St. Petersburg Health & Wellness

**New Patient Questionnaire**

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**General Information Form**

**Name:** Click here to enter text.**­ Date of Birth:** Click here to enter text. **Age:** Click here to enter text. **Gender:** [ ] **Male** [ ] **Female Social Security #:** Click here to enter text.

**Do you have: Medicare?** [ ] **Yes** [ ] **No SSI Disability?** [ ] **Yes** [ ] **No Please Initial** Click here to enter text.

**Insurance Co.** <-Click Tab **Group#** <-Click Tab **Policy#** <-Click Tab **Phone#** <-Click Tab **Street Address** Click here to enter text.

**City** Click here to enter text. **State** Click here to enter text. **Zip** Click here to enter text. **Home:** Click here to enter text.  **can we leave a message** [ ] **Yes** [ ] **No
Cell**  Click here to enter text. **can we leave a message** [ ] **Yes** [ ] **No
Email** Click here to enter text.

**Employment** Click here to enter text. **Job Title** Click here to enter text. **Emergency Contact Name** Click here to enter text. **Phone** Click here to enter text. **Primary Physician:** Click here to enter text. **Phone** Click here to enter text. **Referred by:** [ ]  **Website** [ ]  **Radio** [ ]  **TV** [ ]  **Publication**

**Patient Referral:**  Click here to enter text.

Patient Signature: Click here to enter text. Date: Click here to enter text.

Printed Name: Click here to enter text.

# New Patient Questionnaire

What health concern or symptoms brings you to the clinic?

Click here to enter text.

Click here to enter text.

Click here to enter text.

How long have you experienced this problem? Click here to enter text.

What makes it better? Click here to enter text.

What makes it worse? Click here to enter text.

What kinds of tests or exams have you had already and when? Click here to enter text.

Click here to enter text.

What diagnosis were you given? Click here to enter text.

What kind of medications/supplements have you taken for it? Click here to enter text.

Please elaborate, if necessary: Click here to enter text.

What would you most like to achieve with this health consultation? Click here to enter text.

Click here to enter text.

Click here to enter text.

Are you currently under the care of a physician or health care professional for a medical/health condition?

[ ] Yes [ ] No If yes, please list condition(s): Click here to enter text.

Click here to enter text.

Your Questions: What questions do you have for today’s visit?

1) Click here to enter text.

2) Click here to enter text.

3) Click here to enter text.

4) Click here to enter text.

5) Click here to enter text.

# Past Medical History

**Please check any medical conditions or health problems that you currently have or have had in the past?**

Headaches (Migraines, other) [ ] Yes [ ] No Heart Disease/MI [ ] Yes [ ] No

Seizure Disorder [ ] Yes [ ] No Chest Pain [ ] Yes [ ] No

Recurrent sinus infections [ ] Yes [ ] No Irregular Heart Beat [ ] Yes [ ] No

Seasonal Allergies [ ] Yes [ ] No High Blood Pressure [ ] Yes [ ] No

Psychiatric or Emotional illness [ ] Yes [ ] No Blood Clotting problems [ ] Yes [ ] No

Depression [ ] Yes [ ] No Bleeding disorder [ ] Yes [ ] No

Anxiety or excessive stress [ ] Yes [ ] No Stroke/vascular disease [ ] Yes [ ] No

