How committed are you to making changes to diet and lifestyle as directed by a physician?

❑ Very Little ❑ Moderately ❑ Very Hesitations?_____

List in order of importance what you current problems are:

1) _____

2) _____

3) _____

4) _____

5) _____

Please rate the following:

	Low / Bad					OK				High / Good
Energy	1	2	3	4	5	6	7	8	9	10
Sleep	1	2	3	4	5	6	7	8	9	10
Fatigue	1	2	3	4	5	6	7	8	9	10

How long do you sleep at night? _____hrs If you wake up frequently, what is the reason?_____

❑ Wake refreshed ❑ Nightmares ❑ Grind teeth ❑ Snore ❑ Day naps

Exercise? ❑ NO ❑ YES Frequency / Duration of exercise: _____

Hobbies? Describe:_____

Quality significant relationship(s)? _____ Active spiritual practice? _____

History of mental, physical, emotional or sexual abuse? ❑ NO ❑ YES

If YES, at what age and by whom? _____

Do you enjoy your job? ❑ NO ❑ YES Hours worked per week: _____

Present weight:_____ Ideal weight:_____ Maximum weight:_____

Have you lost or gained weight quickly? ❑ NO ❑ YES If YES, when?_____

Did you grow up near any refinery, polluted area or in a home with leaded paint?

_____

Have you held any jobs where you were exposed to solvents, heavy metals, fumes or toxic materials?

_____

Have you had health problems when you put in new carpeting, installed new cabinets or painted?

_____

Are you sensitive to perfumes, gasoline or other vapors?

_____

Please list all prescription medications, pain medications, antacids, OTC medications, herb/supplements, homeopathic remedies that you are currently taking medicinally.

Medication	Dose	Medication	Dose

Have you had blood work done recently? ❑ NO ❑ YES If YES, when? _____

Where you immunized **(I)** or have you had the following diseases **(D)**?

Measles	❑ I	❑ D	Chicken Pox	❑ I	❑ D	Hemophilus (Hib)	❑ I	❑ D
Tetanus	❑ I	❑ D	Whooping Cough	❑ I	❑ D	Rubella	❑ I	❑ D
German Measles	❑ I	❑ D	Mumps	❑ I	❑ D	Hepatitis	❑ I	❑ D

Other immunizations:_____

Tobacco	❑ NO	❑ YES	How many years:_____	Date Quit:_____
Alcohol	❑ NO	❑ YES	Frequency:_____	Amount:_____
Soda	❑ NO	❑ YES	Type:_____	Per Day:_____
Recreational Drugs	❑ NO	❑ YES	Describe:_____	

Please indicate if an immediate *family* member has had any of the following:

		Relation			Relation
Heart Disease	❑ YES	_____	High Cholesterol	❑ YES	_____
Heart Attack	❑ YES	_____	Epilepsy/Seasures	❑ YES	_____
High Blood Pressure	❑ YES	_____	Arthritis	❑ YES	_____
Stroke	❑ YES	_____	Mental/Emotional Problems	❑ YES	_____
Asthma	❑ YES	_____	Diabetes	❑ YES	_____
Ulcers/Digestive Problems	❑ YES	_____	Hepatitis/Liver Problems	❑ YES	_____
Drugs/Alcohol Problems	❑ YES	_____	Thyroid Disease	❑ YES	_____
Cancer: Breast	❑ YES	_____	Sleep Apnea	❑ YES	_____
Colon	❑ YES	_____	Anemia/Blood Disease	❑ YES	_____
Prostate	❑ YES	_____	HIV/AIDS	❑ YES	_____
Other	❑ YES	_____	Tuberculosis	❑ YES	_____
Kidney Stones	❑ YES	_____	Osteoporosis	❑ YES	_____
Gallbladder Disease	❑ YES	_____			

FOR THE FINAL SECTION, LEAVE THE SPACE/SECTION BLANK IF THE ANSWER IS NO OR NOT RELEVANT. MARK **Y** FOR YES OR **P** FOR IN THE PAST.

