Solutions medical center

Health looks Different here

Patient Intake Questionnaire

General Information

Today's Date: _____

Full Legal Name: _____ HT: _____ WT: _____

Preferred Name: _____ Date of Birth: _____ Age: _____ Gender: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Email Address: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

How did you hear about our practice? _____

Current Providers

Name	Type (PCP, OBGYN, Chiropractor, etc.)	Last Seen

Allergies

Name of Medication/Supplement/Food:	Reaction
1.	
2.	
3.	
4.	
5.	

Current Health Concerns

Please rank current and ongoing concerns in order of priority

Describe Problem	Severity	Mild	Moderate	Severe	Prior Treatment/Approach	Success	Excellent	Good	Fair
Example: Post Nasal Drip		*X*			*Elimination Diet*		*X*		
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									

LIFESTYLE REVIEW

Sleep

How many hours of sleep do you get each night on average? _____

Do you have problems falling asleep? ☐ Yes ☐ No Staying asleep? ☐ Yes ☐ No

Do you have problems with insomnia? ☐ Yes ☐ No Do you snore? ☐ Yes ☐ No

Do you feel rested upon awakening? ☐ Yes ☐ No

Do you use sleeping aids? ☐ Yes ☐ No

If yes, explain: _____

Exercise

Current Exercise Program:

Activity	Type	# of Times per Week	Time/Duration
Cardio/Aerobic			
Strength/Resistance			
Flexibility/Stretching			
Balance			
Sports/Leisure (e.g., golf)			
Other:			

Do you feel motivated to exercise? ☐ Yes ☐ A little ☐ No

Are there any problems that limit exercise? ☐ Yes ☐ No

If yes, explain: _____

Do you feel unusually fatigued or sore after exercise? ☐ Yes ☐ No

If yes, explain: _____

Nutrition

Please mark any special diet or nutrition regimens you currently follow: *(check all that apply)*

☐ NONE ☐ Vegetarian ☐ Vegan ☐ Elimination ☐ Allergy ☐ Low Fat

☐ High Protein ☐ No Dairy ☐ No Wheat ☐ Gluten Free ☐ Ketogenic ☐ Paleo

☐ Low Carb ☐ Blood Type ☐ Low Sodium ☐ WHOLE30 ☐ AIP ☐ Other: _____

Do you have sensitivities to certain foods? ☐ Yes ☐ No

If yes, list food and symptoms: _____

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

If yes, explain: _____

Do you adversely react to? *(check all that apply)*

☐ Chocolate (wine, dried fruit) ☐ Alcohol ☐ Garlic/Onion ☐ Cheese ☐ Citrus Foods ☐ Red Wine

☐ Preservatives ☐ Food Colorings ☐ Artificial Sweeteners

☐ Sulfite-containing foods ☐ Monosodium glutamate (MSG) ☐ Other: _____

Are there any foods that you crave or binge on? ☐ Yes ☐ No

If yes, which foods? _____

Nutrition Continued

Do you eat 3 meals a day? ☐ Yes ☐ No If no, how many? _____

Does skipping a meal greatly affect you? ☐ Yes ☐ No

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

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

- ☐ Fast eater
- ☐ Eat too much
- ☐ Late-night eating
- ☐ Dislike healthy foods
- ☐ Time constraints
- ☐ Travel frequently
- ☐ More than 50% of meals away from home
- ☐ Healthy foods not readily available
- ☐ Poor snack choices
- ☐ Don't know how to cook
- ☐ Confused about nutrition advice
- ☐ Others in household dislike healthy foods
- ☐ Others in household have special dietary needs
- ☐ Love to eat
- ☐ Eat because I have to
- ☐ Have a negative relationship with food
- ☐ Struggle with eating issues
- ☐ Emotional eater (eat when sad, lonely, bored, etc.)
- ☐ Eat too much under stress
- ☐ Eat too little under stress
- ☐ Don't care to cook

Diet

Please record what you eat in a typical day:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Fluids: Average DAILY water intake _____ oz, Others: _____

How many servings do you eat in a typical **WEEK** of the foods listed below?

