Medicatrix

Where Healthcare Is Individualized

Health Questionnaire

500 N. Fourth Street
Albemarle, NC 28001

(704) 438-7396
www.medicatrix.doctorsoffice.net

Medicatrix

Where Healthcare Is Individualized

GENERAL INFORMATION

Name *First* *Middle* *Last*

Preferred Name

Date of Birth

Age

Gender ○ Male ○ Female

Genetic Background ☐ African ☐ European ☐ Native American ☐ Mediterranean ☐ Asian ☐ Ashkenazi ☐ Middle Eastern ☐ _____

Mother's Name Occupation

Father's Name Occupation

Person completing this questionnaire

Primary Address *Number, Street* *Apt. No.*

City *State* *Zip*

Alternate Address *Number, Street* *Apt. No.*

City *State* *Zip*

Home Phone 1

Home Phone 2

Parent's Work Phone

Parent's Cell Phone

Fax

Email

Emergency Contact *Name* *Phone Number*

Address *Apt. No.*

City *State* *Zip*

Physician *Name* *Phone Number*

Fax

Referred by ○ Book ○ Website ○ Media ○ Friend or Family Member ○ Other _____

PHARMACY INFORMATION

Primary Pharmacy

Name _____ *Phone Number* _____

Address _____

City _____ *State* _____ *Zip* _____

E-mail _____ **Fax*** _____

**** It is extremely important that you list the pharmacy's fax number.***

Compounding/ Supplement Pharmacy

Name _____ *Phone Number* _____

Address _____

City _____ *State* _____ *Zip* _____

E-mail _____ **Fax*** _____

**** It is extremely important that you list the pharmacy's fax number.***

CREDIT CARD INFORMATION

Patient _____ Date _____

DOB _____

Preferred Method of Payment *(please circle one)*: Cash / Check / Credit Card

If paying by credit card, we accept VISA, MasterCard and Discover

**Note: If Discover is your primary card, please provide another card (i.e., MasterCard or Visa) for transactions (i.e., supplement orders, etc.) that we may need to process. Some pharmacies do not accept Discover.*

PRIMARY CARD

Name on Card _____

Card Type ○ Visa ○ MasterCard ○ Discover

Account Number _____

Expiration Date (mm/yy) _____

CVV# _____

SECONDARY CARD

Name on Card _____

Card Type ○ Visa ○ MasterCard ○ Discover

Account Number _____

Expiration Date (mm/yy) _____

CVV# _____

Medical Questionnaire

ALLERGIES

Medication/Supplement/Food	Reaction

COMPLAINTS/CONCERNS

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

_____

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

1. _____
2. _____
3. _____

When was the last time you felt well? _____

_____

Did something trigger your change in health? _____

_____

What makes you feel worse? _____

_____

What makes you feel better? _____

_____

Please list current and ongoing problems in order of priority:

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

MEDICAL HISTORY

☑ = *Past Condition* ☑ = *Ongoing Condition*

DISEASES/DIAGNOSIS/CONDITIONS *Check appropriate box and provide date of onset*

GASTROINTESTINAL

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

CARDIOVASCULAR

☐ ☐ Heart Attack _____
☐ ☐ Other Heart Disease _____
☐ ☐ Stroke _____
☐ ☐ Elevated Cholesterol _____
☐ ☐ Arrythmia (irregular heart rate) _____
☐ ☐ Hypertension (high blood pressure) _____
☐ ☐ Rheumatic Fever _____
☐ ☐ Mitral Valve Prolapse _____
☐ ☐ Other _____

METABOLIC/ENDOCRINE

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

CANCER

☐ ☐ Lung Cancer _____
☐ ☐ Breast Cancer _____
☐ ☐ Colon Cancer _____
☐ ☐ Ovarian Cancer _____
☐ ☐ Prostate Cancer _____
☐ ☐ Skin Cancer _____
☐ ☐ Other _____

GENITAL AND URINARY SYSTEMS

☐ ☐ Kidney Stones _____
☐ ☐ Gout _____
☐ ☐ Interstitial Cystitis _____
☐ ☐ Frequent Urinary Tract Infections _____
☐ ☐ Frequent Yeast Infections _____
☐ ☐ Erectile Dysfunction
or Sexual Dysfunction _____
☐ ☐ Other _____