SKIN			
Rash	❑ Y ❑ P	Color Change	❑ Y ❑ P
Hives	❑ Y ❑ P	Lumps	❑ Y ❑ P
Psoriasis/eczema	❑ Y ❑ P	Itchy	❑ Y ❑ P
Dry	❑ Y ❑ P	Warts/moles	❑ Y ❑ P
Cancer	❑ Y ❑ P	Excessive Perspiration	❑ Y ❑ P
HEAD			
Headaches	❑ Y ❑ P	Migraines	❑ Y ❑ P
Dandruff	❑ Y ❑ P	Head Injury	❑ Y ❑ P
Oil/dry hair	❑ Y ❑ P	Hair loss	❑ Y ❑ P
NOSE			
Frequent Colds	❑ Y ❑ P	Nosebleeds	❑ Y ❑ P
Congestion	❑ Y ❑ P	Post Nasal Drip	❑ Y ❑ P
Polyps	❑ Y ❑ P	Seasonal Allergies	❑ Y ❑ P
EYES			
Dry/Watery	❑ Y ❑ P	Blurry Vision	❑ Y ❑ P
Double Vision	❑ Y ❑ P	Cataracts	❑ Y ❑ P
Glaucoma	❑ Y ❑ P	Styes	❑ Y ❑ P
Strain	❑ Y ❑ P	Discharge	❑ Y ❑ P
Itchy	❑ Y ❑ P	Dark Under Eyelid	❑ Y ❑ P
MOUTH/THROAT			
Canker Sores	❑ Y ❑ P	Cold Sores	❑ Y ❑ P
Sore Throat	❑ Y ❑ P	Gum Disease	❑ Y ❑ P
Dentures	❑ Y ❑ P	Cavities	❑ Y ❑ P
Loss of Taste	❑ Y ❑ P	Hoarseness	❑ Y ❑ P
NECK			
Stiffness	❑ Y ❑ P	Swollen Glands	❑ Y ❑ P
Full Movement	❑ Y ❑ P	Tension	❑ Y ❑ P
RESPIRATORY			
Cough	❑ Y ❑ P	TB	❑ Y ❑ P
Shortness of Breath w/ Exertion	❑ Y ❑ P	Bronchitis	❑ Y ❑ P
Shortness of Breath Sitting	❑ Y ❑ P	Pneumonia	❑ Y ❑ P
Shortness of Breath Lying	❑ Y ❑ P	Asthma	❑ Y ❑ P
Wheezing	❑ Y ❑ P	Painful Breathing	❑ Y ❑ P
CARDIOVASCULAR			
High Blood Pressure	❑ Y ❑ P	Rheumatic Fever	❑ Y ❑ P
Low Blood Pressure	❑ Y ❑ P	Murmurs	❑ Y ❑ P
Arrhythmias	❑ Y ❑ P	Palpitations	❑ Y ❑ P
Edema	❑ Y ❑ P	Chest Pain	❑ Y ❑ P
URINARY			
Incontinence	❑ Y ❑ P	Pain w/ Urination	❑ Y ❑ P
Frequent Infections	❑ Y ❑ P	Kidney Stones	❑ Y ❑ P
Urgency	❑ Y ❑ P	Discharge of Blood	❑ Y ❑ P

GASTROINTESTINAL			
Heartburn	❑ Y ❑ P	Bowel Movement Frequency:_____	
Indigestion	❑ Y ❑ P	Recent BM Change	❑ Y
Bloating	❑ Y ❑ P	Diarrhea/Constipation	❑ Y ❑ P
Nausea	❑ Y ❑ P	Hemorrhoids	❑ Y ❑ P
Vomiting	❑ Y ❑ P	Gall Bladder Disease	❑ Y ❑ P
Change in Appetite	❑ Y ❑ P	Liver Disease	❑ Y ❑ P
Pancreatitis	❑ Y ❑ P	Ulcers	❑ Y ❑ P
MALE GENITALIA			
Testicular Pain/Swelling	❑ Y ❑ P	Sexually Active	❑ Y ❑ P
Hernia	❑ Y ❑ P	S.T.D.	❑ Y ❑ P
Discharge	❑ Y ❑ P	Prostate Problems	❑ Y ❑ P
Impotency	❑ Y ❑ P	Sexual Orientation:	❑ Hetero ❑ Homo ❑ Bi
FEMALE GENITALIA			
Age Period Began: _____		How often do periods occur? _____	
How long do periods last? _____		Heavy Menstrual Bleeding	❑ Y ❑ P
Menstrual Cramping	❑ Y ❑ P	Menstrual Pain	❑ Y ❑ P
PMS	❑ Y ❑ P	Food Cravings	❑ Y ❑ P
Pregnancies:_____		How many live births?_____	
Miscarriages:_____		Abortions:_____	
Last Pap Smear:_____		Diagnosis:_____	
Abnormal Paps	❑ Y ❑ P	Abnormal when?_____	
Menopausal since what age? _____		Healthy Libido	❑ Y ❑ P
Hormone Replacement Therapy	❑ Y ❑ P	Sexually Active	❑ Y ❑ P
Dry Vagina	❑ Y ❑ P	Vaginitis	❑ Y ❑ P
Pain w/ Intercourse	❑ Y ❑ P	Mammography	❑ Y ❑ P
S.T.D.	❑ Y ❑ P	When was the last mammogram?_____	
Dexa Scan	❑ Y ❑ P		
MUSCULOSKELETAL			
Weakness	❑ Y ❑ P	Arthritis	❑ Y ❑ P
Stiffness	❑ Y ❑ P	Leg Cramps	❑ Y ❑ P
Tremors	❑ Y ❑ P	Pain	❑ Y ❑ P
NERVOUS			
Paralysis	❑ Y ❑ P	Sciatica	❑ Y ❑ P
Tingling/Numbness	❑ Y ❑ P	Carpal Tunnel	❑ Y ❑ P
Seizures	❑ Y ❑ P	Fainting	❑ Y ❑ P
MENTAL/EMOTIONAL			
Depression	❑ Y ❑ P	Anger/Irritability	❑ Y ❑ P
Suicidal	❑ Y ❑ P	High-Strung/Tense	❑ Y ❑ P
Anxiety	❑ Y ❑ P	Fear/Panic	❑ Y ❑ P
Eating Disorder	❑ Y ❑ P	Psych Hospitalization	❑ Y ❑ P