	CANCER
☐	☐	Lung Cancer
☐	☐	Breast Cancer
☐	☐	Colon Cancer
☐	☐	Ovarian Cancer
☐	☐	Prostate Cancer
☐	☐	Skin Cancer
☐	☐	Other

Past	Ongoing	GENITAL & URINARY SYSTEMS
☐	☐	Kidney Stones
☐	☐	Gout
☐	☐	Interstitial Cystitis
☐	☐	Frequent Urinary Tract Infections
☐	☐	Frequent Yeast Infections
☐	☐	Erectile Dysfunction or Sexual Dysfunction
☐	☐	Other

Past	Ongoing	MUSCULOSKELETAL/PAIN
☐	☐	Osteoarthritis
☐	☐	Fibromyalgia
☐	☐	Chronic Pain
☐	☐	Other

Past	Ongoing	INFLAMMATORY/AUTOIMMUNE
☐	☐	Chronic Fatigue Syndrome
☐	☐	Autoimmune System
☐	☐	Rheumatoid Arthritis
☐	☐	Lupus SLE
☐	☐	Immune Deficiency Disease
☐	☐	Herpes-Genital
☐	☐	Severe Infectious Disease
☐	☐	Poor Immune Function (frequent infections)
☐	☐	Food Allergies
☐	☐	Environmental Allergies
☐	☐	Multiple Chemical Sensitivities
☐	☐	Latex Allergy
☐	☐	Hepatitis
☐	☐	Other

Medical History *(continued)*

Diseases/Diagnosis/Conditions *Check appropriate box and provide date of onset.*

Past	Ongoing	RESPIRATORY DISEASE
☐	☐	Asthma
☐	☐	Chronic Sinusitis
☐	☐	Bronchitis
☐	☐	Emphysema
☐	☐	Pneumonia
☐	☐	Tuberculosis
☐	☐	Sleep Apnea
☐	☐	COVID-19
☐	☐	Other

Past	Ongoing	SKIN DISEASE
☐	☐	Eczema
☐	☐	Psoriasis
☐	☐	Acne
☐	☐	Melanome
☐	☐	Skin Cancer
☐	☐	Other

Past	Ongoing	MISCELLANEOUS
☐	☐	Anemia
☐	☐	Chicken Pox
☐	☐	German Measles
☐	☐	Measles
☐	☐	Mononucleosis
☐	☐	Mumps
☐	☐	Sleep Apnea
☐	☐	Whooping Cough

Past	Ongoing	NEUROLOGIC/MOOD
☐	☐	Depression
☐	☐	Anxiety
☐	☐	Bipolar Disorder
☐	☐	Schizophrenia
☐	☐	Headaches
☐	☐	Migraines
☐	☐	ADD/ADHD
☐	☐	Autism
☐	☐	Mild Cognitive Impairment
☐	☐	Memory Problems
☐	☐	Parkinson's Disease
☐	☐	Multiple Sclerosis
☐	☐	ALS
☐	☐	Seizures
☐	☐	Alzheimer's
☐	☐	Other

Medical History *(continued)*

Check appropriate box and provide date of test/injuries/surgeries.

PREVENTIVE TESTS
☐ Full Physical Exam
☐ Bone Density
☐ Colonoscopy
☐ Cardiac Stress Test
☐ EBT Heart Scan
☐ EKG
☐ Hemoccult Test- stool test for blood
☐ MRI
☐ CT Scan
☐ Upper Endoscopy
☐ Upper GI Series
☐ Ultrasound
☐ Mammogram
☐ X-Ray
☐ Other

SURGERIES
☐ Appendectomy
☐ Hysterectomy +/- Ovaries
☐ Gall Bladder
☐ Hernia
☐ Tonsillectomy
☐ Dental Surgery
☐ Joint Replacement (Knee/Hip)
☐ Heart Surgery - ByPass Valve
☐ Angioplasty or Stent
☐ Pacemaker
☐ Other *(List Below)*

INJURIES
☐ Back Injury
☐ Neck Injury
☐ Head Injury
☐ Broken Bones
☐ Other

BLOOD TYPE *(Please Check One)*
☐ A
☐ B
☐ AB
☐ O
☐ Rh+
☐ Unknown

Hospitalizations

☐ *NONE*

Date	Reason

COMMENTS

Gynecologic History

For Women Only

OBSTETRIC HISTORY *(Check Box If Yes And Provide Number Of)*

- ☐ Pregnancies
- ☐ Caesarean
- ☐ Vaginal Deliveries
- ☐ Miscarriage
- ☐ Abortion
- ☐ Living Children
- ☐ Post Partum Depression
- ☐ Toxemia
- ☐ Gestational Diabetes
- ☐ Baby Over 8 pounds
- ☐ Breast Feeding for how long?

MENSTRUAL HISTORY *(Check Box If Yes)*

Age at First Period?_____ Mensus Frequency?_____ Length?_____ Pain? ◯ Yes ◯ No

Clotting: ◯ Yes ◯ No Has your period ever skipped? ◯ Yes ◯ No For how long?