Fruits (not juices)	_____	Vegetables (not including white potatoes)	_____
Nuts & Seeds	_____	Can of soda (regular or diet)	_____
Fats & Oils	_____	Legumes (beans, peas, etc)	_____
Red Meat	_____	Sweets (candy, cookies, cake, ice cream, etc.)	_____
Fish	_____	Dairy/Alternatives	_____

Do you drink other caffeinated beverages? ☐ Yes ☐ No *(If yes, check amounts below)*

Coffee (cups per day)	☐ 1	☐ 2-4	☐ >4
Tea	☐ 1	☐ 2-4	☐ >4
Caffeinated sodas *(regular or diet)*	☐ 1	☐ 2-4	☐ >4

Do you have adverse reactions to caffeine? ☐ Yes ☐ No

If yes, explain: _____

Nicotine

Do you smoke currently? ☐ Yes ☐ No Packs per day? _____ Number of years? _____

What type? ☐ Cigarettes ☐ Smokeless ☐ Pipe ☐ Cigar ☐ E-Cig/Vape

Have you attempted to quit? ☐ Yes ☐ No

If yes, using what methods? _____

If you smoked previously: Packs per day? _____ Number of years? _____

Are you regularly exposed to secondhand smoke? ☐ Yes ☐ No

Alcohol

How many alcoholic beverages do you drink in a week? *(1 drink = 5oz wine, 12oz beer, 1.5 oz spirits)*

☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ >10 ☐ None

Previous alcohol intake: ☐ Yes *(☐ Mild ☐ Moderate ☐ High)* ☐ No

Have you ever had a problem with alcohol? ☐ Yes ☐ No

If yes, when? _____

Explain the problem: _____

Have you ever thought about getting help to control or stop the problem? ☐ Yes ☐ No

Other Substances

Are you currently using any recreational drugs? ☐ Yes ☐ No

If yes, type: _____

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

Stress

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

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

How much do each of the following cause stress on a daily basis? *(rate on a scale of 1-10, 10 being highest)*

Family _____ Social _____ Finances _____ Health _____

Work _____ Other _____

Do you use relaxation techniques? ☐ Yes ☐ No

If yes, how often? _____

Which techniques do you use? *(check all that apply)*

☐ Meditation ☐ Breathing ☐ Tai Chi ☐ Yoga ☐ Prayer ☐ Other: _____

Have you ever sought counseling? ☐ Yes ☐ No

Are you currently in therapy? ☐ Yes ☐ No

If yes, describe: _____

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

What are your hobbies or leisure activities? _____

Relationships

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Long-Term Relationship ☐ Widowed

With whom do you live? (Include children, parents, relatives, friends, pets) _____

_____

Current occupation: _____

Previous occupations: _____

Do you have resources for emotional support? ☐ Yes ☐ No *(check all that apply)*

☐ Spouse/Partner ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other: _____

Do you have a religious or spiritual practice? ☐ Yes ☐ No

If yes, what kind? _____

How well have things been going for you? (Mark on a scale of 1-10, or N/A if not applicable)

	N/A	Poorly					Fine				Very Well
Overall	☐	1	2	3	4	5	6	7	8	9	10
At school	☐	1	2	3	4	5	6	7	8	9	10
In your job	☐	1	2	3	4	5	6	7	8	9	10
In your social life	☐	1	2	3	4	5	6	7	8	9	10
With close friends	☐	1	2	3	4	5	6	7	8	9	10
With sex	☐	1	2	3	4	5	6	7	8	9	10
With your attitude	☐	1	2	3	4	5	6	7	8	9	10
With your boyfriend/girlfriend	☐	1	2	3	4	5	6	7	8	9	10
With your children	☐	1	2	3	4	5	6	7	8	9	10
With your parents	☐	1	2	3	4	5	6	7	8	9	10
With your spouse	☐	1	2	3	4	5	6	7	8	9	10

HISTORY

Birth/Childhood History

You were born: ☐ Term ☐ Premature ☐ Don't know Via: ☐ Vaginal Delivery ☐ C-Section

Were there any pregnancy or birth complications? ☐ Yes ☐ No

If yes, explain: _____

You were: ☐ Breast-fed/How long? _____ ☐ Bottle-fed/Type of formula? _____ ☐ Don't know

Age of introduction of: Solid food _____ Wheat _____ Dairy _____

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

As a child, were there any foods that were avoided because they gave you symptoms? ☐ Yes ☐ No