Asthma [ ] Yes [ ] No Constipation/diarrhea [ ] Yes [ ] No

Chronic bronchitis [ ] Yes [ ] No Hepatitis/Liver disease [ ] Yes [ ] No

Lung or breathing problems [ ] Yes [ ] No Kidney Disease [ ] Yes [ ] No

Chronic indigestion [ ] Yes [ ] No Menstrual Disorders [ ] Yes [ ] No

Stomach Ulcers [ ] Yes [ ] No Reproductive Problems [ ] Yes [ ] No

Intestinal Disease [ ] Yes [ ] No Prostate Problems [ ] Yes [ ] No

Skin problems/dermatitis [ ] Yes [ ] No Sexual/Libido problems [ ] Yes [ ] No

Back Pain or Sciatica [ ] Yes [ ] No Tendonitis [ ] Yes [ ] No

Herniated Disc [ ] Yes [ ] No Chronic Pain problems [ ] Yes [ ] No

Neck Pain [ ] Yes [ ] No Shoulder problems [ ] Yes [ ] No

Chronic muscle or joint pain [ ] Yes [ ] No Osteoarthritis [ ] Yes [ ] No

Carpal Tunnel Syndrome [ ] Yes [ ] No Rheumatoid Arthritis [ ] Yes [ ] No

Fibromyalgia [ ] Yes [ ] No Artificial joint/implants [ ] Yes [ ] No

Diabetes [ ] Yes [ ] No Cancer [ ] Yes [ ] No

Thyroid disease [ ] Yes [ ] No Psoriasis or eczema [ ] Yes [ ] No

Osteoporosis/Osteopenia [ ] Yes [ ] No

**List any additional health problems not listed above:** Click here to enter text.

Click here to enter text.

Click here to enter text.

**List any surgeries/operations you have had, and when:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Surgery** | **Date/Place** | **Reason** | **Long Term Problems** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

**Social History**

Smoking [ ]  Yes [ ] No How many years? Click here to enter text.

Alcohol [ ] None [ ] Rarely [ ] Social # per week Click here to enter text. # per day Click here to enter text.

1 drink = 5 oz wine, 12 oz beer or 1.5 oz spirits

Caffeine beverages per day Click here to enter text. (includes coffee, tea, caffeinated soda, energy drinks)

Current Recreational drug use: [ ] Yes [ ] No If yes please describe Click here to enter text.

Past Recreational drug use: Click here to enter text.

## MEDICATIONS

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Current Medications** | **Dosage** | **Times/Day** | **Start Date** | **Reason for Use** |
| Click here to enter text. |   <-Click Tab  |  <-Click Tab  |   <-Click Tab  |  Click here to enter text. |
|  Click here to enter text. |   <-Click Tab  |   <-Click Tab  |   <-Click Tab  |  Click here to enter text. |
|  Click here to enter text. |   <-Click Tab  |   <-Click Tab  |   <-Click Tab  |  Click here to enter text. |
|  Click here to enter text. |   <-Click Tab  |   <-Click Tab  |   <-Click Tab  |  Click here to enter text. |
|  Click here to enter text. |   <-Click Tab  |   <-Click Tab  |   <-Click Tab  |  Click here to enter text. |
|  Click here to enter text. |   <-Click Tab  |   <-Click Tab  | <-Click Tab  |  Click here to enter text. |
|  Click here to enter text. |   <-Click Tab  |   <-Click Tab  |  <-Click Tab  |  Click here to enter text. |
|  Click here to enter text. |  <-Click Tab  |   <-Click Tab  |  <-Click Tab  |  Click here to enter text. |
|  Click here to enter text. |  <-Click Tab  |   <-Click Tab  |   <-Click Tab  |  Click here to enter text. |
| **Previous Medications**  | **Dosage** | **Times/Day** | **Date Ended** | **Reason for Use** |
| Click here to enter text. |   <-Click Tab  |   <-Click Tab  |  <-Click Tab   |  Click here to enter text. |
|  Click here to enter text. |   <-Click Tab  |   <-Click Tab  |   <-Click Tab  |  Click here to enter text. |
|  Click here to enter text. |   <-Click Tab  |  <-Click Tab   |   <-Click Tab  |  Click here to enter text. |
| **Nutritional Supplements**  |  |  |   |  |
| **(Vitamins/Minerals/Herbs/Homeopathy)** | **Dosage** | **Times/Day** | **Start Date** |  |
| Click here to enter text. |   <-Click Tab  |   <-Click Tab  | <-Click Tab   |  Click here to enter text. |
|  Click here to enter text. |   <-Click Tab  |   <-Click Tab  |  <-Click Tab  |  Click here to enter text. |
|  Click here to enter text. |  <-Click Tab  |   <-Click Tab  |   <-Click Tab  |  Click here to enter text. |
|  Click here to enter text. |   <-Click Tab  |   <-Click Tab  |   <-Click Tab  |  Click here to enter text. |
|  Click here to enter text. |   <-Click Tab  |  <-Click Tab   |   <-Click Tab  |  Click here to enter text. |

If you take more than 5 supplements, please list in this space:

Click here to enter text.