Last Menstrual Period?____

Use of hormonal contraception such as? ☐ Birth Control Pills ☐ Patch ☐ Nuva Ring

How Long?_____

Do you use contraception ◯ Yes ◯ No ☐ Condom ☐ Diaphragm ☐ IUD ☐ Partner Vasectomy

WOMEN'S DISORDERS/ HORMONAL IMBALANCES

Do you experience breast tenderness, water retention, irritability or PMS symptoms in the second half of your cycle?
◯ Yes ◯ No

Please advise of any other symptoms that you feel are significant:_____

☐ Fibrocystic Breasts ☐ Endometriosis ☐ Fibroids ☐ Infertility
☐ Painful Periods ☐ Heavy Periods ☐ PMS

Last Mammogram?_____ Breast Biopsy/Date:_____

Last PAP Test?_____ ◯ Normal ◯ Abnormal

Last Bone Density?_____ Results: ◯ High ◯ Low ◯ Within Normal Range

Are You Menopause? ◯ Yes ◯ No Age at Menopause?_____

Please check off if you're experiencing any of the following symptoms:

☐ Hot Flashes ☐ Mood Swings ☐ Concetration/ Memory Problems ☐ Joint Pains
☐ Vaginal Dryness ☐ Decreased Libido ☐ Heavy Bleeding ☐ Headaches
☐ Weight Gain ☐ Loss of Control of Urine ☐ Palpitations

☐ Use of hormone replacement therapy? *How Long?*_____

What Type? ☐ Estrogen ☐ Progesterone ☐ Ogen ☐ Estrace
☐ Premarin ☐ Proverq ☐ Other:_____

Men's History

(For Men Only)

Have you ever had a PSA done? ◯ Yes ◯ No

PSA Level: ◯ 0-2 ◯ 2-4 ◯ 4-10 ◯ >10

☐ Prostate Enlargement ☐ Prostate Infection ☐ Change in Libido ☐ Impotence

☐ Difficulty Obtaining an Erection ☐ Difficulty Maintaining an Erection

☐ Nocturia(urination at night) ◯ Yes ◯ No How many times a night?_____

☐ Urgency/Hesitancy/Change in Urinary System ☐ Loss of urine control

Medications

CURRENT MEDICATIONS

Medication	Dose	Frequency	Start Date *(month/year)*	Reason For Use

PREVIOUS MEDICATIONS
(LAST 10 YEARS)

Medication	Dose	Frequency	Start Date *(month/year)*	Reason For Use

NUTRITIONAL SUPPLEMENTS
(VITAMINS/MINERALS/HERBS/HOMEOPATHY)

Supplication & Brand	Dose	Frequency	Start Date *(month/year)*	Reason For Use

Have your medications or supplements ever cause you unusual side effects or problems? ◯ Yes ◯ No
Describe:_____
Have you had prolonged or regular use of NSAIDS (Advil, Aleve,etc.), Motrin, Aspirin? ◯ Yes ◯ No
Have you had prolonged or regular use of Tylenol? ◯ Yes ◯ No
Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec,etc.) ◯ Yes ◯ No
Frequent antibiotics > 3 times /year ◯ Yes ◯ No
Long term antibiotics ◯ Yes ◯ No
Use of steroids (prednisone, nasal allergy inhalers) in the past ◯ Yes ◯ No
Use of oral contraceptives ◯ Yes ◯ No

Childhood History

Please answer to the best of your knowledge

	Yes	No	Don't Know	Comment
Were you a full term baby?	◯	◯	◯	
A premature birth?	◯	◯	◯	
Vaginal Delivery?	◯	◯	◯	
C-Section?	◯	◯	◯	
Breast fed?	◯	◯	◯	
Bottle fed?	◯	◯	◯	

WHEN PREGNANT WITH YOU, DID YOUR MOTHER:

Smoke tobacco?	◯	◯	◯	
Use recreational drugs?	◯	◯	◯	
Drink alcohol?	◯	◯	◯	
Use estrogen?	◯	◯	◯	
Other prescriptions or non-prescription medications?	◯	◯	◯	

Immunization History

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

	Yes	No	Don't Know	Comment
Smallpox	◯	◯	◯	
Tetanus	◯	◯	◯	
Diphtheria	◯	◯	◯	
Pertussis	◯	◯	◯	
Polio (oral)	◯	◯	◯	
Polio (Injection)	◯	◯	◯	
Mumps	◯	◯	◯	
Measles	◯	◯	◯	
Rubella (German Measles)	◯	◯	◯	
Typhoid	◯	◯	◯	
Cholera	◯	◯	◯	
COVID-19 # shots taken	◯	◯	◯	

Childhood Diet

Was your childhood diet high in:

	Yes	No	Don't Know	Comment
Sugar? (Sweets, Candy, Cookies, etc)	◯	◯	◯	
Soda?	◯	◯	◯	
Fast food, pre-packaged foods, artificial sweeteners?	◯	◯	◯	
Milk, Cheeses, or other Dairy Products?	◯	◯	◯	
Meat, Vegetables, & Potato Diet	◯	◯	◯	
Vegetarian Diet?	◯	◯	◯	
Diet high in white breads?	◯	◯	◯	

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

If yes, please explain: (EX: milk – diarrhea)_____

Childhood Illnesses

Please indicate which of the following problems/conditions you experienced as a child (ages birth to 12 years) and the approximate age of onset.

