New Client Intake Form

DR. LAUREN PETERS, DOCTOR OF PHYSICAL THERAPY, RWP
FUNCTIONAL MEDICINE

FIRST _____

LAST _____

DOB _____

GENDER _____

OCCUPATION _____

EXERCISE _____

PHONE NUMBER

ADDRESS

_____

_____

_____

EMERGENCY CONTACT

NAME

PHONE #

RELATIONSHIP

ALLERGIES

_____

_____

ARE YOU A SMOKER?

☐ CIGARETTES ☐ MARIJUANA ☐ NONE

HOW MANY YEARS? _____
PACKS PER DAY? _____
ATTEMPTS TO QUIT? _____
☐ MEDICINAL USE ☐ RECREATIONAL

REFERRED BY: _____

WHAT SERVICES ARE YOU INTERESTED IN?

☐ Functional Medicine
☐ Physical Therapy
  ☐ Virtual
  ☐ Home Visits
☐ Pelvic Floor Therapy
  ☐ Virtual
  ☐ Home Visits
☐ Wellness Consultations
☐ Nutrition Coaching
☐ Other

ALCOHOL CONSUMPTION?

How many drinks per week?
1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits
☐ None ☐ 1-3 ☐4-6 ☐ 7-10 ☐> 10
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 ever take an eye-opener? ☐ 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

MEDICATIONS/SUPPLEMENT	REASON FOR TAKING

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 (PPI, Tagamet, Zantac, Prilosec, etc.)
□ Yes □ No
Antibiotics: Long-term or multiple bouts of antibiotics? □ Yes □ No
Antibiotics at a young age? □ Yes □ No
Frequent antibiotics > 3 times/year □ Yes □ No
Use of steroids (prednisone, nasal allergy inhalers) in the past □ Yes □ No
Use of oral contraceptives □ Past □ Current □ Never

WHAT DO YOU HOPE TO ACHIEVE?

IF YOU HAD A MAGIC WAND, WHAT WOULD YOU CHANGE?

HOW DO YOU FEEL?

WHEN'S THE LAST TIME YOU FELT WELL?

WHAT MAKES YOU FEEL BETTER?

WHAT MAKES YOU FEEL WORSE?

BOWEL HABITS

HOW OFTEN ARE YOUR BOWEL MOVEMENTS?

HARD, SOFT OR WATERY?

URGENT, EASY OR DIFFICULT TO PASS?

LIST OF ONGOING ISSUES IN ORDER OF PRIORITY

PROBLEM	MILD	MOD	SEVERE

PRIOR TREATMENTS/APPROACH

TREATMENT/APPROACH	EXCELLENT	GOOD	FAIR
Example: Gluten Free	✓		

ANYTHING ELSE YOU HAVE NOTICED? LET'S CONNECT THE DOTS!

PERSONAL HISTORY: PLEASE CHECK WHAT'S APPLICABLE

GASTROINTESTINAL

- ☐ Irritable Bowel Syndrome
- ☐ Inflammatory Bowel Disease
- ☐ Crohn's
- ☐ Ulcerative Colitis
- ☐ Gastritis/Peptic Ulcer Disease
- ☐ GERD (reflux)
- ☐ Celiac Disease
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas/Bloating
- ☐ Abdominal Pain

CANCER

- ☐ Lung
- ☐ Breast
- ☐ Prostate
- ☐ Pancreatic
- ☐ Liver
- ☐ Skin
- ☐ Colon
- ☐ Ovarian
- ☐ Cervical
- ☐ Other

CARDIOVASCULAR

- ☐ Heart attack
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Rheumatic Fever
- ☐ Mitral Valve Prolapse
- ☐ Other Cardiac diseases
- ☐ Elevated Cholesterol
- ☐ Peripheral Vascular Dz
- ☐ Irregular heartbeat (Arrhythmia)

GENITAL/URINARY

- ☐ Kidney stones
- ☐ Gout
- ☐ Yeast infection
- ☐ UTI
- ☐ Interstitial cystitis
- ☐ Organ Prolapse
- ☐ Erectile dysfunction
- ☐ Incontinence
- ☐ Urinary frequency
- ☐ Wake up at night to urinate? 1x 2x 3x

