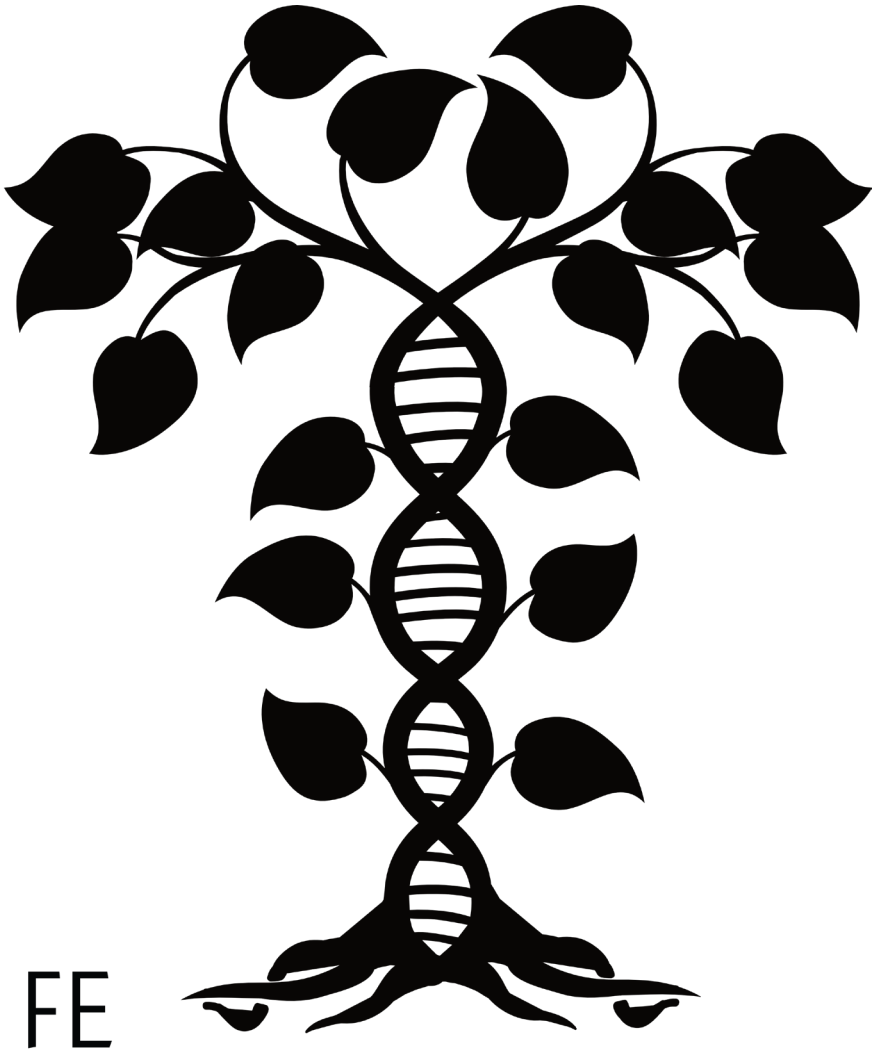

SANTA FE
Family & Functional
Medicine

Health Questionnaire

401 Botulph Ln.
Santa Fe, NM 87505

(505) 983-8387
(505) 820-2733

www.santafefamilymedicine.com

SANTA FE
Family & Functional Medicine

GENERAL INFORMATION

*Name *First* *Middle* *Last*

Preferred Name

*Date of Birth

Age

*Sex ○ *Male* ○ *Female*

Genetic Background ☐ *African* ☐ *Asian* ☐ *European* ☐ *Native American* ☐ *Other*

Highest Education Level ○ *High School* ○ *Graduate* ○ *Post Graduate*

Social Security Number

*Marital Status ○ *Married* ○ *Single* ○ *Divorced* ○ *Other* *Spouse's Name*

Job Title

Employer

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

City *State* *Zip+4*

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

City *State* *Zip+4*

*Home Phone

Work Phone

Cell Phone

Fax

E-mail

*Emergency Contact / *Name* *Phone* *Relationship*

*Guardian (if under 18) *Address* *Apt.No.*

City *State* *Zip+4*

Social Security # of Responsible Party

* REQUIRED INFORMATION

INSURANCE INFORMATION

*Primary Insurance

Company Name | *Policy #* | *Group #*

Claims Address

City | *State* | *Zip+4*

Phone

**Policy Holder's Name* | **Policy Holder's DOB*

**Policy Holder's Address (if different from Patient)*

City | *State* | *Zip+4*

Secondary Insurance (if Applicable)