	Yes	Age
ADD (Attenion Deficient Disorder)	☐	
Asthma	☐	
Brochitis	☐	
Chicken Pox	☐	
Colic	☐	
Congenital problems	☐	
Ear Infections	☐	
Fever Blisters	☐	
Frequent colds or Flu	☐	
Frequent Headaches	☐	
Hyperactivity	☐	
Jaundice	☐	

	Yes	Age
Mumps	☐	
Pneumonia	☐	
Seasonal Allergies	☐	
Skin Disorders	☐	
Strep Infections	☐	
Tonsillitis	☐	
Upset Stomach, Digestive Problems	☐	
Whooping Cough	☐	
Other (describe)	☐	
Other (describe)	☐	
Other (describe)	☐	
Measles	☐	

As a child did you: Have a high absence from school? ◯ Yes ◯ No

If yes, why?_____

Experience chronic exposure to second hand smoke in your home? ◯ Yes ◯ No

Experience Abuse? ◯ Yes ◯ No

Have alcholic parents? ◯ Yes ◯ No

Family Health History

Please indicate current and past history to the best of your knowledge
Please check family member that apply

	Father	Mother	Brother	Sister	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandfather	Paternal Grandmother
Age (if still living)									
Heart Attack	☐	☐	☐	☐	☐	☐	☐	☐	☐
Age at death (if deceased)									
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	☐	☐	☐	☐	☐	☐	☐	☐	☐

Family Health History

Please indicate current and past history to the best of your knowledge

Please check family member that apply

	Father	Mother	Brother	Sister	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandfather	Paternal Grandmother
Epilepsy	☐	☐	☐	☐	☐	☐	☐	☐	☐
Flu	☐	☐	☐	☐	☐	☐	☐	☐	☐
Genetic Disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐	☐
Headache	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing spondylitis)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Inflammatory Bowel Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Insomnia	☐	☐	☐	☐	☐	☐	☐	☐	☐
Irritable Bowel Syndrome	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Nervous breakdown	☐	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐
Parkinson's	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pneumonia/Bronchitis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psoriasis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sleep Apnea	☐	☐	☐	☐	☐	☐	☐	☐	☐
Smoking addiction	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐
Substance abuse (such as alcoholism)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ulcers	☐	☐	☐	☐	☐	☐	☐	☐	☐

Review Of Symptoms

Check those items that applied to you in the past. Circle those that presently apply.

Past	Ongoing	GENERAL
☐	☐	Fever
☐	☐	Chills/Cold all over
☐	☐	Aches/Pains
☐	☐	General Weakness
☐	☐	Difficulty sweating
☐	☐	Excessive Sweating
☐	☐	Swollen Glands
☐	☐	Cold hands & Feet
☐	☐	Fatigue
☐	☐	Difficulty falling asleep
☐	☐	Sleepwalker
☐	☐	Nightmares
☐	☐	No dream recall
☐	☐	Early waking
☐	☐	Daytime sleepiness
☐	☐	Distorted vision

		EARS
☐	☐	Aches
☐	☐	Discharge/Conjunctivitis
☐	☐	Pains
☐	☐	Ringing
☐	☐	Deafness/Hearing loss
☐	☐	Itching
☐	☐	Pressure
☐	☐	Hearing Aid
☐	☐	Frequent Infections
☐	☐	Tubes in Ears
☐	☐	Sensitive to loud noises
☐	☐	Hearing Hallucinations

Past	Ongoing	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
☐	☐	Feeling of sand in eyes
☐	☐	Double vision
☐	☐	Blurred vision
☐	☐	Poor night vision
☐	☐	See bright flashes
☐	☐	Halo around lights
☐	☐	Eye pains
☐	☐	Dark circles under eyes
☐	☐	Strong light irritates
☐	☐	Cataracts
☐	☐	Floaters in eyes
☐	☐	Visual hallucinations
☐	☐	Conjunctivitis

Past	Ongoing	SKIN
☐	☐	Cuts heal slowly
☐	☐	Bruise easily
☐	☐	Rashes
☐	☐	Pigmentation
☐	☐	Changing Moles
☐	☐	Calluses
☐	☐	Eczema
☐	☐	Psoriasis
☐	☐	Dryness/cracking skin
☐	☐	Oiliness
☐	☐	Itching
☐	☐	Acne
☐	☐	Boils
☐	☐	Hives
☐	☐	Fungus on Nails
☐	☐	Peeling Skin
☐	☐	Shingles
☐	☐	Nails Split
☐	☐	White Spots/Lines on Nails
☐	☐	Crawling Sensation
☐	☐	Burning on Bottom of Feet
☐	☐	Athletes Foot
☐	☐	Cellulite
☐	☐	Bugs love to bite you
		Is your skin sensitive to?:
☐	☐	Sun
☐	☐	Fabrics
☐	☐	Detergents
☐	☐	Lotions/Creams