Click here to enter text.

Click here to enter text.

Click here to enter text.

Click here to enter text.

Click here to enter text.

|  |  |
| --- | --- |
| **ALLERGIES** | **Reaction** |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |

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

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

Frequent antibiotics > 3 times/year? [ ] Yes [ ] No

Long term antibiotics? [ ] Yes [ ] No

Use of steroids (prednisone, nasal allergy inhalers) in the past? [ ] Yes [ ] No

Use of birth control? [ ] Yes [ ] No

**Food Allergies**: (ever tested? Please include copies of reports if available) Click here to enter text.

Click here to enter text.

**Environmental Allergies**: Click here to enter text.

Click here to enter text.

**Dental Procedures**: (root canals, etc. – do you have mercury fillings?) [ ] Yes [ ] No

Have you had your wisdom teeth extracted? [ ] Yes [ ] No

Click here to enter text.

Click here to enter text.

**Occupational Exposures**: [ ] Yes [ ] No If yes, please explain: Click here to enter text.

Click here to enter text.

**Diet**: Do you follow any particular diet regimens or restrictions? Click here to enter text.

Click here to enter text.

**Women:**

Last Pap? Click here to enter text. First day of last menstrual period? Click here to enter text.

Are your periods regular or irregular? [ ]  Regular [ ]  Irregular

Do you have heavy bleeding or cramping? [ ]  Yes [ ] No

Mammogram? Click here to enter text. Bone Scan? Click here to enter text.

Menopause? [ ] Yes [ ] No If yes when did you start? Click here to enter text.

Hysterectomy? [ ] Yes [ ] No If yes when? Click here to enter text.

Marital History: [ ] Single/[ ] Married/[ ] Divorced Years Married <-Click Tab # Children <-Click Tab

Ages of children? Click here to enter text. # Pregnancies? Click here to enter text. # Deliveries? Click here to enter text.

Any complications? [ ]  Yes [ ]  No Explain? Click here to enter text.

Any fertility problems? [ ]  Yes [ ]  No Any treatment for infertility? [ ]  Yes [ ]  No

Birth control use: [ ]  Yes [ ]  No What kind and for how long (include past history):

Click here to enter text.

Include pills, depo shots, rings, etc.

**Men:**

PSA: Click here to enter text. When last done? Click here to enter text. Last prostate exam? Click here to enter text.

Decrease in nocturnal erections? Click here to enter text.

Loss of libido? Click here to enter text.

Decrease in hardness of erections? Click here to enter text.

More time to recover between erections needed? Click here to enter text.

Increased abdominal fat? Click here to enter text.

**Preventative Tests: Month/Year of last test Test Results (if known)**

**0 if None**

Cholesterol Click here to enter text. Click here to enter text.

Bone Density Click here to enter text. Click here to enter text.

Colonoscopy Click here to enter text. Click here to enter text.

Exercise stress test Click here to enter text. Click here to enter text.

## Family History

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Click on # to enter age** | **Father** | **Mother** | **Brother(s)**  | **Sister(s)** | **Children** | **Maternal Grandmother** | **Maternal Grandfather** | **Paternal Grandmother** | **Paternal Grandfather** | **Aunts** | **Uncles** | **others** |
| **FAMILY HISTORY** |  |  | # | # | # | # | # | # | # | # | # | # |
| Age (if still alive) | # | # | # | # | # | # | # | # | # | # | # | # |
| Age at death (if deceased) | # | # | # | # | # | # | # | # | # | # | # | # |
| Cancers |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Colon Cancer |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Breast or Ovarian Cancer |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Heart Disease |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Hypertension |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Obesity |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Diabetes |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Stroke |[ ] [ ] [ ]   |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Inflammatory Arthritis |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| (Rheumatoid,Psoriatic,Ankylosing Spondylitis) |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Inflammatory Bowel Disease |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Multiple Sclerosis |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Auto Immune Diseases (such as Lupus) |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Irritable Bowel Syndrome |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Celiac Disease |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Asthma |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Eczema / Psoriasis |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Food Allergies, Sensitivities or Intolerances |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Environmental Sensitivities |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Dementia |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Parkinson’s |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| ALS or other Motor Neuron Diseases |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Genetic Disorders |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Substance Abuse (such as alcoholism) |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Psychiatric Disorders |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Depression |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Schizophrenia |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| ADHD |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Autism |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Bipolar Disease |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