Company Name | *Policy #* | *Group #*

Claims Address

City | *State* | *Zip+4*

Phone

I understand that I am responsible for all charges not paid by my insurance company. I understand that if my insurance has not paid my claim within 90 days, the balance is my responsibility. I authorize the release of medical information to my insurance company. If insurance claims are filed through this office, I authorize medical benefits for those services to be paid to this office. If my insurance company (including Medicaid/Presbyterian Salud) requires a prior authorization referral, it is my responsibility to obtain this referral from my primary care physician prior to visiting Santa Fe Family and Functional Medicine. In the event that I choose to be seen without prior authorization, I understand that I will be responsible for services rendered. I further under stand that payment, co-payment and deductible payments for all office services are due at the time of visit. If payment or co-payment is not made at the time of service, an additional fee may be added to my bill.

CASH, CHECKS AND CREDIT CARDS ACCEPTED

**Signature*

How did you hear about our practice? _____

GIVE YOUR INSURANCE CARD(S) TO THE RECEPTIONIST TO COPY

*REQUIRED INFORMATION

Privacy Practices Acknowledgment

I have received the Notice of Privacy Practices. Santa Fe Family and Functional Medicine may use or disclose my PHI (Protected Health Information) for treatment purposes, to ensure my bills are paid and to operate the business of the practice.

Patient Signature (or Signature of Parent or Guardian of Minor *Date*

Witness Signature *Date*

Medical Questionnaire

ALLERGIES

Medications/ Supplement/ Food	*Reaction*

COMPLAINTS/CONCERNS

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

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

1. _____
2. _____
3. _____

When was the last time you felt well? _____

Did something trigger your change in health? _____

What makes you feel worse? _____

What makes you feel better? _____

Please list current and ongoing problems in order of priority:

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

MEDICAL HISTORY

DISEASES/DIAGNOSIS/CONDITIONS

☑ = Past Condition ☑ = Ongoing Condition

Check appropriate box and provide date of onset

GASTROINTESTINAL

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

CARDIOVASCULAR

- ☐ ☐ Heart Attack *date*
- ☐ ☐ Other Heart Disease
- ☐ ☐ Stroke *date*
- ☐ ☐ Elevated Cholesterol
- ☐ ☐ Arrythmia (irregular heart rate)
- ☐ ☐ Hypertension (high blood pressure)
- ☐ ☐ Rheumatic Fevert
- ☐ ☐ Mitral Valve Prolapse
- ☐ ☐ Other

METABOLIC/ENDOCRINE

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

CANCER

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

GENITAL AND URINARY SYSTEMS

- ☐ ☐ Kidney Stones
- ☐ ☐ Gout
- ☐ ☐ Interstitial
- ☐ ☐ Cystitis
- ☐ ☐ Frequent Urinary Tract Infections
- ☐ ☐ Frequent Yeast Infections
- ☐ ☐ Erectile Dysfunction
- ☐ ☐ Other

MUSCULOSKELETAL PAIN

- ☐ ☐ Osteoarthritis
- ☐ ☐ Fibromyalgia
- ☐ ☐ Chronic Pain
- ☐ ☐ Other

INFLAMATORY/AUTOIMMUNE

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

RESPIRATORY DISEASES

- ☐ ☐ Asthma
- ☐ ☐ Chronic Sinusitus
- ☐ ☐ Bronchitis
- ☐ ☐ Emphysema/COPD
- ☐ ☐ Pneumonia
- ☐ ☐ Tuberculosis
- ☐ ☐ Sleep Apnea
- ☐ ☐ Other

SKIN DISEASES

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

MEDICAL HISTORY (CONTINUED)

☑ = Past Condition ☑ = Ongoing Condition

- ☐ ☐ Depression _____
- ☐ ☐ Anxiety _____
- ☐ ☐ Bipolar Disorder _____
- ☐ ☐ Schizophrenia _____
- ☐ ☐ Headaches _____
- ☐ ☐ Migraines _____
- ☐ ☐ ADD/ ADHD _____

- ☐ ☐ Autism
- ☐ ☐ Mild Cognitive Impairment
- ☐ ☐ Memory Problems
- ☐ ☐ Parkinson's Disease
- ☐ ☐ Multiple Sclerosis
- ☐ ☐ ALS
- ☐ ☐ Seizures
- ☐ ☐ Other Neurological Problems

PREVENTATIVE TESTS AND DATE OF LAST TEST

check box if yes and provide date

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

SURGERIES

check box if yes and provide date of surgery

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

INJURIES

check box if yes

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

BLOOD TYPE:

