Mind - Body Soulutions LLC

GENERAL INFORMATION

Name _____

Date of Birth _____ Age_____

Place of Employment _____

Job Title_____ Full-time/Part-time

Name of Insurance Company: _____

Insurance ID#_____ Insurance Group#_____

Insurance Phone Number:_____

Home Address *Number, Street* _____

City, State, Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Fax _____

Email _____

Emergency Contact *Name* _____

Address _____

City, State, Zip _____

Phone _____

I hereby authorize Mind-Body Soulutions and Dr. Cindy Solliday to leave voicemail messages and send email and/or text messages to all of my contact information listed above. In the event of an emergency, I also authorize Mind-Body Soulutions and Dr. Cindy Solliday to release information to the emergency contact person(s) listed above.

Your signature below indicates agreement with this Teletherapy Patient Consent Agreement.

Patient's Signature: _____Date: _____

INTEGRATIVE HEALTH QUESTIONNAIRE

ALLERGIES:

Medications/Supplement/Food Reaction

_____ _____
_____ _____
_____ _____
_____ _____

COMPLAINTS/CONCERNS:

What do you hope to achieve in your visit 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 overall health and well-Being? _____
_____

What makes you feel worse? _____
_____

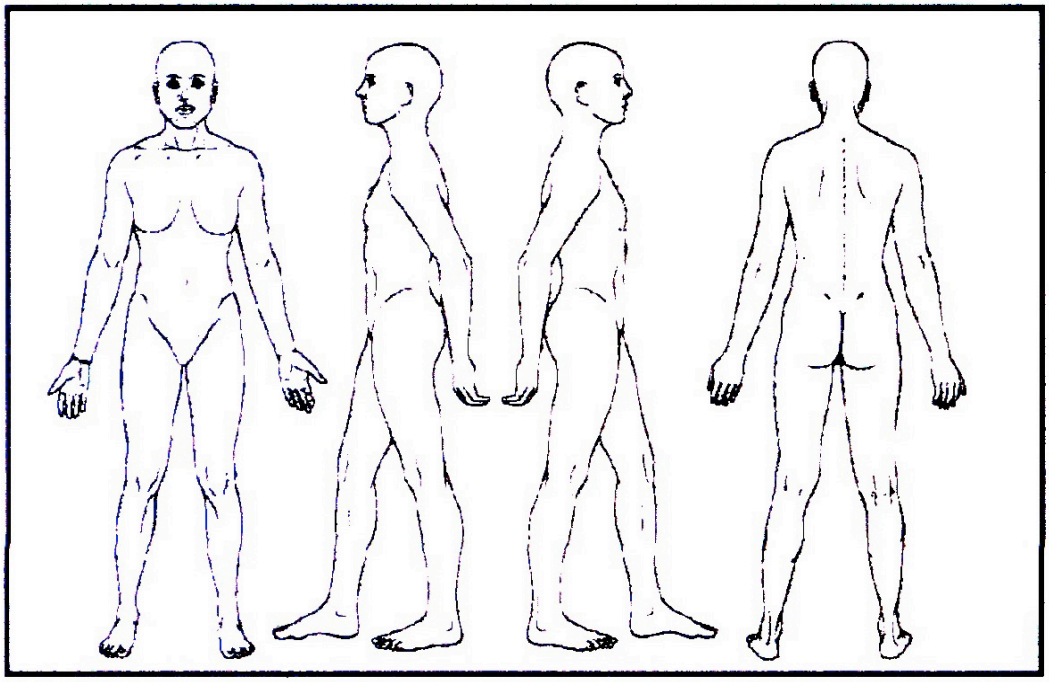
What makes you feel better? _____
_____

What else do you think is important for us to know about your complaints/concerns: _____
_____
_____
_____
_____
_____
_____
_____
_____

Please list current and ongoing problems in order of priority:

Describe Problem	Mild	Moderate	Severe	Prior Treatment/Approach	Mild	Moderate	Severe
Example: Chronic Pain		**X**		*Elimination Diet*		**X**	

Circle any specific areas where you are experiencing physical pain:



Please list anything else you think is important for us to know about your physical concerns/complaints:_____

_____

_____

_____

_____

MEDICAL HISTORY

Do you suffer from chronic or persistent pain/discomfort? Yes/ No

If yes, for how long? _____

If yes, where at do you experience chronic pain/discomfort? _____
_____

Do you know what caused it or when the symptoms seem to get worse or better?
_____