MUSCULOSKELETAL/PAIN

☐ ☐ Osteoarthritis _____
☐ ☐ Fibromyalgia _____
☐ ☐ Chronic Pain _____
☐ ☐ Other _____

INFLAMMATORY/AUTOIMMUNE

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

RESPIRATORY DISEASES

☐ ☐ Asthma _____
☐ ☐ Chronic Sinusitis _____
☐ ☐ Bronchitis _____
☐ ☐ Emphysema _____
☐ ☐ Pneumonia _____
☐ ☐ Tuberculosis _____
☐ ☐ Sleep Apnea _____
☐ ☐ Other _____

SKIN DISEASES

☐ ☐ Eczema _____
☐ ☐ Psoriasis _____
☐ ☐ Acne _____
☐ ☐ Melanoma _____
☐ ☐ Skin Cancer _____
☐ ☐ Other _____

MEDICAL HISTORY (CONTINUED)

☑ = *Past Condition* ☑ = *Ongoing Condition*

NEUROLOGIC/MOOD

- ☐ ☐ Depression _____
- ☐ ☐ Anxiety _____
- ☐ ☐ Bipolar Disorder _____
- ☐ ☐ Schizophrenia _____
- ☐ ☐ Headaches _____
- ☐ ☐ Migraines _____
- ☐ ☐ ADD/ADHD _____
- ☐ ☐ Autism _____
- ☐ ☐ Mild Cognitive Impairment _____
- ☐ ☐ Memory Problems _____
- ☐ ☐ Parkinson's Disease _____
- ☐ ☐ Multiple Sclerosis _____
- ☐ ☐ ALS _____
- ☐ ☐ Seizures _____
- ☐ ☐ Other Neurological Problems _____

PREVENTIVE TESTS AND DATE OF LAST TEST

Check box if yes and provide date

- ☐ Full Physical Exam _____
- ☐ Bone Density _____
- ☐ Colonoscopy _____
- ☐ Cardiac Stress Test _____
- ☐ EBT Heart Scan _____
- ☐ EKG _____
- ☐ Hemoccult Test-stool test for blood _____
- ☐ MRI _____
- ☐ CT Scan _____
- ☐ Upper Endoscopy _____
- ☐ Upper GI Series _____
- ☐ Ultrasound _____

SURGERIES

Check box if yes and provide date of surgery

- ☐ Appendectomy _____
- ☐ Hysterectomy +/- Ovaries _____
- ☐ Gall Bladder _____
- ☐ Hernia _____
- ☐ Tonsillectomy _____
- ☐ Dental Surgery _____
- ☐ Joint Replacement–Knee/Hip _____
- ☐ Heart Surgery–Bypass Valve _____
- ☐ Angioplasty or Stent _____
- ☐ Pacemaker _____
- ☐ Other _____
- ☐ None _____

INJURIES

Check box if yes

- ☐ Back Injury
- ☐ Neck Injury
- ☐ Head Injury
- ☐ Broken Bones
- ☐ Other _____

BLOOD TYPE:

○ A ○ B ○ AB ○ 0
○ 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

Age at First Period:_____ Menses Frequency:_____ Length:_____ Pain: ○ Yes ○ No Clotting: ○ Yes ○ No

Has your period ever skipped?_____ For how long?_____

Last Menstrual Period:_____

Use of hormonal contraception such as: ☐ Birth Control Pills ☐ Patch ☐ Nuva Ring How long?_____

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

WOMEN'S DISORDERS/HORMONAL IMBALANCES

☐ Fibrocystic Breasts ☐ Endometriosis ☐ Fibroids ☐ Infertility

☐ Painful Periods ☐ Heavy periods ☐ PMS

Last Mammogram:_____ ☐ Breast Biopsy/Date:_____

Last PAP Test:_____ ○ Normal ○ Abnormal

Last Bone Density:_____ Results: ○ High ○ Low ○ Within Normal Range

Are you in menopause? ○ Yes ○ No

Age at Menopause_____

☐ Hot Flashes ☐ Mood Swings ☐ Concentration/Memory Problems ☐ Vaginal Dryness ☐ Decreased Libido

☐ Heavy Bleeding ☐ Joint Pains ☐ Headaches ☐ Weight Gain ☐ Loss of Control of Urine ☐ Palpitations