Current Symptoms**: Please click on the # and enter a number Level 1-5 (1 Mild – 5 Severe)**

|  |  |  |
| --- | --- | --- |
| **GENERAL** | # Muscle Weakness | **DIGESTION** |
| # Cold Hands & Feet | # Neck Muscle Spasm | # Anal Spasms |
| # Cold Intolerance | # Tendonitis | # Bad Teeth |
| # Low Body Temperature | # Tension Headache | # Bleeding Gums |
| # Low Blood Pressure | # TMJ Problems | # Bloating of: |
| # Daytime Sleepiness |   | # Lower Abdomen |
| # Difficulty Falling Asleep | **MOOD/NERVES** | # Whole Abdomen |
| # Early Waking | # Agoraphobia | # Bloating After Meals |
| # Fatigue | # Anxiety | # Blood in Stools |
| # Fever | # Auditory Hallucinations | # Burping |
| # Flushing | # Black-out | # Canker Sores |
| # Heat Intolerance | # Depression | # Cold Sores |
| # Night Waking | # Difficulty: | # Constipation |
| # Nightmares | # Concentrating | # Cracking at Corner of Lips |
| # No Dream Recall | # With Balance | # Cramps |
|   | # With Thinking | # Dentures w/Poor Chewing |
| **HEAD, EYES & EARS** | # With Judgment | # Diarrhea |
| # Conjunctivitis | # With Speech | # Alternating Diarrhea and Constipation |
| # Distorted Sense of Smell | # With Memory | # Difficulty Swallowing |
| # Distorted Taste | # Dizziness (spinning) | # Dry Mouth |
| # Ear Fullness | # Fainting | # Excess Flatulence/Gas |
| # Ear Pain | # Fearfulness | # Fissures |
| # Ear Ringing/Buzzing | # Irritability | # Foods “Repeat” (Reflux) |
| # Lid Margin Redness | # Light-headedness | # Gas |
| # Eye Crusting | # Numbness | # Heartburn |
| # Eye Pain | # Other Phobias | # Hemorrhoids |
| # Hearing Loss | # Panic Attacks | # Indigestion |
| # Hearing Problems | # Paranoia | # Nausea |
| # Headache | # Seizures | # Upper Abdominal Pain |
| # Migraine | # Suicidal Thoughts | # Vomiting |
| # Sensitivity to Loud Noises | # Tingling | # Intolerance to: |
| # Vision problems (other than glasses) | # Tremor/Trembling | # Lactose |
| # Macular Degeneration | # Visual Hallucinations | # All Dairy Products |
| # Vitreous Detachment |   | # Wheat |
| # Retinal Detachment | **EATING** | # Gluten |
|   | # Binge Eating | # Corn |
| **MUSCULOSKELETAL** | # Bulimia | # Eggs |
| # Back Muscle Spasm | # Can’t Gain Weight | # Fatty Foods |
| # Calf Cramps | # Can’t Lose Weight | # Yeast |
| # Chest Tightness | # Can’t Maintain Healthy Weight | # Liver Disease/Jaundice |
| # Foot Cramps | # Frequent Dieting |  (Yellow Eyes or Skin) |
| # Joint Deformity | # Poor Appetite | # Abnormal Liver Function Tests |
| # Joint Pain | # Salt Cravings | # Lower Abdominal Pain |
| # Joint Redness | # Carbohydrate Craving  (Bread and Pasta) | # Mucus in Stools |
| # Joint Stiffness | # Sweet Cravings (Candy, Cookies, Cakes) | # Periodontal Disease |
| # Muscle Pain | # Chocolate Cravings | # Sore Tongue |
| # Muscle Spasms | # Caffeine Dependency | # Strong Stool Odor |
| # Muscle Stiffness |   | # Undigested Food in Stools |
| # Muscle Twitches: |   |   |
| # Around Eyes |   |   |
| # Arms or Legs |   |   |