○ A ○ B ○ AB ○ O ○ UNKNOWN

○ RH - ○ RH+

HOSPITALIZATIONS ○ None

Date	Reason

COMMENTS:

GYNECOLOGIC HISTORY (WOMEN ONLY)

OBSTETRIC HISTORY *check box if yes and provide number of*

☐ Pregnancies _____ ☐ Caesarean _____ ☐ Vaginal Deliveries _____

☐ Miscarriage _____ ☐ Abortion _____ ☐ Living Children _____

☐ Post Partum Depression ☐ Toxemia ☐ Gestaional Diabetes ☐ Baby over 8 pounds

☐ Breast Feeding For how long? _____

MENSTRUAL HISTORY

Age at first period: _____ Menses Frequency: _____ Length: _____ Pain: ○ Yes ○ No Clotting: ○ Yes ○ No

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

Last Menstrual Period:

Use of hormonal contraception: ☐ Birth Control Pills ☐ Patch ☐ Nuva Ring How Long? _____

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

WOMEN'S DISORDERS / HORMONAL IMBALANCES

☐ Fibrocystic Breasts ☐ Endometriosis ☐ Fibroids ☐ Infertility

☐ Painful Periods ☐ Heavy periods ☐ PMS

Last Mammogram: _____ ☐ Breast Biopsy/ Date _____

Last PAP test: _____ ○ Normal ○ Abnormal

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

Are you in menopause? ○ Yes ○ No

Age at Menopause _____

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

☐ Decreased Libido ☐ Heavy Bleeding ☐ Joint Pains ☐ Headaches ☐ Weight Gain

☐ Incontinence Palpitations ☐ Use of hormone replacement therapy. How long? _____

MEN'S HISTORY (MEN ONLY)

Have you had a PSA done? ○ Yes ○ No

PSA Level: ☐ 0-2 ☐ 2-4 ☐ 4-10 ☐ > 10

☐ Prostate Enlargement ☐ Prostate Infection ☐ Change in Libido ☐ Impotence

☐ Difficulty Obtaining an Erection ☐ Difficulty Maintaining an Erection

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

☐ Urgency/ Hesitancy / Change in Urinary Stream ☐ Incontinence

GI HISTORY

Foreign Travel? ○ Yes ○ No Where? _____

Wilderness Camping? ○ Yes ○ No Where? _____

Have you ever had severe? ○ Gastroenteritis ○ Diarrhea

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

Do you get bloated after meals? ○ Yes ○ No

PATIENT BIRTH HISTORY

○ Term ○ Premature

Pregnancy Complications: _____

Birth Complications: _____

☐ Breast Fed How Long _____ ☐ Bottle-fed

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

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

DENTAL HISTORY

☐ Dental surgery

☐ Silver Mercury Fillings How many? _____

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

☐ Gingivitis ☐ Problems with Chewing ☐ TMJ

Do you floss regularly? ○ Yes ○ No

MEDICATIONS

CURRENT MEDICATIONS

Medication	*Dose*	*Frequency*	*Start Date (mm/yy)*	*Reason For Use*

PREVIOUS MEDICATIONS *Last 10 Years*

Medication	*Dose*	*Frequency*	*Start Date (mm/yy)*	*Reason For Use*

NUTRITIONAL SUPPLEMENTS (VITAMINS / MINERALS / HERBS / HOMEOPATHY)

Supplication and Brand	*Dose*	*Frequency*	*Start Date (mm/yy)*	*Reason For Use*

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

Have you had prolonged or regular use of NSAIDS - ibuprofin, napraxen (Advil, Aleve)? ○ Yes ○ No

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

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

Frequent antibiotics > 3 times/year? ○ Yes ○ No

Long term antibiotics? ○ Yes ○ No

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

Use of oral contraceptives? ○ Yes ○ No

FAMILY HISTORY

Check family members that apply	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age (if still alive)												
Age at death (if decease												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflamatory Arthritis												
(Theumatoid, Psoriatic, Ankylosing Sondylitis)												
Inflamatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Disease												
Irritable Bowel Diseases (such as Lupus)												
Celiac Disease												
Asthma												
Eczema/ Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												