☐ Use of hormone replacement therapy. How long?_____

MEN'S HISTORY *(for men only)*

Have you had a PSA done? ○ Yes ○ No

PSA Level: ☐ 0-2 ☐ 2-4 ☐ 4-10 ☐ > 10

☐ Prostate Enlargement ☐ Prostate infection ☐ Change in Libido ☐ Impotence

☐ Difficulty Obtaining an Erection ☐ Difficulty Maintaining an Erection

☐ Nocturia (urination at night). How many times at night? _____

☐ Urgency/Hesitancy/Change in Urinary Stream ☐ Loss of Control of Urine

GI HISTORY

Foreign Travel? ○ Yes ○ No Where? _____

Wilderness Camping? ○ Yes ○ No Where? _____

Have you ever had severe: ☐ Gastroenteritis ☐ Diarrhea

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

Do you feel bloated after meals? ○ Yes ○ No

PATIENT BIRTH HISTORY

○ Term ○ Premature

Pregnancy Complications: _____

Birth Complications: _____

☐ Breast Fed. How long? _____ ☐ Bottle-fed

Age at introduction of: Solid Foods: _____ Dairy: _____ Wheat: _____

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

DENTAL HISTORY

DENTAL SURGERY

☐ Silver Mercury Fillings How many? _____

☐ Gold Fillings ☐ Root Canals ☐ Implants ☐ Tooth Pain ☐ Bleeding Gums

☐ Gingivitis ☐ Problems with Chewing

Do you floss regularly? ○ Yes ○ No

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 and Brand	Dose	Frequency	Start Date (month/year)	Reason For Use

Have your medications or supplements ever caused you unusual side effects or problems? ○ Yes ○ No
Describe: _____

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ○ Yes ○ No

Have you had prolonged or regular use of Tylenol? ○ Yes ○ No

Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.) ○ Yes ○ No

Frequent antibiotics > 3 times/year ○ Yes ○ No

Long term antibiotics ○ Yes ○ No

Use of steroids (prednisone, nasal allergy inhalers) in the past ○ Yes ○ No

Use of oral contraceptives ○ Yes ○ No

FAMILY HISTORY

Check family members that apply	Mother	Father	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)												
Cancers	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Breast or Ovarian Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Sondylitis)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Inflammatory Bowel Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Auto Immune Diseases (such as Lupus)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Irritable Bowel Syndrome	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Celiac Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Eczema / Psoriasis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Food Allergies, Sensitivities or Intolerances	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Environmental Sensitivities	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Parkinson's	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
ALS or other Motor Neuron Diseases	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Genetic Disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Substance Abuse (such as alcoholism)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric Disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
ADHD	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Autism	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bipolar Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

SOCIAL HISTORY

NUTRITION HISTORY

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

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

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

Check all that apply:

☐ Low Fat ☐ Low Carbohydrate ☐ High Protein ☐ Low Sodium ☐ Diabetic ☐ No Dairy ☐ No Wheat

☐ Gluten Restricted ☐ Vegetarian ☐ Vegan ☐ Ultrametabolism

☐ Specific Program for Weight Loss/Maintenance Type: _____ ☐ Other_____

Height (feet/inches)_____	Current Weight _____
Usual Weight Range +/- 5 lbs _____	Desired Weight Range +/- 5 lbs _____
Highest adult weight _____	Lowest adult weight _____
Weight Fluctuations (> 10 lbs.) ○ Yes ○ No	Body Fat % _____

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

Have you ever had your metabolism (resting metabolic rate) checked? ○ Yes ○ No If yes, what was it? _____

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

_____

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

_____

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

Do you read food labels? ○ Yes ○ No _____

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

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

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

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

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

_____

SMOKING

Currently Smoking? ○ Yes ○ No How many years? _____ Packs per day: _____

Attempts to quit: _____

Previous Smoking: How many years? _____ Packs per day? _____

Second Hand Smoke Exposure? _____

ALCOHOL INTAKE

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

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

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

Have you ever been told you should cut down your alcohol intake? ○ Yes ○ No

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

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

Do you ever take an eye-opener? ○ Yes ○ No

Do you notice a tolerance to alcohol (can you "hold" more than others)? ○ Yes ○ No

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

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

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

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

OTHER SUBSTANCES

Caffeine Intake: ○ Yes ○ No | Coffee cups/day: ☐ 1 ☐ 2-4 ☐ > 4 | Tea cups/day: ☐ 1 ☐ 2-4 ☐ > 4