**Current Symptoms (cont’d): Please click on the # and enter a number Level 1-5 (1 Mild – 5 Severe)**

|  |  |  |
| --- | --- | --- |
| **SKIN PROBLEMS** | # Hands | # Breathlessness |
| # Acne on Back | # Any Cracking? | # Heart Murmur |
| # Acne on Chest | # Any Peeling? | # Irregular Pulse |
| # Acne on Face | # Mouth/Throat | # Palpitations |
| # Acne on Shoulders | # Scalp | # Phlebitis |
| # Athlete’s Foot | # Any Dandruff? | # Swollen Ankles/Feet |
| # Bumps on Back of Upper Arms | # Skin In General | # Varicose Veins |
| # Cellulite |   |   |
| # Dark Circles Under Eyes | **LYMPH NODES** | **URINARY** |
| # Ears Get Red | # Enlarged/neck | # Bed Wetting |
| # Easy Bruising | # Tender/neck | # Hesitancy (trouble getting started) |
| # Lack Of Sweating | # Other Enlarged/Tender | # Infection |
| # Eczema | # Lymph Nodes | # Kidney Disease |
| # Hives |   | # Leaking/Incontinence |
| # Jock Itch | **NAILS** | # Pain/Burning |
| # Lackluster Skin | # Bitten | # Prostate Infection |
| # Moles w/Color/Size Change | # Brittle | # Urgency |
| # Oily Skin | # Curve Up |   |
| # Pale Skin | # Frayed | **MALE REPRODUCTIVE** |
| # Patchy Dullness | # Fungus-Fingers | # Discharge From Penis |
| # Rash | # Fungus-Toes | # Ejaculation Problem |
| # Red Face | # Pitting | # Genital Pain |
| # Sensitivity to Bites | # Ragged Cuticles | # Impotence |
| # Sensitivity to Poison Ivy/Oak | # Ridges | # Prostate or Urinary Infection |
| # Shingles | # Soft | # Lumps In Testicles |
| # Skin Darkening | # Thickening of: | # Poor Libido (sex drive) |
| # Strong Body Odor | # Fingernails |   |
| # Hair Loss | # Toenails | **FEMALE REPRODUCTIVE** |
| # Vitiligo | # White Spots/Lines | # Breast Cysts |
|   |   | # Breast Lumps |
| **ITCHING SKIN** | **RESPIRATORY** | # Breast Tenderness |
| # Skin in General | # Bad Breath | # Ovarian Cyst |
| # Anus | # Bad Odor in Nose | # Poor Libido (sex drive) |
| # Arms | # Cough-Dry | # Vaginal Discharge |
| # Ear Canals | # Cough-Productive | # Vaginal Odor |
| # Eyes | # Hoarseness | # Vaginal Itch |
| # Feet | # Sore Throat | # Vaginal Pain with Sex |
| # Hands | # Hay Fever: | # Premenstrual: |
| # Legs | # Spring | # Bloating # Breast Tenderness |
| # Nipples | # Summer | # Carbohydrate Cravings |
| # Nose | # Fall | # Chocolate Cravings |
| # Penis | # Change Of Season | # Constipation |
| # Roof of Mouth | # Nasal Stuffiness | # Decreased Sleep |
| # Scalp | **#** Nose Bleeds | # Diarrhea |
| # Throat | # Post Nasal Drip | # Fatigue |
|   | # Sinus Fullness | # Increased Sleep |
| **SKIN, DRYNESS OF** | # Sinus Infection | # Irritability |
| # Eyes | # Snoring | # Menstrual: |
| # Feet | # Wheezing | # Cramps |
| # Any Cracking? | # Winter Stuffiness | # Heavy Periods |
| # Any Peeling? |   | # Irregular Periods |
| # Hair | **CARDIOVASCULAR** | # No Periods |
| # And Unmanageable? | # Angina/chest pain | # Scanty Periods |
|   |   | # Spotting Between |