If yes, what foods and what symptoms? (Example: milk-gas and diarrhea)

_____

_____

Dental History

Check if you have any of the following, and provide number if applicable:

☐ Silver mercury fillings _____ ☐ Gold fillings _____ ☐ Root canals _____ ☐ Implants _____

☐ Caps/Crowns _____ ☐ Tooth pain ☐ Bleeding Gums ☐ Gingivitis

☐ Problems with chewing ☐ Other dental concerns: _____

Have you had any mercury fillings removed? ☐ Yes ☐ No If so, when? _____

Do you brush regularly? ☐ Yes ☐ No Do you floss regularly? ☐ Yes ☐ No

Environmental/Detoxification History

Do any of these significantly affect you?

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

Check any of the following that you are exposed to on a daily basis:

☐ Water Leaks ☐ Renovations ☐ Chemicals ☐ Airplane travel ☐ Paints ☐ Pesticides

☐ Damp Environments ☐ Carpets or Rugs ☐ Stagnant or Stuffy Air ☐ Smokers ☐ Old paint ☐ Mold

☐ Cleaning Chemicals ☐ Heavy metals (lead, mercury, etc.) ☐ Herbicides ☐ Electromagnetic Radiation

☐ Harsh chemicals (solvents, glue, gas, acids, etc. ☐ Other: _____

Have you had a significant exposure to any harmful chemicals? ☐ Yes ☐ No

If yes, Chemical name. length of exposure, date: _____

Male History

Check box if applicable:

☐ Testicular Mass ☐ Testicular Pain ☐ Prostate Enlargement ☐ Prostate Infection

☐ Change in Sex Drive ☐ Impotence ☐ Premature Ejaculation ☐ Vasectomy

☐ Difficulty maintaining an erection ☐ Loss of control of urine ☐ Urinary urgency/hesitancy/change in stream

☐ Nocturia (urinating at night) # of times per night _____

☐ Sexually Transmitted Diseases (describe): _____

Screening/Procedures *(If applicable provide date)*

Last PSA test: _____ ☐ 0-2 ☐ 2-4 ☐ 4-10 ☐ >10

Female History

OBSTETRIC HISTORY *(Check boxes and provide number if applicable)*

☐ Pregnancies _____ ☐ Miscarriages _____ ☐ Abortions _____ ☐ Living Children _____
☐ Vaginal deliveries _____ ☐ Cesarean _____ ☐ Term births _____ ☐ Premature births _____

Birth weight of largest baby: _____ Birth weight of smallest baby: _____

Did you develop any problems during or after pregnancy, for example, toxemia (high blood pressure), diabetes, post-partum depression, issues with breastfeeding, etc.? ☐ Yes ☐ No
If yes, please explain: _____

MENSTRUAL HISTORY

Age at first period _____ First day of last menstrual period ____/____/____

Length of cycle _____ Time between cycles _____

Cramping? ☐ Yes ☐ No Pain? ☐ Yes ☐ No

Have you ever had premenstrual problems (bloating, breast tenderness, irritability, etc.)? ☐ Yes ☐ No
If yes, please describe: _____

Do you have other problems with your periods (heavy, irregular, spotting, skipping, etc.)? ☐ Yes ☐ No
If yes, please describe: _____

Use of hormonal birth control: ☐ Birth control pills ☐ IUD-Hormonal ☐ Implant ☐ NuvaRing
Other: _____ How long: _____

Any problems with hormonal birth control? ☐ Yes ☐ No
If yes, explain: _____

Use of other contraception? ☐ Yes ☐ No *(select below)*
☐ Condoms ☐ Diaphragm ☐ Copper IUD ☐ Partner Vasectomy ☐ Other: _____

Are you in menopause? ☐ Yes ☐ No If yes, age at last period? _____
Was it surgical menopause? ☐ Yes ☐ No If yes, why? _____

Do you currently have symptomatic problems with menopause? *(Check all that apply)*
☐ Hot flashes ☐ Mood swings ☐ Headaches ☐ Joint pain ☐ Loss of control of urine
☐ Vaginal dryness ☐ Decreased libido ☐ Weight gain ☐ Palpitations ☐ Concentration/memory problems