Do you see a Chiropractor? Yes/No

If so, how often? _____

Are you currently suffering from any pain related to traumatic experience (i.e. car accidents, sports injuries, surgeries) Yes/No

If yes, briefly explain (what and when)
_____
_____

Are you currently under medical care? Yes/No

Do you have any conditions that may require a doctor's note? Yes/No

Is it okay for us to contact your health care provider? Yes/No

If yes, please input info below:

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

MEDICAL HISTORY (CONTINUED)

☐ - Past Condition ☐ - Ongoing Condition

GASTROINTESTINAL

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

CARDIOVASCULAR

☐ ☐ Heart Attack _____
☐ ☐ Other Heart Disease _____
☐ ☐ Stroke _____
☐ ☐ Elevated Cholesterol _____
☐ ☐ Arrhythmia (irregular heart rate) _____
☐ ☐ Hypertension (high blood pressure) _____
☐ ☐ Rheumatic Fever _____
☐ ☐ Mitral Valve Prolapse _____
☐ ☐ Other _____

METABOLIC/ENDOCRINE

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

GENITAL AND URINARY SYSTEMS

☐ ☐ Kidney Stones _____
☐ ☐ Gout _____
☐ ☐ Interstitial Cystitis _____
☐ ☐ Frequent Urinary Tract Infections _____
☐ ☐ Frequent Yeast Infections _____
☐ ☐ Erectile Dysfunction
Or Sexual Dysfunction
_____
☐ ☐ Other _____

MUSCULOSKELETAL/PAIN

☐ ☐ Osteoarthritis _____
☐ ☐ Fibromyalgia _____
☐ ☐ Chronic Plan _____
☐ ☐ Other _____

INFLAMMATORY/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 DISEASE

☐ ☐ Asthma _____
☐ ☐ Chronic Sinusitis _____
☐ ☐ Bronchitis _____
☐ ☐ Emphysema _____
☐ ☐ Pneumonia _____
☐ ☐ Tuberculosis _____
☐ ☐ Sleep Apnea _____
☐ ☐ Other _____

MEDICAL HISTORY (CONTINUED)

☐ - Past Condition ☐ - Ongoing Condition

CANCER

☐ ☐ Lung Cancer _____
☐ ☐ Breast Cancer _____
☐ ☐ Colon Cancer _____
☐ ☐ Prostate Cancer _____
☐ ☐ Skin Cancer _____
☐ ☐ Other _____

SKIN DISEASES

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

NEUROLOGICAL/MOOD

☐ ☐ 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 _____

PREVENTIVE 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 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 ☐ Rh+
☐ Unknown

HOSPITALIZATION ☐ None

Date	Reason

Please list anything else you think is important for us to know about your previous specific medical treatment or general healthcare related experiences:

OTHER COMMENTS:

GYNECOLOGIC HISTORY *(for women only)*

OBSTETRIC HISTORY ***Check box if yes and provide number of***
☐ Pregnancies _____ ☐ Caesarean _____ ☐ Vaginal deliveries _____
☐ Miscarriage _____ ☐ Abortion _____ ☐ Living Children: _____
☐ Post Partum Depression ☐ Toxemia ☐ Gestational Diabetes ☐ Baby over 8 pounds
☐ Breast Feeding For how long? _____
MENSTRUAL HISTORY
Age at first period _____ Menses Frequency: _____ Length: _____ Pain: ☐ Yes ☐ No
Has your period ever skipped? _____ For how long? _____
Last Menstrual Period _____
Use of hormonal contraception such as: ☐ Birth Control Pill ☐ Patch ☐ Nuva Ring How Long?_____
Do you use contraception? ☐ yes ☐ No
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
Date of 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
☐ Loss of Control of Urine ☐ Palpitations
☐ Use of hormone replacement therapy? How long?