Caffeinated Sodas or Diet Sodas Intake: ○ Yes ○ No

12-ounce can/bottle ☐ 1 ☐ 2-4 ☐ > 4 per day

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

Are you currently using any recreational drugs? ○ Yes ○ No Type _____

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

EXERCISE

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

Activity	Type	Frequency Per Week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength			
Other (yoga, pilates, gyrotonics, 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

PSYCHOSOCIAL

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

Are you happy? ○ Yes ○ No

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

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

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

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

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

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

STRESS/COPING

Have you ever sought counseling? ○ Yes ○ No

Are you currently in therapy? ○ Yes ○ No Describe: _____

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

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

Daily Stressors: Rate on scale of 1-10

Work _____ Family _____ Social _____ Finances_____ Health_____ Other_____

Do you practice meditation or relaxation techniques? ○ Yes ○ No How often? _____

Check all that apply: ☐ Yoga ☐ Meditation ☐ Imagery ☐ Breathing ☐ Tai Chi ☐ Prayer ☐ Other: _____

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

SLEEP/REST

Average number of hours you sleep per night: ☐ >10 ☐ 8-10 ☐ 6-8 ☐ < 6

Do you 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: _____

ROLES/RELATIONSHIP

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

List Children:

Child's Name	Age	Gender

Who is Living in Household? Number:_____ Names: _____

Their Employment/Occupations: _____

Resources for emotional support?

Check all that apply: ☐ Spouse ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other: _____

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

How well have things been going for you?	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	○	○	○	○

ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

Do you have known adverse food reactions or sensitivities? ○ Yes ○ No If yes, describe symptoms: _____

_____

Do you have any food allergies or sensitivities? ○ Yes List all: _____ ○ No

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

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

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

☐ Monosodium glutamate (MSG) ☐ Aspartame (Nutrasweet) ☐ Caffeine ☐ Bananas ☐ Garlic ☐ Onion

☐ Cheese ☐ Citrus Foods ☐ Chocolate ☐ Alcohol ☐ Red Wine

☐ Sulfite Containing Foods (wine, dried fruit, salad bars) ☐ Preservatives (ex. sodium benzoate)

☐ Other: _____

Which of these significantly affect you? *Check all that apply*:

☐ Cigarette Smoke ☐ Perfumes/Colognes ☐ Auto Exhaust Fumes ☐ Other: _____

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

Have you ever turned yellow (jaundiced)? ○ Yes ○ No

Have you ever been told you have Gilbert's syndrome or a liver disorder? ○ Yes ○ No

Explain: _____

Do you have a known history of significant exposure to any harmful chemicals such as the following:

☐ Herbicides ☐ Insecticides (frequent visits of exterminator) ☐ Pesticides ☐ Organic Solvents

☐ Heavy Metals ☐ Other _____

Chemical Name, Date, Length of Exposure: _____

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

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

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

SYMPTOM REVIEW

Please check all current symptoms occurring or present in the past 6 months.

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

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

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

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

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

Difficulty:
- ☐ Concentrating
- ☐ With Balance
- ☐ With Thinking
- ☐ With Judgment
- ☐ With Speech
- ☐ With Memory

- ☐ Dizziness (Spinning)
- ☐ Fainting
- ☐ Fearfulness
- ☐ Irritability
- ☐ Light-headedness
- ☐ Numbness
- ☐ Other Phobias
- ☐ Panic Attacks
- ☐ Paranoia
- ☐ Seizures
- ☐ Suicidal Thoughts
- ☐ Tingling
- ☐ Tremor/Trembling
- ☐ Visual Hallucinations

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

DIGESTION
- ☐ Anal Spasms
- ☐ Bad Teeth
- ☐ Bleeding Gums

Bloating of:
- ☐ Lower Abdomen
- ☐ Whole Abdomen
- ☐ Bloating After Meals

- ☐ Blood in Stools
- ☐ Burping
- ☐ Canker Sores
- ☐ Cold Sores
- ☐ Constipation
- ☐ Cracking at Corner of Lips
- ☐ Cramps
- ☐ Dentures w/Poor Chewing
- ☐ Diarrhea
- ☐ Alternating Diarrhea and Constipation
- ☐ Difficulty Swallowing
- ☐ Dry Mouth
- ☐ Excess Flatulence/Gas
- ☐ Fissures
- ☐ Foods "Repeat" (Reflux)
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Upper Abdominal Pain
- ☐ Vomiting