# Exercise

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Activity** |   | **DURATION** | **TIMES/WK** |  |  |
| Stretching | [ ]  | <-Click Tab | <-Click Tab |  |  |
| Cardio/Aerobics | [ ]  | <-Click Tab | <-Click Tab |  |  |
| Strength | [ ]  | <-Click Tab | <-Click Tab |  |  |
| Sports or Leisure Activities (golf, tennis, rollerblading, etc.) | [ ]  | <-Click Tab | <-Click Tab |  |  |
| Other (yoga, Pilates, gyro tonics, etc.) | [ ]  | <-Click Tab | <-Click Tab |  |  |
| Rate your level of motivation for including exercise in your life? | [ ] Low  | [ ] Medium | [ ] High |  |  |
| List problems that limit activity: Click here to enter text. |   |  |
| Click here to enter text. |   |  |
| Do you feel unusually fatigued after exercise? | [ ] Yes | [ ] No |  |  |  |
| If yes, please describe: Click here to enter text. |  |  |
|  |  |  |
| Do you usually sweat when exercising? | [ ] Yes | [ ] No |  |  |  |

# Sleep/Rest

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Average number of hours you sleep per night: | [ ] <6 | [ ] 6 to 8 | [ ] 8 to 10 | [ ] >10 |
| 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: Click here to enter text. |  |  |  |  |
| Click here to enter text. |  |  |  |  |

# Roles/Relationship

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Marital status | [ ] Single | [ ] Married | [ ] Divorced | [ ] Gay |
|  | [ ] Lesbian | [ ] Widow | [ ] Long term Partner |
| List Children: | Age | Gender | Health Status |
| Click here to enter text. |  <-Click Tab |  <-Click Tab | <-Click Tab |
|  Click here to enter text. |  <-Click Tab |  <-Click Tab | <-Click Tab |
|  Click here to enter text. |  <-Click Tab |  <-Click Tab | <-Click Tab |
| Who is Living in Household? Click here to enter text.  |   |  | Number: | <-Click Tab |
| Resources for emotional support? | [ ] Religion | [ ] Family | [ ] Friends | [ ] Spouse |
|  | [ ] Pets | [ ] Other |  |  |
| Are you satisfied with your sex life? | [ ] Yes | [ ] No |  |  |

# Environmental And Detoxification Assessment

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
| Do you have known adverse food reactions or sensitivities? | [ ] Yes | [ ] No |  |  |  |
| If Yes, list symptoms: Click here to enter text..Click here to enter text. |  |  |  |  |  |
| Do you have any food allergies or sensitivities?  | [ ] Yes | [ ] No |  |  |
| List all: | Click here to enter text. | Click here to enter text. |  |
|  | Click here to enter text. | Click here to enter text. |  |
| Do you have an adverse reaction to caffeine? | [ ] Yes | [ ] No |  |  |
| When you drink caffeine do you feel: | [ ] Irritable | [ ] Wired | [ ] Aches & Pains | [ ]  Citrus Foods |  |
| Do you adversely react to (Mark those that apply). List others: | [ ] Sucralose | [ ] Aspartame | [ ] Caffeine | [ ] Bananas |  |
| Click here to enter text. | [ ] Garlic | [ ] Onions | [ ] Cheese | [ ] MSG |  |
| Click here to enter text. | [ ] Chocolate | [ ] Alcohol | [ ]  Sulfites | [ ] Red Wine |  |
| Click here to enter text. | [ ] Preservatives | [ ] Other |  [ ] Nothing |   |  |
| Which of these significantly affect you? (Mark those that apply) | [ ] Cigarettes | [ ] Exhaust | [ ] Colognes | [ ] Perfumes |
|  In your work or home environment, are you exposed to: | [ ] Chemicals | [ ] Mold | [ ] Electromagnetic Radiation |
| Have you ever turned yellow (jaundiced)? | [ ] Yes | [ ] No |  |  |
| Have you ever been told you have Gilbert’s syndrome or a liver disorder? | [ ] Yes | [ ] No |  |  |
| If Yes, Explain: Click here to enter text.Click here to enter text. | Click here to enter text. |  |
| Do you have a known history of exposure to any harmful chemicals such as the following: Click here to enter text. | [ ] Herbicides | [ ] Pesticides | [ ] Insecticides | [ ] Organic Solvents |
| Click here to enter text. | [ ] Heavy Metals | [ ] Other: Please List |
| Chemical Name, Date, Length of Exposure: | Date | Length of exposure |  |
|  Click here to enter text. | <-Click Tab |  Click here to enter text. |  |
|  Click here to enter text. |  <-Click Tab |  Click here to enter text. |  |
|  Click here to enter text. |  <-Click Tab |  Click here to enter text. |  |
|  Click here to enter text. |  <-Click Tab |  Click here to enter text. |  |
| Do you dry clean your clothes frequently? | [ ] Yes | [ ] No |  |  |
| Do you or have you lived or worked in a damp or moldy environment or had other mold exposures? | [ ] Yes | [ ] No |  |  |
| Do you have any pets or farm animals? | [ ] Yes | [ ] No |  |  |