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
☐ Difficulty Obtaining an Erection ☐ Difficulty Maintaining an Erection
☐ Nocturia (urination at night) How man times at night? _____
☐ Urgency/Hesitancy/Change in Urinary Stream ☐ Loss of Control of Urine

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 you food well? ☐ Yes ☐ No
Do you feel 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 child ☐ Yes ☐ No

DENTAL HISTORY

☐ Silver Mercury Fillings How many? _____
☐ Gold Fillings ☐ Root canals ☐ Implants ☐ Tooth pain ☐ Bleeding gums ☐ Gingivitis
☐ Problems with chewing
Do you floss regularly? ☐ Yes ☐ No

FAMILY HISTORY

Check family members that apply	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunt(s)	Uncle(s)	Other
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)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Disease (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)												
Depression												
Anxiety												
Bipolar Disorder												
ADHD												
Autism												
Psychotic Disorder												

MEDICATIONS

CURRENT MEDICATIONS:

Medications	Dose	Frequency	Start Date (mm/yy)	Reason for Use

PREVIOUS MEDICATIONS: ***Last 10 years***

Medications	Dose	Frequency	Start Date (mm/yy)	Reason for Use

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY):

Supplement/Brand	Dose	Frequency	Start Date (mm/yy)	Reason for Use

Have your medications or supplements ever caused you unusual side effects or problems? ☐ Yes ☐ No
Describe _____
Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ☐ Yes ☐ No
Have you had prolonged or regular use of 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

NUTRITIONAL HISTORY

Have you ever had a nutrition consultation? ☐ Yes ☐ No
Have you 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 Range =/- 5 lbs. _____ 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 do you eat out per week ☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ >5 meals per week

Check all the factors 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
☐ Travel frequently
☐ Non-availability of healthy foods
☐ Do no plan meals or menus
☐ Reliance on convenience items
☐ Poor snack choices
☐ 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 with food
☐ Struggle with eating issues
☐ Emotional eater
☐ Eat too much under stress
☐ Eat too little under stress
☐ Don't care to cook
☐ Eating in the middle of the night
☐ Confused about nutrition advice

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

SMOKING

Currently smoking? ☐ Yes ☐ No How many years? _____ Packs per day _____
Attempts to quit: _____
Previous Smoking: How many years? _____ Packs per day _____
2nd Hand Smoke Exposure? ☐ Yes ☐ No

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) ☐ None
Have you 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 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

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-ounces can/bottle/day ☐ 1 ☐ 2-4 ☐ >4 a day
List favorite type (*such as 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

EXERCISE

Current Exercise Program:

Activity	Type	Frequency per week	Duration in minutes
Stretching			
Cardio/Aerobics			
Strength			
Other (yoga, pilates, 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

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 experienced major losses in you 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 you 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 techniques? ☐ 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 _____

RELATIONSHIPS

Marital status ☐ Single ☐ Married ☐ Divorced ☐ 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: ☐ Spouse ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other
Are you satisfied with your sex life? ☐ Yes ☐ No
Is there anything else you would like to share about your relationship preferences, sexuality or identity?

_____
_____
_____
_____
_____
_____

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

ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

Do you have known adverse food reactions or sensitivities? ☐ Yes ☐ No
If yes, describe your symptoms _____
_____
Do you have any food allergies or sensitivities ☐ Yes List: _____ ☐ No
Do you have an adverse reaction to caffeine? ☐ Yes ☐ No
When you drink caffeine do you feel: ☐ Irritable or Wired ☐ Aches & 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 ☐ Perfumes/Colognes ☐ Auto Exhaust Fumes ☐ Other
In your work or home environment, are you expose to: ☐ Chemicals ☐ Electromagnetic Radiation ☐ Mold
Have you ever turned yellow (jaundiced)? ☐ Yes ☐ No
Have you ever been told you have Gilbert'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

Is there anything else you would like share about specific sensitivities or other concerns about sensitivities?

_____
_____
_____
_____
_____
_____
_____
_____

SYMTOM REVIEW *Please check all current symptoms occurring or present in the past 6 months*

GENERAL
- ☐ Cold Hands & Feet
- ☐ Cold Intolerance
- ☐ Low Body Temperature
- ☐ Low Blood Pressure
- ☐ 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 Detachment
- ☐ Retinal Detachment

EATING
- ☐ Binge Eating
- ☐ Bulimia
- ☐ Can't Gain Weight
- ☐ Can't Loss Weight
- ☐ Can't Maintain Healthy Weight
- ☐ Frequent Dieting
- ☐ Poor Appetite
- ☐ Salt Cravings
- ☐ Carbohydrate Cravings
- ☐ Sweet Cravings
- ☐ Chocolate Cravings
- ☐ Caffeine Dependent

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 Weakness
- ☐ Neck Muscle Spasm