Intolerance to:
- ☐ Lactose
- ☐ All Dairy Products
- ☐ Wheat
- ☐ Gluten (Wheat, Rye, Barley)
- ☐ Corn
- ☐ Eggs
- ☐ Fatty Foods
- ☐ Yeast

- ☐ Liver Disease/Jaundice (Yellow Eyes or Skin)
- ☐ Abnormal Liver Function Tests
- ☐ Lower Abdominal Pain
- ☐ Mucus in Stools
- ☐ Periodontal Disease
- ☐ Sore Tongue
- ☐ Strong Stool Odor
- ☐ Undigested Food in Stools

SKIN PROBLEMS
- ☐ Acne on Back
- ☐ Acne on Chest
- ☐ Acne on Face
- ☐ Acne on Shoulders
- ☐ Athlete's Foot
- ☐ Bumps on Back of Upper Arms
- ☐ Cellulite
- ☐ Dark Circles Under Eyes
- ☐ Ears Get Red
- ☐ Easy Bruising
- ☐ Lack Of Sweating
- ☐ Eczema
- ☐ Hives
- ☐ Jock Itch
- ☐ Lackluster Skin
- ☐ Moles w/Color/Size Change
- ☐ Oily Skin
- ☐ Pale Skin
- ☐ Patchy Dullness
- ☐ Rash
- ☐ Red Face
- ☐ Sensitivity to Bites
- ☐ Sensitivity to Poison Ivy/Oak
- ☐ Shingles
- ☐ Skin Darkening
- ☐ Strong Body Odor
- ☐ Hair Loss
- ☐ Vitiligo

ITCHING SKIN
- ☐ Skin in General
- ☐ Anus
- ☐ Arms
- ☐ Ear Canals
- ☐ Eyes
- ☐ Feet
- ☐ Hands
- ☐ Legs
- ☐ Nipples
- ☐ Nose
- ☐ Penis
- ☐ Roof of Mouth
- ☐ Scalp
- ☐ Throat

SKIN, DRYNESS OF
- ☐ Eyes
- ☐ Feet
  - ☐ Any Cracking?
  - ☐ Any Peeling?
- ☐ Hair
  - ☐ And Unmanageable?
- ☐ Hands
  - ☐ Any Cracking?
  - ☐ Any Peeling?
- ☐ Mouth/Throat
- ☐ Scalp
  - ☐ Any Dandruff?
- ☐ Skin In General

LYMPH NODES
- ☐ Enlarged/neck
- ☐ Tender/neck
- ☐ Other Enlarged/Tender
- ☐ Lymph Nodes

NAILS
- ☐ Bitten
- ☐ Brittle
- ☐ Curve Up
- ☐ Frayed
- ☐ Fungus-Fingers
- ☐ Fungus-Toes
- ☐ Pitting
- ☐ Ragged Cuticles
- ☐ Ridges
- ☐ Soft

Thickening of:
- ☐ Fingernails
- ☐ Toenails

- ☐ White Spots/Lines

RESPIRATORY
- ☐ Bad Breath
- ☐ Bad Odor in Nose
- ☐ Cough-Dry
- ☐ Cough-Productive
- ☐ Hoarseness
- ☐ Sore Throat

Hay Fever:
- ☐ Spring
- ☐ Summer
- ☐ Fall
- ☐ Change Of Season

- ☐ Nasal Stuffiness
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Fullness
- ☐ Sinus Infection
- ☐ Snoring
- ☐ Wheezing
- ☐ Winter Stuffiness

CARDIOVASCULAR
- ☐ Angina/chest pain
- ☐ Breathlessness
- ☐ Heart Murmur
- ☐ Irregular Pulse
- ☐ Palpitations
- ☐ Phlebitis
- ☐ Swollen Ankles/Feet
- ☐ Varicose Veins

URINARY
- ☐ Bed Wetting
- ☐ Hesitancy (trouble getting started)
- ☐ Infection
- ☐ Kidney Disease
- ☐ Leaking/Incontinence
- ☐ Pain/Burning
- ☐ Prostate Infection
- ☐ Urgency

MALE REPRODUCTIVE
- ☐ Discharge From Penis
- ☐ Ejaculation Problem
- ☐ Genital Pain
- ☐ Impotence
- ☐ Prostate or Urinary Infection
- ☐ Lumps In Testicles
- ☐ Poor Libido (Sex Drive)