		THROAT
☐	☐	Mucus
☐	☐	Difficulty swallowing
☐	☐	Frequent hoarseness Tonsillitis
☐	☐	Enlarged glands
☐	☐	Constant clearing of throat
☐	☐	Throat closes up

Review Of Symptoms *(continued)*

Past	Ongoing	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

Past	Ongoing	CIRCULATION/ RESPIRATION
☐	☐	Swollen Ankles
☐	☐	Sensitive to hot
☐	☐	Sensitive to cold
☐	☐	Extremities cold or clammy
☐	☐	Hands/Feet go to sleep/ numbness/tingling
☐	☐	High Blood Pressure
☐	☐	Chest Pain
☐	☐	Pain between shoulders
☐	☐	Dizziness upon standing
☐	☐	Fainting Spells
☐	☐	High cholestrol
☐	☐	High triglycerides
☐	☐	Wheezing
☐	☐	Irregular heartbeat
☐	☐	Palpitations
☐	☐	Low exercise tolerance
☐	☐	Frequent coughs
☐	☐	Breathing heavily
☐	☐	Frequently sighing
☐	☐	Shortness of breath
☐	☐	Night sweats
☐	☐	Varicose veins/spider veins
☐	☐	Mitral valve prolapse
☐	☐	Murmurs
☐	☐	Skipped heartbeat
☐	☐	Heart enlargement
☐	☐	Angina pain
☐	☐	Bronchitis/Pneumonia
☐	☐	Emphysema
☐	☐	Croup
☐	☐	Frequent colds
☐	☐	Heavy/tight chest
☐	☐	Prior heart attack ?
		When: / /
☐	☐	Phlebitis

Past	Ongoing	NECK
☐	☐	Stiffness
☐	☐	Swelling
☐	☐	Lumps
☐	☐	Neck glands swell

		MOUTH
☐	☐	Coated tongue
☐	☐	Sore tongue
☐	☐	Dental problems
☐	☐	Bleeding gums
☐	☐	Canker sores
☐	☐	TMJ
☐	☐	Cracked lips/corners
☐	☐	Chapped lips
☐	☐	Fever blisters
☐	☐	Wear dentures
☐	☐	Grind teeth when sleeping
☐	☐	Bad breath
☐	☐	Dry mouth

Review Of Symptoms *(continued)*

Past	Ongoing	GASTROINTESTINAL
☐	☐	Peptic/Duodenal Ulcer
☐	☐	Poor appetite
☐	☐	Excessive appetite
☐	☐	Gallstones
☐	☐	Gallbladder pain
☐	☐	Nervous stomach
☐	☐	Full feeling after
☐	☐	Small 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

Past	Ongoing	MEN'S HISTORY *For Men Only*
☐	☐	Prostate enlargement
☐	☐	Prostate infection
☐	☐	Change in libido
☐	☐	Impotence
☐	☐	Diminished/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 bladder control

Past	Ongoing	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

Past	Ongoing	WOMENS 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
☐	☐	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 bladder control
☐	☐	Palpitations

Review Of Symptoms

Check those items that applied to you in the past. Circle those that presently apply.

Past	Ongoing	EMOTIONAL
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Fainting Spells
☐	☐	Blackouts/Amnesia
☐	☐	Had prior shock therapy
☐	☐	Frequently keyed up and jittery
☐	☐	Startled by sudden noises
☐	☐	Anxiety/Feeling of panic
☐	☐	Go to pieces easily
☐	☐	Forgetful
☐	☐	Listless/groggy
☐	☐	Withdrawn feeling/Feeling 'lost'
☐	☐	Had nervous breakdown
☐	☐	Unable to concentrate/short attention span Vision changes
☐	☐	Unable to reason
☐	☐	Tends to worry needlessly
☐	☐	Considered a nervous person by others
☐	☐	Unusual tension
☐	☐	Frustration
☐	☐	Emotional numbness
☐	☐	Often break out in cold sweats
☐	☐	Profuse sweating
☐	☐	Depressed
☐	☐	Often awakened by frightening dreams
☐	☐	Previously admitted for psychiatric care
☐	☐	Family member had nervous breakdown
☐	☐	Use tranquilizers
☐	☐	Misunderstood by others
☐	☐	Irritable
☐	☐	Feeling of hostility/volatile or aggressive
☐	☐	Fatigue
☐	☐	Hyperactive
☐	☐	Restless leg syndrome
☐	☐	Considered clumsy
☐	☐	Vision changes

Past	Ongoing	EMOTIONAL *(continued)*
☐	☐	Unable to coordinate muscles
☐	☐	Have difficulty falling asleep
☐	☐	Have difficulty staying asleep
☐	☐	Daytime sleepiness
☐	☐	Am a workaholic
☐	☐	Have had hallucinations