SOCIAL HISTORY

NUTRITIONAL HISTORY

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

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

Describe: _____

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

check all that apply

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

☐ Gluten Restricted ☐ Vegetarian ☐ Vegan ☐ Ultrametabolism

☐ Specific Program for Weight Loss/ Maintenance - Type: _____ Other: _____

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

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

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

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

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

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

Do you read food labels? ○ Yes ○ No

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

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

check all that apply to your current lifestyle and eating habits

☐ Fast eater
☐ Erratic eating pattern
☐ Eat too much
☐ Late night eating
☐ Dislike healthy food
☐ Time constraints
☐ Eat more than 50% of meals away from home
☐ 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 member have special dietary needs or preferences
☐ Love to eat
☐ Eat because I have to
☐ Have a negative relationship with food
☐ Struggle with eating issues
☐ Emotional eater (eat when sad, lonely, depressed, bored
☐ Eat too little under stress
☐ Don't care to cook
☐ Eating in the middle of the night
☐ Confused about nutrition advice

SMOKING

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

Attempts to quit: _____

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

Second Hand smoke exposure? ○ Yes ○ No

ALCOHOL INTAKE

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

○ None ○ 1-3 ○ 4-6 ○ 7-10 ○ > 10 *If "none" skip to other substances*

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

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

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

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

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

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

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

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

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

OTHER SUBSTANCES

Caffeine intake: ○ Yes ○ No Cups/day: □ Coffee/ □ Tea ○ 1 ○ 2-4 ○ > 4 a day

Caffeinated Sodas or Diet Sodas Intake: ○ Yes ○ No
12 -ounce can/bottle/day ○ 1 ○ 2-4 ○ > 4 a day

List favorite type: *ex: Diet Coke, Pepsi, etc.* _____

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

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

EXCERCISE

Current Excercise Program: *Activity (list type, number of sessions/week amd duration of activity)*

Activity	*Type*	*Frequency (per week)*	*Duration in Minutes*
Cardio/ Aerobics			
Stretching			
Strength			
Other (yoga, pilates, gyrotonics, etc)			
Sports or Leisure Activities			

Rate your level of motivation for including excercise in your life: ○ Low ○ Medium ○ High

List problems that limit activity: _____

Do you feel unusually fatigued after excercise? ○ Yes ○ No

If yes, please describe: _____

Do you usually sweat when excercising? ○ Yes ○ No

PSYCHOSOCIAL

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

Are you happy? ○ Yes ○ No

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

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

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

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

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

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

STRESS / COPING

Have you ever sought counseling? ○ Yes ○ No

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

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

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

Daily Stressors: Rate on a scale of 1 - 10

Work _____ Family_____ Social _____ Finances _____ Health _____ Other _____

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

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

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

SLEEP / REST

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

Do you have trouble falling asleep? ○ Yes ○ No

Do you feel rested upon awakening? ○ Yes ○ No

Do you have problems with insomnia? ○ Yes ○ No

Do you snore? ○ Yes ○ No

Do you use sleeping aids? ○ Yes ○ No Explain: _____

ROLES / RELATIONSHIP

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

List Children

Child's Name	*Age*	*Gender*

Who is living in your Household? Number Names

Their Employment/Occupation:

Resources for Emotional Support?

check all that apply: ☐ Partner ☐ Spouse ☐ Family ☐ Friends ☐ Religious/ Spiritual ☐ Pets ☐ Other

Are you satisfied with your sex life? Yes No

How well have things been going for you?	**Very Well**	**Fine**	**Poorly**	**Does Not Apply**
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	☐	☐	☐	☐
Overall	☐	☐	☐	☐

ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

Do you have any known adverse food reactions or sensitivities? ○ Yes ○ No

If yes, describe symptoms: _____

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

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

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

Do you adversely react to? *Check all that apply*

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

☐ Cheese ☐ Citrus foods ☐ Chocolate ☐ Alcohol ☐ Red Wine

☐ Sulfite containing foods (wine, dried fruit, salad bars) ☐ Preservatives (ex. sodium benzoate)

☐ Other _____

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

☐ Cigarette Smoke ☐ Perfunes/Colognes ☐ Auto Exhaust Fumes ☐ Other _____

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

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

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

Explain: _____

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

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

☐ Heavy Metals ☐ Other _____

Chemical Name, Date, Length of Exposure _____

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

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

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

SYMPTOM REVIEW

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

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

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

MUSCULOSKELETAL
- ☐ Back Muscle Spasm
- ☐ Calf Cramps
- ☐ Chest Tightness
- ☐ Foot Cramps
- ☐ Joint Deformity
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Stiffness
- ☐ Muscle Pain
- ☐ Muscle Spasms
- ☐ Muscle Stiffness
- ☐ Muscle Twitches
  - ☐ Around Eyes
  - ☐ Arms Or Legs
- ☐ Muscle Weakness
- ☐ Neck Muscle Spasm
- ☐ Tendonitis
- ☐ Tension Headache
- ☐ TMJ Problems