FEMALE REPRODUCTIVE
- ☐ Breast Cysts
- ☐ Breast Lumps
- ☐ Breast Tenderness
- ☐ Ovarian Cyst
- ☐ Poor Libido (Sex Drive)
- ☐ Vaginal Discharge
- ☐ Vaginal Odor
- ☐ Vaginal Itch
- ☐ Vaginal Pain with Sex

Premenstrual:
- ☐ Bloating Breast Tenderness
- ☐ Carbohydrate Cravings
- ☐ Chocolate Cravings
- ☐ Constipation
- ☐ Decreased Sleep
- ☐ Diarrhea
- ☐ Fatigue
- ☐ Increased Sleep
- ☐ Irritability

Menstrual:
- ☐ Cramps
- ☐ Heavy Periods
- ☐ Irregular Periods
- ☐ No Periods
- ☐ Scanty Periods
- ☐ Spotting Between

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 a relaxation technique ..... ○5 ○4 ○3 ○2 ○1

Engage in regular exercise ..... ○5 ○4 ○3 ○2 ○1

Have periodic lab tests to assess your 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 (very unsupportive):

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

Comments

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

How much on-going support and contact (e.g., telephone consults, e-mail correspondence) from our professional staff would be helpful to you as you implement your personal health program? - ○5 ○4 ○3 ○2 ○1

Comments

3-DAY DIET DIARY INSTRUCTIONS

It is important to keep an accurate record of your usual food and beverage intake as a part of your treatment plan. Please complete this Diet Diary for 3 consecutive days including one weekend day.

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

DIET DIARY

Name: _____ Date: _____

DAY 1

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Bowel Movements (#, form, color) _____

Stress/Mood/Emotions _____

Other Comments _____

DAY 2

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Bowel Movements (#, form, color) _____

Stress/Mood/Emotions _____

Other Comments _____

DAY 3

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Bowel Movements (#, form, color) _____

Stress/Mood/Emotions _____

Other Comments _____

MSQ - MEDICAL SYMPTOM/TOXICITY QUESTIONNAIRE

NAME: _____ **DATE:** _____

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are completing this after your first time, then record your symptoms for the last 48 hours ONLY.

POINT SCALE

0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

DIGESTIVE TRACT

___ Nausea or vomiting
___ Diarrhea
___ Constipation
___ Bloated feeling
___ Belching or passing gas
___ Heartburn
___ Intestinal/Stomach pain

Total 0

EARS

___ Itchy ears
___ Earaches, ear infections
___ Drainage from ear
___ Ringing in ears, hearing loss

Total 0

EMOTIONS

___ Mood swings
___ Anxiety, fear or nervousness
___ Anger, irritability or aggressiveness
___ Depression

Total 0

ENERGY/ACTIVITY

___ Fatigue, sluggishness
___ Apathy, lethargy
___ Hyperactivity
___ Restlessness

Total 0

EYES

___ Watery or itchy eyes
___ Swollen, reddened or sticky eyelids
___ Bags or dark circles under eyes
___ Blurred or tunnel vision (does not include near or far-sightedness)

Total 0

HEAD

___ Headaches
___ Faintness
___ Dizziness
___ Insomnia

Total 0

HEART

___ Irregular or skipped heartbeat
___ Rapid or pounding heartbeat
___ Chest pain

Total 0

JOINTS/MUSCLES

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

Total 0

LUNGS

___ Chest congestion
___ Asthma, bronchitis
___ Shortness of breath
___ Difficult breathing

Total 0

MIND

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

Total 0

MOUTH/THROAT

___ Chronic coughing
___ Gagging, frequent need to clear throat
___ Sore throat, hoarseness, loss of voice
___ Swollen/discolored tongue, gum, lips
___ Canker sores

Total 0

NOSE

___ Stuffy nose
___ Sinus problems
___ Hay fever
___ Sneezing attacks
___ Excessive mucus formation

Total 0

SKIN

___ Acne
___ Hives, rashes or dry skin
___ Hair loss
___ Flushing or hot flushes
___ Excessive sweating

Total 0

WEIGHT

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

Total 0

OTHER

___ Frequent illness
___ Frequent or urgent urination
___ Genital itch or discharge

Total 0

GRAND TOTAL 0

KEY TO QUESTIONNAIRE

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

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