Past	Ongoing	JOINT/MUSCLES/TENDONS
☐	☐	Pain wakes you
☐	☐	Weakness in legs and arms
☐	☐	Balance problems
☐	☐	Muscle cramping
☐	☐	Head injury
☐	☐	Muscle stiffness in morning
☐	☐	Damp weather bothers you

Pain Assessment

Are you currently in pain? ◯ Yes ◯ No

Is the source of your pain due to an injury? ◯ Yes ◯ No

If yes, please describe your injury and the date in which it occured_____

_____

If no, please describe how long you have experienced this pain and what you believe it is attributed to

_____

Please use the area(s) and illustrations below to describe the severity of your pain. (0=no pain, 10=severe pain)

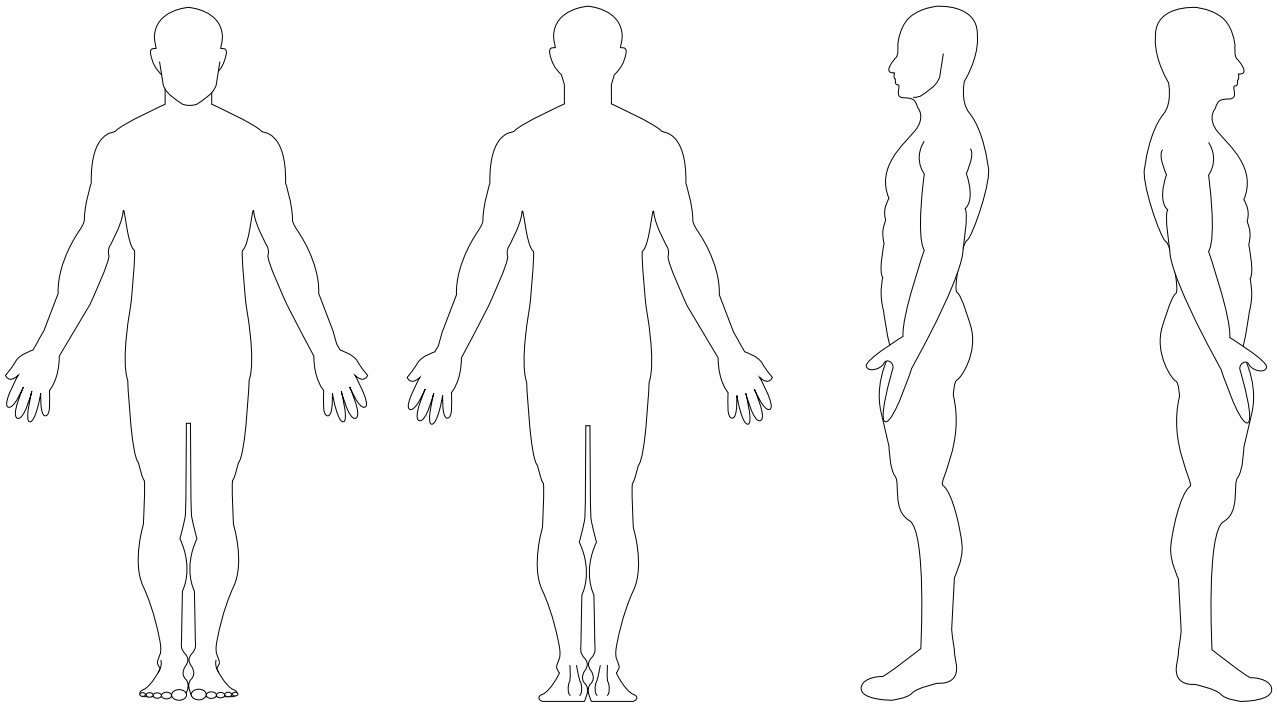
*Example:*_____*Neck*_____*5*_____

Area 1._____ Area 2._____

Area 3._____ Area 4._____

Use the letters provided to mark your area(s) of pain on the illustration.

A= ache B= burning N= numbness S= stiffness T=tingling Z= sharp/shooting



Front Back Left Right

Dental History

	Yes	No
Problem with sore gums (gingivitis)?		
Ringing in the ears (tinnitus)?	◯	◯
Have TMJ (temporal mandibular joint) problems?	◯	◯
Metallic taste in mouth?	◯	◯
Problems with bad breath (halitosis) or white tongue (thrush)?	◯	◯
Previously or currently wear braces?	◯	◯
Problems chewing?	◯	◯
Floss regularly?	◯	◯
Do you have amalgam dental fillings? How many?	◯	◯
Did you receive these fillings as a child?	◯	◯
Do you have Gold Fillings?	◯	◯
Do you have Root Canals?	◯	◯
Implants?	◯	◯
Tooth Pain?	◯	◯
Bleeding Gums?	◯	◯
Gingivitis?	◯	◯

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

Age	Type of dental work:	Health Problems following dental work? (describe)

Social History

Height (feet/inches)	Current Weight
Usual Weight +/- 5lbs.	Desired Weight Range (+/- 5lbs.)
Highest Adult Weight	Lowest Adult Weight
Weight Fluctuations (>10 lbs.)	Body Fat %

