Introductory Patient Information

Premier Health & Wellness
540 N. Golden Circle Drive Suite, #112
Santa Ana, CA 92705

Phone 714-599-3339
Fax 657-232-8112

www.PremierHealthOC.com
info@PremierHealthOC.com

Innovative Health & Wellness Center
297 Lake Havasu Avenue, Suite 200
Lake Havasu City, AZ 86403

Phone 928-854-7666
Fax 928-854-7660

www.InnovativeHealthAndWellnessCenter.com
InnovativeHealthAndWellness@yahoo.com

Dear New Member,

Welcome to our Office! We are very glad you have decided to give us the opportunity to work with you to improve your health.

We take your health journey very seriously and need your cooperation in completing the following paperwork **prior to your appointment** to maximize your time during your visit. Failure to complete **all** paperwork will cause a delay in your treatment plan and we would much rather spend your appointment time speaking with you than doing paperwork. If significant amount of information is not completed the appointment will have to be rescheduled at the fee below

Please note that your appointment may be forfeited if the following forms are not completed in their entirety and in our office prior to your appointment.

Allow yourself **a minimum of 60-90 minutes to complete your intake forms.** We know how valuable your time is and understand this may seem like too much information; however, the more we know about you, the better we can determine what treatment plan is best for you. It is difficult in a short conversation to gather all your medical background thus the many questions ahead of time.

APPOINTMENT POLICY

We understand that unexpected emergencies occur and discernment of the validity of the situation will be determined by the staff (i.e., auto accident or death). Our office requires a 24 hour notice should you need to reschedule your appointment. Therefore we ask that you plan accordingly so that we may continue to serve our patients in an excellent manner. **Please note a $97 charge will apply for missed or cancelled appointments not done within 24 hours.** You can notify us by phone or email. For our California members call 714-599-3339 or email info@PremierHealthOC.com and for Arizona members call **928-854-7666** or email **Innovativehealthandwellness@yahoo.com**

I am committed to becoming healthy and changing my life and improving my health. I have read and completed all my paperwork. Additionally, I have read and understand the appointment policy above and authorize the cancellation fees to be applied to my credit card.

_____	_____	_____
Print Your Name	Sign Your Name	Date

Many of our patients come from far and have waited weeks to see Dr. Linda and therefore appreciate your prompt arrival to your appointment, which allows us to maintain on time with our schedule.

DIRECTIONS TO PREMIER HEALTH & WELLNESS CENTER FOR FUNCTIONAL MEDICINE

The Premier Health & Wellness Center for Functional Medicine is conveniently located in central Orange County. We are located between the 5 & 55 freeways off of the Irvine/4th Street exit for the 55 FWY and 1st/4th Street exit for the 5 FWY. We are located in The Theme Building.

Cheers to the start of great health, energy and vitality!

Health & Blessings,
Dr. Linda Marquez Goodine, DC *(CA licensed)*, Holistic Nutritionist

PRACTICE POLICIES

Our goal in functional medicine and holistic nutrition is to provide you with the highest level of personalized care. We are committed to helping you achieve optimal health.

It is important to read all the enclosed information carefully and mail or fax the medical questionnaire to our office at least 3 days prior to your appointment (address on previous page). This will allow us to help solve your problems more efficiently and enhance the quality of your care. If your patient packet is late, it may take up to 30 minutes of your appointment time to review.

MEDICAL RECORDS

Medical records can only be released with your authorization. You are responsible for obtaining previous medical records from other physicians or health care providers.

CONSULTATION

Your initial consultation is approximately 45 minutes. The initial consultation is designed to save money and time in the long-term by performing the appropriate diagnostic testing and evaluation before treatment begins. Our approach is "test, don't guess." Identifying the underlying patterns contributing to disease is the key to a successful and lasting outcome.

FOLLOW UP VISITS

After your initial consultation, you can decide how you want to move forward with your wellness plan. After deciding which tests to order a follow up visit will be scheduled 2-3 weeks in advance to review your test results and customize a wellness plan according to your blood tests. Additional testing maybe required and will be reviewed with you. You are able to determine what testing to complete based on how much testing you want to do and your out of pocket expense for labs. Testing is frequently done to assess nutritional status including amino acids, fatty acids, oxidative stress, vitamin levels, mitochondrial function, food allergies, and heavy metals. Many additional tests are available, including genetic testing for a variety of conditions, bone health, gastrointestinal health, and others. You can decide whether you need coaching during your new health journey or will go about it alone and check in 3-6 months later.