METABOLIC/ENDOCRINE

- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes
- ☐ PCOS
- ☐ Hypoglycemia
- ☐ Metabolic Syndrome
- ☐ Insulin Resistance or Pre Diabetes
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Weight gain
- ☐ Weight loss
- ☐ Bulemia
- ☐ Anorexia
- ☐ Night eating syndrome
- ☐ Eating disorder

RESPIRATORY

- ☐ Asthma
- ☐ Chronic Sinusitis
- ☐ Bronchitis
- ☐ COPD
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Sleep Apnea

INFLAMMATORY/IMMUNE

- ☐ Chronic Fatigue Syndrome
- ☐ Autoimmune Disease
- ☐ Lupus (SLE)
- ☐ Raynauds Phenomenon
- ☐ Rheumatoid Arthritis
- ☐ Ankylosing Spondylitis
- ☐ Herpes
- ☐ Immunocompromised
- ☐ Food Allergies
- ☐ Chemical Sensitivies
- ☐ Latex Allergy
- ☐ Environmental Allergies
- ☐ Severe Infectious Disease

SKIN

- ☐ Psoriasis
- ☐ Eczema
- ☐ Acne
- ☐ Melanoma
- ☐ Tinea Vesicolor
- ☐ Athlete's Foot
- ☐ Fungal Disease

NEUROLOGIC/MOOD

- ☐ Depression
- ☐ Anxiety
- ☐ Panic Disorder
- ☐ Bipolar Disorder
- ☐ Dementia
- ☐ Alzheimer's Disease
- ☐ Schizophrenia
- ☐ Headaches
- ☐ Migraines
- ☐ Mood Disorders
- ☐ ADHD/ADD
- ☐ Autism
- ☐ Memory Issues
- ☐ Parkinson's Disease
- ☐ Mild Cognitive Impairments
- ☐ ALS
- ☐ Multiple Sclerosis
- ☐ Seizures

MUSCULOSKELETAL

- ☐ Osteoarthritis
- ☐ Chronic Pain
- ☐ Fibromyalgia
- ☐ Osteoporosis
- ☐ Tension Headaches

PREVENTATIVE AND LAST DATE OF TEST

- ☐ Physical Exam _____
- ☐ Bone Density _____
- ☐ Colonoscopy _____
- ☐ Cardiac Stress Test _____
- ☐ EKG _____
- ☐ MRI _____
- ☐ Upper Endoscopy _____
- ☐ Routine Blood Work _____
- ☐ GI Mapping _____
- ☐ Cardiac Stress Test _____
- ☐ MRT _____
- ☐ CT Scan _____

INJURIES & DATE OF INJURY

- ☐ Back Injury _____
- ☐ Neck Injury _____
- ☐ Work Related Injury _____
- ☐ Head Injury _____
- ☐ Broken Bones _____

SURGICAL HISTORY & DATE

- ☐ Back Surgery _____
- ☐ Hernia Repair _____
- ☐ Appendectomy _____
- ☐ Gall Bladder Removal _____
- ☐ Hysterectomy _____
- ☐ Exploratory Laprascopic _____
- ☐ Dental Surgery_____
- ☐ Joint Replacement_____
- ☐ Angioplasty/stent placement_____
- ☐ Cardiac Stress Test_____
- ☐ Pacemaker_____
- ☐ Cardiac Surgery_____

TRAVEL HISTORY

Foreign Travel? ☐ yes ☐ no
- ☐ where? _____
- ☐ Wilderness Camping?
- ☐ Increased bloating?
- ☐ Ever have severe Diarrhea? _____
- ☐ Ever Have Gastroenteritis? _____
- ☐ Severe Constipation? _____

DENTAL HISTORY

- ☐ Root Canals? _____
- ☐ Silver Mercury Fillings?
  - ☐ How Many?_____
- ☐ Gold Fillings? _____
- ☐ Issues with Chewing? _____
- ☐ Implants? _____
- ☐ Tooth pain? _____
- ☐ Bleeding Gums? _____
- ☐ Gingivitis? _____

Do you floss? ☐ yes ☐ no

YOUR BIRTH HISTORY

- ☐ Vaginal Birth? _____
- ☐ C-Section? _____
- ☐ Bottle Fed? _____
- ☐ Breast Fed? _____
- ☐ Pregnancy Complications? _____
- ☐ Birth Complications? _____