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

Do you grocery shop? ◯ Yes ◯ No
*If no, who does the shopping?*_____

Do you avoid any particular foods? ◯ Yes ◯ No
*If yes, types and reason*_____

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

Do you cook? ◯ Yes ◯ No
*If no, who does the cooking?*_____

Do you read food labels? ◯ Yes ◯ No

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

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

☐ Erratic eating pattern	☐ Love to eat
☐ Fast eater	☐ Eat because i have to
☐ Late night eating	☐ Have a negative relationship to food
☐ Dislike healhy food	☐ Struggle with eating issues
☐ Significant other or family members don't like healthy foods	☐ Emotional eater (eat when sad, lonely, depressed, bored)
☐ Eat more than 50% meals away from home	☐ Eat too much under stress
☐ Travel frequently	☐ Eat too little under stress
☐ Non-availability of healthy foods	☐ Don't care to cook
☐ Do not plan meals or menus	☐ Eating in the middle of the night
☐ Reliance on convenience	☐ Confused about nutrition advice
☐ Poor snack choices	☐ Significant other or family members have special dietary needs or food preferences
☐ Time constraints	☐ Eat too much

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

_____

Nutritional History

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

Food Diary

Place a check mark next to the food/drink that applies to your current diet.

	USUAL BREAKFAST
☐	None
☐	Bacon/Sausage
☐	Bagel
☐	Butter
☐	Cereal
☐	Coffee
☐	Donut
☐	Eggs
☐	Fruit
☐	Juice
☐	Margarine
☐	Milk
☐	Oat bran
☐	Sugar
☐	Sweet roll
☐	Sweetener
☐	Tea
☐	Toast
☐	Water
☐	Wheat bran
☐	Yogurt
☐	Oat meal
☐	Milk protein shake
☐	Slim fast
☐	Carnation shake
☐	Soy protein
☐	Whey protein
☐	Rice protein
☐	Other: (List below)

	USUAL LUNCH
☐	None
☐	Butter
☐	Coffee
☐	Eat in a cafeteria
☐	Eat in restaurant
☐	Fish sandwich
☐	Fried foods
☐	Hamburger
☐	Hot dogs
☐	Juice
☐	Leftovers
☐	Lettuce
☐	Margarine
☐	Mayo
☐	Meat sandwich
☐	Milk
☐	Pizza
☐	Potato chips
☐	Salad
☐	Salad dressing
☐	Soda
☐	Soup
☐	Sugar
☐	Sweetener
☐	Tea
☐	Tomato
☐	Vegetables
☐	Water
☐	Yogurt
☐	Slim fast
☐	Carnation shake
☐	Protein shake
☐	Other: (List below)

	USUAL DINNER
☐	None
☐	Beans (legumes)
☐	Brown rice
☐	Butter
☐	Carrots
☐	Coffee
☐	Fish
☐	Green vegetables
☐	Juice
☐	Margarine
☐	Milk
☐	Pasta
☐	Potato
☐	Poultry
☐	Red meat
☐	Rice
☐	Salad
☐	Salad dressing
☐	Soda
☐	Sugar
☐	Sweetener
☐	Tea
☐	Vinegar
☐	Water
☐	White rice
☐	Yellow vegetables
☐	Other: (List below)

Nutritional History *(continued)*

How much of the following do you consume each week?

Candy	
Cheese	
Chocolate	
Cups of coffee containing caffeine	
Cups od decaffeinated coffee or tea	
Cups of Hot chocolate	
Diet Soda	
Ice Cream	
Salty foods	
Slices of white bread (rolls,bagels,etc)	
Soda with caffeine	
Soda wthout caffeine	
Cups of tea containing caffeine	

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

☐ Gluten-Free ☐ Diabetic ☐ Dairy Restricted ☐ Vegetarian ☐ Vegan ☐ Blood type diet

☐ Other:_____

Please tell us if there is anything special about your diet that we should know._____

_____

Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc? ○ Yes ○ No

If yes, are these symptoms associated with any particular food or supplement? ○ Yes ○ No

If yes, please name the food or supplement and symptom(s)._____

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

DO YOU FEEL WORSE WHEN YOU EAT A LOT OF:		DO YOU FEEL BETTER WHEN YOU EAT A LOT OF:	
High fat foods	☐	High fat foods	☐
High protein foods	☐	High protein foods	☐
High carbohydrate foods (breads, pasta, potatoes)	☐	High carbohydrate foods (breads, pasta, potatoes)	☐
Refined sugar (junk food)	☐	Refined sugar (junk food)	☐
Fried foods	☐	Fried foods	☐
1 or 2 alchoholic drinks	☐	1 or 2 alchoholic drinks	☐
Other:		Other:	

Nutritional History *(continued)*

Does skipping meals greatly affect your symptoms? ○ Yes ○ No

Has there ever been a food that you have craved or 'binged' on over a period of time? ○ Yes ○ No