Muscle Twitches:
- ☐ Around Eyes
- ☐ Arms or Legs

- ☐ Tendonitis
- ☐ Tension Headaches
- ☐ TMJ Problems

MOOD/NEVERS
- ☐ Agoraphobia
- ☐ Anxiety
- ☐ Auditory Hallucinations
- ☐ Black-outs
- ☐ Depression

Difficulty with:
- ☐ Concentrating
- ☐ Balance
- ☐ Thinking
- ☐ Judgment
- ☐ Speech
- ☐ Memory

- ☐ Dizziness (spinning)
- ☐ Fainting
- ☐ Fearfulness
- ☐ Irritability
- ☐ Light-headedness
- ☐ Numbness
- ☐ Other Phobia
- ☐ Panic Attacks
- ☐ Paranoia
- ☐ Seizures
- ☐ Suicidal Thoughts
- ☐ Tingling
- ☐ Tremor/Trembling
- ☐ Visual Hallucinations

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 with Poor Chewing
- ☐ Diarrhea
- ☐ Alternating Diarrhea and Constipation
- ☐ Difficulty swallowing
- ☐ Dry Mouth
- ☐ Excess Flatulence/Gas
- ☐ Fissures
- ☐ Food "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
- ☐ Abnormal Liver Function Tests
- ☐ 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 Arm
- ☐ 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
- ☐ Sensitive 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
- ☐ Roof of Mouth
- ☐ Scalp
- ☐ Throat

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

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 Infection
- ☐ Snoring
- ☐ Wheezing
- ☐ Winter Stuffiness

CARDIOOVASCULAR
- ☐ Angina/Chest Pain
- ☐ Breathlessness
- ☐ Heart Murmur
- ☐ Irregular Pulse
- ☐ Palpitations
- ☐ Phlebitis
- ☐ Swollen Ankles/Feet
- ☐ Varicose Veins

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

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

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

FEMALE REPRODUCTIVE
- ☐ Breast Cysts
- ☐ Breast Lumps
- ☐ Breast Tenderness
- ☐ Ovarian Cysts
- ☐ Poor Libido (Sex Drive)
- ☐ Vaginal Discharge
- ☐ Vaginal Odor
- ☐ Vaginal Pain with Sex

Premenstrual:
- ☐ Bloating Breast Tenderness
- ☐ Carbohydrate Cravings
- ☐ Chocolate Cravings
- ☐ Constipation
- ☐ Decreased Sleep
- ☐ Diarrhea
- ☐ Fatigue
- ☐ Increased Sleep
- ☐ Irritability

Menstrual:
- ☐ Cramps
- ☐ Heavy Periods
- ☐ Irregular Periods
- ☐ No Periods
- ☐ Scanty Periods
- ☐ Spotting Between

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 (i.e., 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
Have periodic lab tests to assess your 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 avove 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 (very unsupportive)
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 (frequent contact) to 1 (very infrequent contact)
How much on-going support and contact (i.e., telephone consults, e-mail correspondence) from our professional staff would be helpful to you as you implement your personal health program? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Comments

_____

_____

_____

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.

- Do not change your eating behavior at this time, as the purpose of this food record is to analyze your present eating habits
- Record information as soon as possible after the food as been consumed
- Describe the food or beverage as accurately as possible i.e., milk – what kind? (whole, 2%, nonfat); toast – (whole wheat, white, buttered); chicken – (fried, baked, breaded), coffee – (decaffeinated with sugar and ½ & ½)
- Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, ½ cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.
- Record all beverages, including water, coffee, tea, sports drinks, sodas/diet sodas, etc.
- 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.)

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

DIET DIARY

Name _____ Date _____

DAY 1

Time	Food/Beverage/Amount	Comments

Bowel Movements (#, form, color) _____
Stress/Mood/Emotions _____
Other Comments _____

DAY 2

Time	Food/Beverage/Amount	Comments

Bowel Movements (#, form, color) _____
Stress/Mood/Emotions _____
Other Comments _____

DAY 3

Time	Food/Beverage/Amount	Comments

Bowel Movements (#, form, color) _____
Stress/Mood/Emotions _____
Other Comments _____

MEDICAL SYMPTOM/TOXICITY QUESTIONNAIRE

NAME_____ DATE _____

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are taking after the first time, record your symptoms for the last 48 hours ONLY.

