



Karla Koch, ND, DOM

Introductory Patient Information

3538 Anderson Ave. SE
Albuquerque, NM 87106

Phone: 505-573-4325

Fax: 505-404-0875

www.salubrio.net
kkochnd@yahoo.com

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PATIENT CHECKLIST

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 3538 Anderson Ave. SE Albuquerque, NM 87106

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, and Visa. 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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IMPORTANT PATIENT INFORMATION

Patient Acceptance Policy

In order to best serve you, the *Patient Acceptance Policy* should be carefully reviewed. It is Dr. Koch'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. Koch 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. Koch assist in helping you. The medical questionnaire will allow Dr. Koch to quickly narrow 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. Koch. Once Dr. Koch 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. Koch has your completed questionnaires and copies of all your medical records, a one-hour appointment will be scheduled to review your case. Dr. Koch 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. Koch's time for reviewing your medical questionnaire, medical records and written report is **\$250**.

4. Based on your scheduled appointment and review of all your medical information, it may be necessary to obtain comprehensive blood chemistry. The blood chemistry test may include:

- 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

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 cash, check and/or credit card**. We accept Visa or Mastercard. We are also planning to implement an in-house medical credit card called **Care Credit** which can be used to cover the expense of any of your medical fees. Information on **Care Credit** can be obtained at my office and is subject to credit approval.

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. Koch 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. Koch. Dr. Koch 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 \$100 per hour, or \$60.00 for 30 minutes.

11. **Abnormal laboratory tests** will need to be re-evaluated. The success of your treatment will not only be measured on the reduction or 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

Karla Koch, ND, DOM

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 **Salubrio** 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 Salubrio; 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: _____



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Health Questionnaires

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kkochnd@yahoo.com



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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):

- African American Hispanic Mediterranean Asian
- Native American Caucasian Northern European 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 symptoms 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				

ILLNESSES	Date	Date	Date	Comments
Sleep apnea				
Stroke				
Thyroid disease				
Other (describe)				
INJURIES	Date	Date	Date	Comments
Head Injury				
Neck Injury				
Back Injury				
Fracture				
Other (describe)				
DIAGNOSTIC STUDIES	Date	Date	Date	Comments
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)				
OPERATIONS	Date	Date	Date	Comments
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(es) that required hospitalization. | |

If yes, please explain your illness:

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 1st 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 2nd 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
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												

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



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 you 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? _____

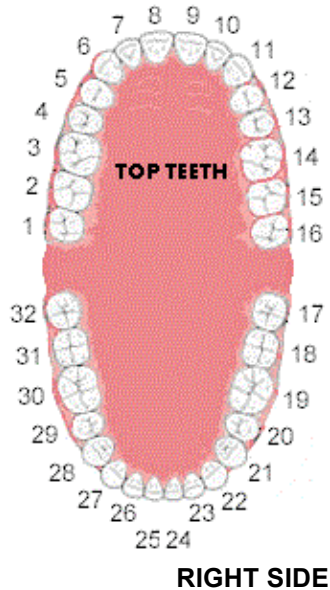
Did you play with mercury as a child or adult? Yes ____ No ____

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:

MEDICATIONS & SUPPLEMENTS

ANTIBIOTIC USE

Antibiotics: How often have you taken antibiotics?

	< 5 times	> 5 times
Infancy/Childhood		
Teen		
Adulthood		

STEROID USE

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

	< 5 times	> 5 times
Infancy/Childhood		
Teen		
Adulthood		

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

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

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

Yes ____ No ____ If yes, please describe: _____

ALLERGIES	
Medication/Supplement/Food	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

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?

- Organic Foods 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:

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

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

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

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) _____

Do you have an aversion to certain foods? Yes _____ No _____

If yes, what food(s) _____

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

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 2nd hand smoke? If yes, please explain: _____

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	_____
TOTAL SCORE					_____

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
TOTAL SCORE			_____

* 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)

- | | |
|--|--|
| <input type="checkbox"/> Childhood traumas | <input type="checkbox"/> Illness, either short-term or chronic |
| <input type="checkbox"/> Perfectionism | <input type="checkbox"/> Dieting: <i>constantly trying a new and improved diet program</i> |
| <input type="checkbox"/> Divorce or change in a relationship | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> Care giving: <i>taking care of a sick family member</i> | |
| <input type="checkbox"/> Job or career challenges | |

DO YOU WORRY OVER?

- | | |
|------------------------------------|---------------------------------|
| <input type="checkbox"/> Home life | <input type="checkbox"/> Job |
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Income |
| <input type="checkbox"/> Children | |

IS YOUR LIFE:

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Satisfactory | <input type="checkbox"/> Unsatisfactory |
| <input type="checkbox"/> Boring | <input type="checkbox"/> Money Problems |
| <input type="checkbox"/> Demanding | |

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?

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

Please indicate the occupation of your parents during your childhood:

- 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. _____

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, *Karla Koch*