Age of introduction to dairy? _____
Age of introduction to soild foods? _____
Age of introduction to wheat ? _____
Did you eat a lot of sugar/soda/candy?
☐ yes ☐ no

Women Only

OBSTETRICS/GYNECOLOGICAL HISTORY

- ☐ Pregnancies _____
- ☐ Miscarriages _____
- ☐ Abortion _____
- ☐ C-Section _____
- ☐ Difficulty Conceiving _____
- ☐ Hormonal Birth Control Use, how long _____
- ☐ Vaginal Deliveries _____
- ☐ Post Pardum Depression_____
- ☐ Diastisis Recti _____
- ☐ Living Children _____
- ☐ Breast Feeding, how long _____
- ☐ Gestational Diabetes_____
- ☐ Baby Over 8 lbs _____

MENSTRUAL HISTORY

- Age of first Period _____
- Menses Frequency _____
- Length, light/heavy? _____
- ☐ Pain, cramping? _____
- ☐ Clotting _____
- ☐ Skipped Period ____How Long? _____
- Last Menstral Period: _____
- Use of contraception? _____

WOMEN'S DISORDERS/HORMONAL IMBALANCES

- ☐ Fibrotic Cysts _____
- ☐ Endometriosis _____
- ☐ Fibroids _____
- ☐ Infertility _____
- ☐ PMS _____
- ☐ Menopause _____
- ☐ Hot Flashes _____
- ☐ Decreased Libido _____
- ☐ Mammogram _____
- ☐ Breast Biopsy _____
- Last Papsmear _____
  - ☐ Normal
  - ☐ Abnormal
- ☐ Mood Swings _____
- ☐ Vaginal Dryness _____
- ☐ Concentration/Memory Issues _____

Men Only

MALE HISTORY

- ☐ PSA _____
- ☐ Prostate Enlargement _____
- ☐ Prostate Infection _____
- ☐ Erectile Dysfunction _____
- ☐ Change in Libido _____
- ☐ Other _____
- ☐ Urination at Night _____
  - ☐ How many times? _____
- ☐ Urgency _____
- ☐ Hesitancy _____
- ☐ Change in stream? _____
- ☐ Loss of Urine Control _____

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

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

_____

_____
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 out
☐ Travel frequently
☐ Non-availability of healthy foods
☐ Do not plan meals or menus
☐ Reliance on convenience items
☐ Poor snack choices
☐ Eating in the middle of the night
☐ Significant other or family members don't like healthy foods
☐ Significant other or family members have special dietary needs or food preferences
☐ Love to eat
☐ Eat because I have to
☐ Have a negative relationship with food
☐ Struggle with eating issues
☐ Emotional eater (eat when sad, lonely depressed, bored)
☐ Eat too much under stress
☐ Eat too little under stress
☐ Don't care to cook

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

Wellness

SLEEP

Average # of hours you sleep per night: □>10 □ 8-10 □ 6-8 □ < 6
Do you have trouble falling asleep? □ Always □ Sometimes □ Never
Do you have trouble staying asleep? □ Always □ Sometimes □ Never
Do you feel rested upon awakening? □ Always □ Sometimes □ Never
Do you have problems with insomnia? □ Always □ Sometimes □ Never
Do you snore? □ Yes □ No
Do you use sleeping aids? □ Yes □ No
Explain: _____

EXERCISE

Current Exercise Regime:

Activity Type: □ Cardio □ Strength Training □ HIIT □ Stretching □ Other _____
Frequency per week: □ 0 □ 1-2x □ 3-4x □ >5x
Duration in Minutes: _____
Sports or Leisure Activities (golf, tennis, rollerblading, etc.) _____
Rate your level of motivation for including exercise in your life? □ Low □ Medium □ High

List of 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
Do you use the Sauna? □Yes □ No

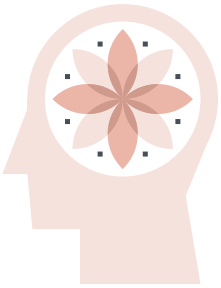
AVERAGE OZ H20 PER DAY

OTHER SUBSTANCES

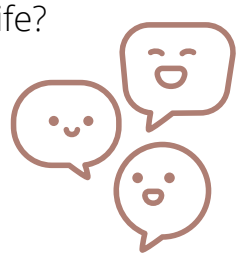
Caffeine Intake: □ Yes □ No
- Coffee cups/day: □ 1 □ 2-4 □ > 4
- Tea cups/day: □ 1 □ 2-4 □ > 4
- Caffeinated Sodas or Diet Sodas Intake: □ Yes □ No
- 12-ounce can/bottle □ 1 □ 2-4 □ > 4 per day