MOOD/NERVES
- ☐ Agoraphobia
- ☐ Anxiety
- ☐ Auditory Hallucinations
- ☐ Black-out
- ☐ Depression
- ☐ Difficulty:
  - ☐ Concentrating
  - ☐ With Balance
  - ☐ With Thinking
  - ☐ With Judgement
  - ☐ With Speech
  - ☐ With Memory
- ☐ Dizziness *(Spinning)*
- ☐ Fainting
- ☐ Fearfulness
- ☐ Irritability
- ☐ Light-headedness
- ☐ Numbness
- ☐ Other Phobias
- ☐ Panic Attacks
- ☐ Paranoia
- ☐ Seizures
- ☐ Suicidal Thoughts
- ☐ Tingling
- ☐ Tremor/Trembling
- ☐ Visual Hallucinations

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

DIGESTION
- ☐ Anal Spasms
- ☐ Bad Teeth
- ☐ Bleeding Gums
- ☐ Bloating of:
  - ☐ Lower Abdomen
  - ☐ Whole Abdomen
  - ☐ Bloating after meals
- ☐ Blood in Stools
- ☐ Burping
- ☐ Canker Sores
- ☐ Cold Sores
- ☐ Constipation
- ☐ Cracking at Corner of Lips
- ☐ Cramps
- ☐ Dentures w/Poor Chewing
- ☐ Diarrhea
- ☐ Alternating Diarrhea and
- ☐ Constipation
- ☐ Difficulty Swallowing
- ☐ Dry Mouth
- ☐ Excess Flatulence/Gas
- ☐ Fissures
- ☐ Foods "Repeat" *(Reflux)*
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Upper Abdominal Pain
- ☐ Vomiting
- ☐ Intolerance to:
  - ☐ Lactose
  - ☐ All Dairy Products
  - ☐ Wheat
  - ☐ Gluten (wheat, Rye, Barley)
  - ☐ Corn
  - ☐ Eggs
  - ☐ Fatty Foods
  - ☐ Yeast
- ☐ Liver Disease/Jaundice *(Yellow Eyes or Skin)*
- ☐ Abnormal Liver Function
- ☐ Lower Abdominal Pain
- ☐ Mucus in Stools
- ☐ Periodontal Disease
- ☐ Sore Tongue
- ☐ Strong Stool Odor
- ☐ Undigested Food in Stool

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

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

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

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

NAILS
- ☐ Bitten
- ☐ Brittle
- ☐ Curve Up
- ☐ Frayed
- ☐ Fungus-Fingers
- ☐ Fungus-Toes
- ☐ Pitting
- ☐ Ragged Cuticles
- ☐ Ridges
- ☐ Soft
- Thickening of
  - ☐ Finger Nails
  - ☐ Toenails
- ☐ White Spots Lines

RESPIRATORY
- ☐ Bad Breath
- ☐ Bad Odor in Nose
- ☐ Cough-Dry
- ☐ Cough-Productive
- ☐ Hoarseness
- ☐ Sore Throat
- Hay Fever:
  - ☐ Spring
  - ☐ Summer
  - ☐ Fall
  - ☐ Change of Season
- ☐ Nasal Stuffiness
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Fullness
- ☐ Sinus Infection
- ☐ Snoring
- ☐ Wheezing
- ☐ Winter Stuffiness

CARDIOVASCULAR
- ☐ Angina/chest pain
- ☐ Breathlessnesss
- ☐ Heart Murmur
- ☐ Irregular Pulse
- ☐ Palpitations
- ☐ Phlebitis
- ☐ Dry Mouth
- ☐ Swollen Ankles/Feet

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

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

FEMALE REPRODUCTIVE
- ☐ Breast Cysts
- ☐ Breast Lumps
- ☐ Breast Tenderness
- ☐ Ovarian Cyst
- ☐ Poor Libido *(Sex Drive)*
- ☐ Vaginal Discharge
- ☐ Vaginal Odor
- ☐ Vaginal Itch
- ☐ Vaginal Pain with Sex
- Premensrual:
  - ☐ Bloating
  - ☐ Breast Tenderness
  - ☐ Carbohydrate Cravings
  - ☐ Chocolate Craving
  - ☐ Constipation
  - ☐ Decreased Sleep
  - ☐ Diarrhea
  - ☐ Fatigue
  - ☐ Increased Sleep
  - ☐ Irritability
- Menstrual:
  - ☐ Cramps
  - ☐ Heavy Periods
  - ☐ Irregular Periods
  - ☐ No Periods
  - ☐ Scanty Periods
  - ☐ Spotting Between