If yes, what food(s) _____

_____

How many times do you chew your food?_____

How much fluid do you drink with your meals?_____

How many servings of fruits & vegetables do you eat per week?_____

What foods do you dislike? _____

What foods do you not tolerate well or do you have reactions to? _____

What type of cuisine do you like? _____

What is your typical breakfast? _____

How much time do you have in the morning to prepare breakfast? _____

What is your typical lunch? _____

What is your typical dinner? _____

What meats do you eat? _____

Do you eat eggs? _____

Do you ever do vegetarian? If so how often? _____

What foods do you crave? _____

Do you have snacks during the day? If so what do you snack on? _____

Do you eat fish or other seafood? If so what types? _____

Do you eat dessert? If so what do you eat? _____

Do you skip any meals? _____

What time do you eat your breakfast, lunch, dinner? _____

What time do you usually eat snacks? _____

What types of beverages do you consume? _____

How many ounces/mls of water do you consume daily? _____

What oils do you cook with? _____

Caffeine Intake: ○ Yes ○ No

Coffee Cups/day: ○ 1 ○ 2-4 ○ > 4 per day

Tea Cups/day: ○ 1 ○ 2-4 ○ > 4 per day

Caffeinated Sodas or Diet Sodas Intake: ○ Yes ○ No

12oz can/bottle: ○ 1 ○ 2-4 ○ > 4 per day

List favorite type (Ex. Diet Coke, Pepsi, etc.):

GI History

Foreign Travel? ○ Yes ○ No Where?

Wilderness Camping? ○ Yes ○ No Where?

Have you ever had severe? ☐ Gastroenteritis ☐ Diarrhea

Do you feel like you digest your food well? ○ Yes ○ No

Do you feel bloated after meals? ○ Yes ○ No

Please complete the following chart as it relates to your bowel movements:

FREQUENCY	
More than 3x a day	☐
1-3x a day	☐
4-6x a week	☐
2-3x a week	☐
1 or fewer x a week	☐

CONSISTENCY	
Soft and well formed	☐
Often floats	☐
Difficult to pass	☐
Diarrhea	☐
Thin, long or narrow	☐
Small and hard	☐
Loose but not watery	☐
Alternating between hard and loose/watery	☐

COLOR	
Medium brown consistently	☐
Very dark or black	☐
Greenish color	☐
Blood is visible	☐
Varies a lot	☐
Dark brown consistently	☐
Yellow, light brown	☐
Greasy, shiny appearance	☐

INTESTINAL GAS:		
	Daily	☐
	Occasionally	☐
	Excessive	☐
	Present with Pain	☐
	Foul Smelling	☐
	Little Odor	☐

Lifestyle History

Smoking

Currently Smoking: ○ Yes ○ No How many years?_____ Packs per day?_____
Attempts to quit:_____
Previous Smoking: How many years?_____ Packs per day?_____
Second Hand Smoke?_____

Alcohol Intake

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

○ None ○ 1-3 ○ 4-6 ○ 7-10 ○ >10 *If "None," skip to Other Substances*

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

Have you been told you should cut down your alchol intake?	○ Yes	○ No
Do you get annoyed when people ask you about your drinking?	○ Yes	○ No
Do you 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 alcohol?	○ Yes	○ No
Have you ever been arrested or hospitalized because of drinking?	○ Yes	○ No
Have you ever thought about getting help to control or stop your drinking?	○ Yes	○ No

Other Substances

Are you currently using any recreational drugs? ○ Yes ○ No Type:_____
Have you ever used IV or inhaled recreational drugs? ○ Yes ○ No Type:_____

Exercise

Do you use exercise regularly? ◯ Yes ◯ No

Current exercise program; (List type of activity, number of sessions/week, and duration)

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

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

List problems that limit activity:_____

_____

Do you feel unusually fatigued after exercise? ◯ Yes ◯ No

If yes please describe:_____

_____

Do you usually sweat when exercising? ◯ Yes ◯ No

Psychosocial

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

Are you happy? ◯ Yes ◯ No

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

Do you still believe stress is presently reducing the quality of your life? ◯ Yes ◯ No

Do you like the work you do? ◯ Yes ◯ No

Have you ever experienced major losses in your life? ◯ Yes ◯ No

Do you spend the majority of your time and money to fulfill responsibilities and obligations ◯ Yes ◯ No

Would you describe your experience as a child in your family as happy and secure? ◯ Yes ◯ No

Stress/Coping

Have you ever sought counseling? ◯ Yes ◯ No

Are your currently in therapy? ◯ Yes ◯ No

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

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

Daily Stressors: Rate on scale 1-10 ◯ Yes ◯ No

Work_____ Family_____ Social_____ Finances_____ Health_____ Other_____

Do you practice meditation or relaxation technique? ◯ Yes ◯ No

Check all that apply

☐ Yoga ☐ Meditation ☐ Imagery ☐ Breathing ☐ Tai Chi ☐ Prayer ☐ Other

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

Hobbies & Leisure activities:_____

Sleep Rest

Average number of hours you sleep per night ◯ >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