Are you on hormone replacement therapy? ☐ Yes ☐ No
If yes, for how long and for what reason (hot flashes, osteoporosis prevention, etc.)? _____

_____

OTHER GYNECOLOGICAL SYMPTOMS: *(Check if applicable)*

☐ Endometriosis ☐ Infertility ☐ Fibroids ☐ Fibrocystic breasts
☐ Ovarian cysts ☐ Reproductive Cancer ☐ Vaginal Infections ☐ Pelvic Inflammatory Disease
☐ Sexually Transmitted disease (describe): _____

SCREENING/PROCEDURES *(If applicable, provide date)*

Last Pap: ____/____/____ ☐ Normal ☐ Abnormal

Last Mammogram: ____/____/____ ☐ Normal ☐ Abnormal

Last Bone Density: ____/____/____ Results: ☐ High ☐ Low ☐ Within Normal Range

Other tests/procedures (list type & dates): _____

_____

FAMILY HISTORY

Check appropriate family members that have/had any of the following health problems

Health Problem	Mother	Father	Brother (s)	Sister (s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other	Notes or Specifications
Age at death (if deceased)											
ADD/ADHD											
ALS/MS/Parkinson's											
Anemia											
Anxiety or Depression											
Arthritis											
Asthma											
Autism											
Arthritis											
Autoimmune Disease (specify)											
Bipolar Disorder											
Bladder Disorder											
Bleeding or Blood Clots											
Cancer (specify)											
Celiac Disease											
COPD or Emphysema											
Dementia or Alzheimer's											
Diabetes											
Eczema or Psoriasis											
Eye Disease											
Genetic Disorders											
Heart Attack											
Heart Disease											
High Blood Pressure											
High Cholesterol											
IBD/IBS											
Insomnia											
Kidney Stones											
Migraines											
Obesity											
Osteoporosis											
Psych Disorder, other (specify)											
Recurrent Lung Infections											
Seizures or Epilepsy											
Sleep Apnea											
Smoking											
Stomach Ulcers											
Stroke											
Substance Abuse											
Thyroid Disease (specify)											
Other:											

MEDICAL HISTORY: ILLNESS/CONDITIONS

Check YES = a condition you currently have and Check PAST = a condition you've had in the past.

Gastrointestinal	Yes	Past
Irritable bowel syndrome		
GERD (reflux)		
Crohn's disease/ulcerative colitis		
Peptic ulcer disease		
Celiac disease		
Gallstones		
Liver disease/Fatty liver		
Other:		

Respiratory	Yes	Past
Bronchitis		
Asthma		
Emphysema		
Pneumonia		
Sinusitis		
Sleep apnea		
Other:		

Urinary/Genital	Yes	Past
Kidney stones		
Gout		
Interstitial cystitis		
Frequent yeast infections		
Frequent urinary tract infections		
Sexual dysfunction		
Sexually transmitted diseases		
Other:		

Endocrine/Metabolic	Yes	Past
Diabetes		
Hypothyroidism (low thyroid)		
Hyperthyroidism (overactive thyroid)		
Polycystic Ovarian Syndrome		
Infertility		
Metabolic syndrome/insulin resistance		
Eating disorder		
Hypoglycemia		
Other:		

Inflammatory/Immune	Yes	Past
Rheumatoid arthritis		
Chronic fatigue syndrome		
Food allergies		
Environmental allergies		
Multiple chemical sensitivities		
Autoimmune disease		
Immune deficiency		
Mononucleosis		
Other:		

Cancer	Yes	Past
Lung		
Breast		
Colon		
Ovarian		
Skin		
Other:		

Skin	Yes	Past
Eczema		
Psoriasis		
Acne		
Skin cancer		
Other:		

Cardiovascular	Yes	Past
Angina		
Heart attack or Heart Failure		
Hypertension (high blood pressure)		
Stroke		
High blood fats (cholesterol, triglycerides)		
Rheumatic fever		
Murmur or Irregular heart rate		
Mitral valve prolapse		
Other:		

Neurologic/Emotional	Yes	Past
Epilepsy/Seizures		
ADD/ADHD		
Headaches or Migraines		
Depression		
Anxiety		
Autism		
Multiple sclerosis or Parkinson's		
Dementia		
Other:		