# 3-Day Diet Diary Instructions

It is important to keep an accurate record of your usual food and beverage intake as a part of your treatment plan.

Please complete this Diet Diary for 3 consecutive days including one weekend day.

1. Do not change your eating behavior at this time, as the purpose of this food record is to analyze your present

 eating habits.

2. Record information as soon as possible after the food has been consumed

3. Describe the food or beverage as accurately as possible e.g., milk - what kind? (whole, 2%, nonfat); toast

 (whole wheat, white, buttered); chicken (fried, baked, breaded); coffee (decaffeinated with sugar and ½ & ½).

4. Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, ½ cup,

 1 teaspoon, etc.

5. Include any added items. For example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.

6. Record all beverages, including water, coffee, tea, sports drinks, sodas/diet sodas, etc.

7. Include any additional comments about your eating habits on this form (ex. craving sweet, skipped meal and

 why, when the meal was at a restaurant, etc).

8. Please note all bowel movements and their consistency (regular, loose, firm, etc.)

## DAY 1

|  |
| --- |
| **DIET DIARY** Name Click here to enter text. Date: Click here to enter text. |
| **TIME FOOD/BEVERAGE/AMOUNT COMMENTS** |
| Click here to enter text. |
|  Click here to enter text. |
|  Click here to enter text. |
|  Click here to enter text. |
|  Click here to enter text. |
|  Click here to enter text. |
|  Click here to enter text. |
|  Click here to enter text. |
|  Click here to enter text. |
|  Click here to enter text. |
|  Click here to enter text. |

Bowel Movements (#, form, color): Click here to enter text.

Stress/Mood/Emotions: Click here to enter text.

Other Comments: Click here to enter text.

## DAY 2

|  |
| --- |
| **DIET DIARY** Name: Click here to enter text. Date: Click here to enter text. |
| **TIME FOOD/BEVERAGE/AMOUNT COMMENTS** |
| Click here to enter text. |
|  Click here to enter text. |
|  Click here to enter text. |
|  Click here to enter text. |
|  Click here to enter text. |
|  Click here to enter text. |
|  Click here to enter text. |
|  Click here to enter text. |
|  Click here to enter text. |
|  Click here to enter text. |
|  Click here to enter text. |

Bowel Movements (#, form, color): Click here to enter text.

Stress/Mood/Emotions: Click here to enter text.

Other Comments: Click here to enter text.

## DAY 3

|  |
| --- |
| **DIET DIARY** Name: Click here to enter text. Date: Click here to enter text. |
| **TIME FOOD/BEVERAGE/AMOUNT COMMENTS** |
| Click here to enter text. |
|  Click here to enter text. |
|  Click here to enter text. |
|  Click here to enter text. |
|  Click here to enter text. |
|  Click here to enter text. |
|  Click here to enter text. |
|  Click here to enter text. |
|  Click here to enter text. |
|  Click here to enter text. |
|  Click here to enter text. |

Bowel Movements (#, form, color): Click here to enter text.

Stress/Mood/Emotions: Click here to enter text.

Other Comments: Click here to enter text.