What time do you go to bed?_____

What time do you wake up?_____

Roles/Relationships

List Children

CHILD'S NAME	AGE	GENDER

Who is living in your household? Number:_____ Names:_____

Their Employment/Occupations:_____

Resources for emotional support?_____

Check all that apply:

☐ Spouse ☐ Family ☐ Friends ☐ Religous/Spiritual ☐ Pets ☐ Other:

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

HOW WELL HAVE THINGS BEEN GOING FOR YOU?	*Very Well*	*Fine*	*Poorly*	*Does Not Apply*
Overall	◯	◯	◯	◯
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	◯	◯	◯	◯

Personal Stress Inventory *(Include past and present events)*

Life Event	Points	Yes
Death of spouse	100	☐
Divorce	73	☐
Maritial Seperation	65	☐
Detenion in jail or other institution	63	☐
Death of a close fmaily member	63	☐
Major personal injury or illness	53	☐
Marriage	50	☐
Being tired from work	47	☐
Maritial reconciliation	45	☐
Retirement from work	45	☐
Major change in health or behavior of a family member	44	☐
Pregnancy	40	☐
Sexual Difficulties	39	☐
Gaining a new family member (birth, adoption, older adult moving in, etc.)	39	☐
Major Business readjustment	39	☐
Major change in financial state (a lot worse or better off than usual)	38	☐
Death of a close friend	37	☐
Changing to a different line of work	36	☐
Major change in number of arguments with spouse on core issues	35	☐
Taking on a mortgage (for home, business, etc.)	31	☐
Foreclosure on a mortgage or loan	30	☐
Major change in responsibilities at work (promotion,demotion, etc.)	29	☐
Son or daughter leaving home (marriage, college, etc.)	29	☐
Conflict or tension with parents/in laws	29	☐
Outstanding personal achievement	28	☐
Spouse beginning or ceasing work outside the home	26	☐
Beginning or completing formal schooling	26	☐
Major change in living condition (new home, remodeling, deterioration of home)	25	☐
Change of personal habits (dress, manners, association, quitting, smoking)	24	☐
Conflict at work with emplyer or manager	23	☐
Major changes in working hours or conditions	20	☐
Changes in residence	20	☐
Changing to a new school	20	☐
Major change in usual type/ or amount of recreation	19	☐
Major change in church activity (a lot more or less than usual)	19	☐
Major change in social activities (clubs, movies, visiting, etc)	18	☐
Taking on a loan (car, TV, appliances, etc..)	17	☐
Major change in sleeping habits (a lot more or less than usual)	16	☐
Major change in number of family get-togethers	15	☐
Major change in eating habits (food amount, meal hours or surrounding)	15	☐
Vacation	13	☐
Major holidays	12	☐
Minor violations of the law (traffic tickets, etc...)	11	☐

Your Total

Disc Scoring Sheet

In order to determine your Communication Style, please complete the following:

For each of the 10 word groups below, select the word that is MOST like you, LEAST like you, and IN BETWEEN. You are to assign 4 points to the word that is most like you, 3 points to the word that is like you, 2 points to the word that is somewhat like you, and 1 point to the word that is least like you. (There should be a 4, a 3, a 2, and a 1 on each line. See the example) Once you have completed this, follow the next set of instructions.

Example:

1.	3	Determined	4	Convincing	1	Predictable	2	Cautious

1.		Determined		Convincing		Predictable		Cautious
2.		Strong Willed		Persuausive		Easy-going		Orderly
3.		Direct		Expressive		Kind		Analytical
4.		Bold		Socialable		Cooperative		Precise
5.		Outspoken		Animated		Patient		Logical
6.		Decisive		Talkative		Loyal		Controlled
7.		Daring		Outgoing		Agreeable		Careful
8.		Restless		Enthusiastic		Considerate		Thorough
9.		Competitive		Inspiring		Consistent		Detailed
10.		Aggressive		Playful		Satisfied		Accurate

Once you have assigned numbers to all 10 word groups, total the points for each column and write the total in the spaces provided below.

Totals:				
Styles:	D	I	S	C

Readiness Assessment

Rate on a scale of: 5 (very willing) to 1 (not willing)

	5	4	3	2	1
In order to improve your health, how willing are you to:	◯	◯	◯	◯	◯
Significantly modify your diet	◯	◯	◯	◯	◯
Take nutritional supplements each day	◯	◯	◯	◯	◯
Keep a record of everything you eat each day	◯	◯	◯	◯	◯
Modify your lifestyle (e.g. work demands, sleep habits)	◯	◯	◯	◯	◯
Practice relaxation techniques	◯	◯	◯	◯	◯
Engage in regular exercise	◯	◯	◯	◯	◯
Have periodic lab tests to assess progress	◯	◯	◯	◯	◯

Comments:

Thank you for taking the time to complete this health history medical questionnaire. The information derived from all of these forms will provide invaluable data in identifying the underlying problems of your health concerns rather than simply treating the symptoms alone. We look forward to helping you achieve lifelong health and well being.

Sincerely,

Your Health Solutions Team