Musculoskeletal	Yes	Past
Fibromyalgia		
Osteoarthritis		
Chronic Pain		
Other:		

MEDICAL HISTORY CONTINUED

Diagnostic Studies	Date	Comments
Bone density		
CT scan		
Colonoscopy		
Cardiac stress test		
EKG		
MRI		
Upper endoscopy		
Upper GI series		
Chest X-ray		
Other X-rays		
Barium enema		
Other:		

Injuries	Date	Comments
Broken bone(s)		
Back injury		
Neck injury		
Head injury		
Other:		

Surgeries	Date	Comments
Appendectomy		
Dental		
Gallbladder		
Hernia		
Hysterectomy		
Tonsillectomy		
Joint replacement		
Heart surgery		
Other:		

Hospitalizations	Date	Reason

Symptom Review

Please check if these symptoms occur presently or have occurred in the last 6 months

General	Mild	Moderate	Severe
Cold hands and feet			
Cold intolerance			
Daytime sleepiness			
Difficulty falling asleep			
Early waking			
Fatigue			
Fever			
Flushing			
Heat intolerance			
Night waking			
Nightmares			
Can't remember dreams			
Low body temperature			

Musculoskeletal	Mild	Moderate	Severe
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			

Cardiovascular	Mild	Moderate	Severe
Angina/chest pain			
Breathlessness			
Heart attack			
Heart murmur			
High blood pressure			
Irregular pulse/Palpitations			
Mitral valve prolapse			
Phlebitis			
Swollen ankles/feet			
Varicose veins			

Head, Eyes, and Ears	Mild	Moderate	Severe
Conjunctivitis			
Distorted sense of smell			
Distorted taste			
Ear fullness			
Ear ringing/buzzing			
Eye crusting			
Eye pain			
Eyelid margin redness			
Hearing loss			
Hearing problems			
Migraine			
Sensitivity to loud noises			
Vision problems			

Mood/Nerves	Mild	Moderate	Severe
Anxiety/Depression			
Hallucinations - Auditory			
Hallucinations - Visual			
Difficulty:			
Concentrating			
With balance			
With judgment			
With speech			
With memory			
Dizziness (spinning)			
Fainting/Blackouts			
Fearfulness/Phobias			
Irritability			
Numbness/Tingling			
Panic attacks			
Paranoia			
Seizures			
Suicidal thoughts			
Tremor/trembling			

Urinary	Mild	Moderate	Severe
Bed wetting			
Hesitancy			
Recurrent Infections			
Kidney disease			
Kidney stone			
Leaking/incontinence			
Pain/burning			
Urgency			

SYMPTOM REVIEW CONTINUED

Please check if these symptoms occur presently or have occurred in the last 6 months

Digestion	Mild	Moderate	Severe
Abdominal Pain-Lower			
Abdominal Pain-Upper			
Anal Fissures			
Anal spasms			
Bad teeth			
Bleeding gums			
Bloating after meals			
Blood in stools			
Belching			
Canker sores			
Cold sores			
Constipation			
Cracking at corner of lips			
Dentures w/poor chewing			
Diarrhea			
Difficulty swallowing			
Dry mouth			
Flatulence (farting)			
Heartburn/Reflux			
Hemorrhoids			
Intolerance to:			
Lactose			
All dairy products			
Gluten (wheat)			
Corn			
Eggs			
Fatty foods			
Yeast			
Liver disease/jaundice			
Mucus in stools			
Nausea			
Periodontal disease			
Sore tongue			
Strong stool odor			
Undigested food in stools			
Vomiting			

Skin	Mild	Moderate	Severe
Acne			
Athlete's foot			
Bumps on back of upper arms			
Cellulite			
Dark circles under eyes			
Dryness			
Eyes			
Feet			
Any cracking or peeling?			
Hair			
And unmanageable?			
Hands			
Any cracking or peeling?			
Mouth/throat			
Scalp			
Any dandruff?			
Skin in general			
Ears get red			
Easy bruising			
Eczema			
Herpes – genital			
Jock itch			
Lackluster skin			
Moles w color/size change			
Oily skin			
Pale skin			
Patchy dullness			
Psoriasis			
Rash			
Red face			
Sensitive to bites			
Sensitive to poison ivy/oak			
Skin darkening			
Strong body odor			
Thick calluses			
Vitiligo			