POINT SCALE

0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not sever
2 = Occasionally have, effect is sever
3 = frequently have it, effect is not severe
4 = frequently have it, effect is severe

DIGESTIVE TRACT
_____ Nausea or vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated Feeling
_____ Belching
_____ Heartburn
_____ Intestinal/Stomach pain
Total _____

EARS
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss
Total _____

EMOTIONS
_____ Mood swings
_____ Anxiety, fear or nervousness
_____ Anger, irritability
_____ Depression
Total _____

ENERGY/ACTIVITY
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness
Total _____

EYES
_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision (does not include near- or far-sightedness)
Total _____

HEAD
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia
Total _____

HEART
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest Pain
Total _____

JOINTS/MUSCLES
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness/limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness
Total _____

LUNGS
_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficult breathing
Total _____

MIND
_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities
Total _____

MOUTH/THROAT
_____ Chronic coughing
_____ Gagging, frequent throat clearing
_____ Sore throat, hoarseness, loss of voice
_____ Swollen/discolored tongue, gum, lips
_____ Canker sores
Total _____

NOSE
_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation
Total _____

SKIN
_____ Acne
_____ Hives, rashes, or dry skin
_____ Hair loss
_____ Flushing or hot flashes
_____ Excessive sweating
Total _____

WEIGHT
_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight
Total _____

OTHER
_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge
Total _____

GRAND TOTAL _____

KEY TO QUESTIONNAIRE: Add individual scores and total each group. Add each group score to get Grand Total.
Optimal: <10 Mild Toxicity: 10-50 Moderate Toxicity: 50-100 Severe Toxicity: >100

QUALITY OF LIFE ASSESSMENT

INSTRUCTIONS: This set of questions asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Answer every question by marking the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

In general, would you say your health is: *(Please check one box.)*
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Compared to one year ago, how would you rate your health in general now? *(Please check one box.)*
☐ Much better than one year ago
☐ Somewhat better now than one year ago
☐ About the same as one year ago
☐ Somewhat worse now than one year ago
☐ Much worse than one year ago

The following questions are about activities you might do during a typical day. Does you health now limit you in these activities? If so, how much? *(Please circle one number on each life.)*

Activities	**Limited A lot**	**Limited a Little**	**Not Limited at All**
Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	1	2	3
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3
Lifting or carrying groceries	1	2	3
Climbing several flights of stairs	1	2	3
Climbing one flight of stairs	1	2	3
Bending, kneeling, or stooping	1	2	3
Walking more than a mile	1	2	3
Walking several blocks	1	2	3
Walking one block	1	2	3
Bathing and dressing yourself	1	2	3

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

(Please Circle one number on each line.)	**Yes**	**No**
Cut down on the amount of time you spent on work or other activities	1	2
Accomplished less than you would like	1	2
Were limited in the kind of work or other activities	1	2
Had difficulty performing the work or other activities (i.e., it took extra effort)	1	2

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (i.e., feeling depressed or anxious)?

(Please circle one number on each line.)	**Yes**	**No**
Cut down on the amount of time you spent on work or other activities	1	2
Accomplished less than you would like	1	2
Didn't do work or other activities as carefully as usual	1	2

During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? *(Please check one box.)*
☐ Not at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely

How much physical pain have you had during the past 4 weeks? *(Please check one box.)*
☐ None ☐ Very Mild ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe

During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? *(Please check one box.)*
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

These questions are about how you feel and how things have been with you during the past 4 weeks. Please give the one answer that is closest to the way you have been feeling for each item.

(Please circle one number on each line.)	**All of the Time**	**Most of the Time**	**Good bit of the Time**	**Some of the Time**	**Little of the Time**	**None of the Time**
Did you feel full of life?	1	2	3	4	5	6
Have you been a very nervous person?	1	2	3	4	5	6
Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
Have you felt calm and peaceful?	1	2	3	4	5	6
Did you have a lot of energy?	1	2	3	4	5	6
Have you felt downhearted and blue?	1	2	3	4	5	6
Have you been a happy person?	1	2	3	4	5	6
Did you feel tired or worn out?	1	2	3	4	5	6

During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.) *(Please check on box.)*
☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

How TRUE or FALSE is each of the following statements for you?

(Please circle one number on each line.)	**Definitely True**	**Mostly True**	**Don't Know**	**Mostly False**	**Definitely False**
I seem to get sick a little easier than other people.	1	2	3	4	5
I am as healthy as anybody I know.	1	2	3	4	5
I expect my health to get worse.	1	2	3	4	5
My health is excellent.	1	2	3	4	5

Thank You!