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

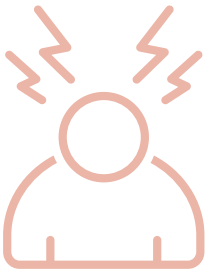
Psychosocial



Do you feel significantly less important than you did a year ago?
☐ Always ☐ Sometimes ☐ Never
Are you happy?
☐ Always ☐ Sometimes ☐ Never
Do you feel your life has meaning and purpose?
☐ Always ☐ Sometimes ☐ Never
Do you believe stress is presently reducing the quality of your life?
☐ Always ☐ Sometimes ☐ Never
Do you like the work you do?
☐ Always ☐ Sometimes ☐ Never
Have you ever experienced major losses in your life?
☐ Yes ☐ No
Do you spend the majority of your time and money to fulfill responsibilities and obligations?
☐ Always ☐ Sometimes ☐ Never
Would you describe your experience as a child in your family as happy and secure?
☐ Yes ☐ No



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?
☐ Always ☐ Sometimes ☐ Never
Do you feel you can easily handle the stress in your life?
☐ Always ☐ Sometimes ☐ Never



Daily Stressors: Rate on 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 significant trauma?
☐Yes ☐ No

Current Symptoms

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

MOOD/NERVES
- ☐ Agoraphobia
- ☐ Anxiety
- ☐ Auditory Hallucinations
- ☐ Black-out
- ☐ Depression

Difficulty:
- ☐ Concentrating
- ☐ With Balance
- ☐ With Thinking
- ☐ With Judgment
- ☐ 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

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 Lose Weight
- ☐ Can't Maintain Healthy Weight
- ☐ Frequent Dieting
- ☐ Poor Appetite
- ☐ Salt Cravings
- ☐ Carbohydrate Craving (breads, pastas)
- ☐ Sweet Cravings (candy, cookies, cakes)
- ☐ Chocolate Cravings
- ☐ Caffeine Dependency

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

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

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

Current Symptoms

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 + 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 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 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
- ☐ Sensitivity to Bites
- ☐ Sensitivity to Poison Ivy/Oak
- ☐ Shingles
- ☐ Skin Darkening
- ☐ Strong Body Odor
- ☐ Hair Loss
- ☐ Vitiligo

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

CARDIOVASCULAR
- ☐ Angina/chest pain
- ☐ Breathlessness
- ☐ Heart Murmur
- ☐ Irregular Pulse
- ☐ Palpitations
- ☐ Phlebitis
- ☐ Swollen Ankles/Feet
- ☐ Varicose Veins

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
  - ☐ Cracking
  - ☐ Peeling
- ☐ Hair
  - ☐Unmanageable
- ☐Hands
  - ☐Cracking ☐Peeling
- ☐ Mouth/Throat
- ☐ Scalp
  - ☐ Dandruff
- ☐ Skin In General

NAILS
- ☐ Bitten
- ☐ Brittle
- ☐ Curve Up
- ☐ Frayed
- ☐ Fungus-Fingers
- ☐ Fungus-Toes
- ☐ Pitting
- ☐ Ragged Cuticles
- ☐ Ridges
- ☐ Soft

Thickening of:
- ☐ Fingernails
- ☐ Toenails
- ☐ White Spots/Lines

Current Symptoms

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

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

Are you ready to change your life?

In order to improve your health, how willing are you to: *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
Have periodic lab tests to assess your progress..... ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Comments:_____

How confident are you in your ability to organize and follow through on the above health-related activities? *5 (very confident) to 1 (not confident at all):* ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
If you are not, what leads you to question your capacity to fully engage in the above activities?
_____

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? *5 (very supportive) to 1 (very unsupportive):* ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Comments: _____
_____

How much ongoing support and contact (e.g., telephone consults, e-mail correspondence) from our professional staff would be helpful to you as you implement your personal health program?
5 (very frequent contact) to 1 (very infrequent contact): ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Comments:_____