Skin, Itching	Mild	Moderate	Severe
Anus			
Ear canals			
Eyes			
Feet			
Genitals			
Hands			

Skin, Itching	Mild	Moderate	Severe
Mouth/Throat			
Nipples			
Nose			
Scalp			
Skin, in general			

SYMPTOM REVIEW CONTINUED

Please check if these symptoms occur presently or have occurred in the last 6 months

Eating	Mild	Moderate	Severe
Binge eating			
Bulimia			
Can't gain weight			
Can't lose weight			
Carbohydrate craving			
Carbohydrate intolerance			
Poor appetite			
Salt cravings			
Frequent dieting			
Sweet cravings			
Caffeine dependency			

Respiratory	Mild	Moderate	Severe
Bad breath			
Bad odor in nose			
Cough – dry			
Cough – productive			
Hay fever:			
Spring			
Summer			
Fall			
Change of season			
Hoarseness			
Nasal stuffiness			
Nose bleeds			
Post nasal drip			
Sinus fullness			
Sinus infection			
Snoring			
Sore throat			
Wheezing			
Winter stuffiness			

Nails	Mild	Moderate	Severe
Bitten			
Brittle			
Curve up			
Frayed			
Fungus			
Pitting			
Ragged cuticles			
Ridges			
Soft			
Thickened			
White spots/lines			

Female Reproductive	Mild	Moderate	Severe
Breast cysts			
Breast lumps			
Breast tenderness			
Ovarian cyst			
Poor libido (sex drive)			
Endometriosis			
Fibroids			
Infertility			
Vaginal discharge			
Vaginal odor			
Vaginal itch			
Vaginal pain			
Premenstrual:			
Bloating			
Breast tenderness			
Carbohydrate craving			
Chocolate craving			
Constipation			
Decreased sleep			
Diarrhea			
Fatigue			
Increased sleep			
Irritability			
Menstrual:			
Cramps			
Heavy periods			
Irregular periods			
No periods			
Scanty periods			
Spotting between			

Male Reproductive	Mild	Moderate	Severe
Difficulty achieving erection			
Difficulty maintaining erection			
Discharge from penis			
Ejaculation problem			
Genital pain			
Infection			
Lumps in testicles			
Poor libido (low sex drive)			

MEDICATIONS/SUPPLEMENTS

Current medications (include prescription and over-the-counter)

Medication	Dosage	Start Date (mo/yr)	Reason for Use

Nutritional supplements (vitamins/minerals/herbs etc.)

Name and Brand	Dosage	Start Date (mo/yr)	Reason for Use

Have medications or supplements ever caused unusual side effects or problems? ☐ Yes ☐ No

If yes, describe: _____

Have you used any of these regularly or for a long period of time:

NSAIDs (Advil, Aleve, etc.), Motrin, Aspirin? ☐ Yes ☐ No

Tylenol (acetaminophen)? ☐ Yes ☐ No

Acid-blocking drugs (Zantac, Prilosec, Nexium, etc.)? ☐ Yes ☐ No

How many times have you taken antibiotics?

	< 5	> 5	Reason for use
Infancy/Childhood			
Teen			
Adulthood			

Have you ever taken long term antibiotics? ☐ Yes ☐ No

If yes, explain: _____

How often have you taken oral steroids (cortisone, prednisone, etc.)?

	< 5	> 5	Reason for use
Infancy/Childhood			
Teen			
Adulthood			

Readiness Assessment

In order to improve your health, how willing are you to:	Rate on a scale of **5 - very willing** to **1 - not willing**				
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

	Rate on a scale of **5 - very confident** to **1 - not confident at all**				
How confident are you of your ability to organize and followthrough 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 follow through? _____

	Rate on a scale of **5 - very supportive** to **1 - not very supportive**				
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

	Rate on a scale of **5 - very frequent contact** to **1 - very infrequent contact**				
How much ongoing support (e.g. telephone consults, email correspondence) from our professional staff would be helpful to you as you implement your personal health program?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Comments _____

Health Goals

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

When was the last time you felt well?

Did something trigger your change in health?

What makes you feel better?

What makes you feel worse?

How does your condition affect you?

What do you think is happening and why?

What do you feel needs to happen for you to get better?