PAYMENT OPTIONS

Our office accepts cash, checks or credit cards for services rendered.

APPOINTMENTS WITH DR. GOODINE

All appointments with Dr. Goodine are self-pay. Appointments with Dr. Goodine are not billed through insurance. Dr. Linda does accept insurance and we do not file insurance paperwork on your behalf. However, we will provide a detailed receipt for services performed for you to submit to your insurance carriers.

Dr. Goodine does not participate in the Medicare program. If you are Medicare Part B beneficiary and wish to become a patient of Dr. Goodine, you are required to accept the terms and conditions set forth in a Private Contract between you and Dr. Goodine. The private contract provides that absolutely no Medicare payment will be made to you or to Dr. Goodine for the services provided, even if such services are covered by Medicare. Under the Private Contract, you acknowledge that you accept full responsibility for the payment of charges for all services rendered by Dr. Goodine; such payments are due in full at the time of service.

DECLARATION OF INFORMED CONSENT TO SERVICES, CONTRACT AND STIPULATION

I understand and acknowledge that Linda Marquez Goodine, D.C., C.N., (be referred to as Dr. Linda) does not guarantee the treatments will cure me of any disease or affliction (including cancer). I believe it is within my constitutional rights to seek any form of diagnosis and treatment, whether orthodox (not recommended by the AMA). It is my choice whether or not to accept such diagnosis and treatment. My sole purpose and intent in seeking the services of Dr. Linda is to get help for my personal health problems.

I understand that Dr. Linda's treatment program includes nutritional guidance and counseling, reflexology, aromatherapy, acupressure. I also understand that the treatment may be unconventional or experimental. In such case, I agree to hold Dr. Linda harmless and blameless from any untoward result.

Payment for the first visit is due prior to services rendered. Future services are paid as noted in the financial agreement. Payment may be made by cash, checks, Mastercard, or Visa.

I understand that any services that have been rendered or products that have not been paid for at the completion of the program will be due promptly no later than 3 days of notification. I understand that any late fees of $10 per/month, collection fees, attorney or court fees associated with collection of an outstanding balance will be added to account.

I further acknowledge that I have not been advised against seeking any other medical examinations or treatments.

I have read (or have had read to me) the DECLARATION OF INFORMED CONSENT TO SERVICES, CONTRACT AND STIPULATIONS and agree to be bound to the terms therein. I have not signed this declaration without first reading it or having it read to me and I may ask any questions useful in helping me to understand it. I further understand my agreement to the provision of this declaration is an entirely voluntary and informed choice to which my signature attests.

I understand that Dr. Linda is a Health, Fitness and Wellness Educator and her advice and treatment is based on her training and experience and reflects her professional judgment how to help me to the fullest. In good faith, I accept and engage the service of Dr. Linda and hold her harmless for the service she has or will render.

_____ _____

Patient print your name Patient signature

_____ _____

Witness Signature Date

Health Questionnaires

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GENERAL INFORMATIONS

Name	*First*	*Middle*	*Last*	
Preferred Name				
Date of Birth				
Age				
Gender	☐ Male	☐ Female		
Genetic Background	☐ African	☐ European	☐ Native American	☐ Mediterranean
	☐ Asian	☐ Ashkenazi	☐ Middle Eastern	☐ _____
Highest Education Level	☐ High School	☐ Under-Graduate	☐ Post-Graduate	
Job Title				
Nature of Business				
Primary Address	*Number, Street*			
	City		*State*	*Zip*
Alternate Address	*Number, Street*			
	City		*State*	*Zip*
Home Phone			Work Phone	
Cell Phone			Fax	
E-mail				
Emergency Contact	*Name*		*Phone Number*	
Relationship			*Cell Phone*	
	Address		*Work Number*	
	City		*State*	*Zip*
Primary Care Physician	*Name*		*Phone Number*	
	Fax			
Referred by	☐ Book	☐ Website	☐ Media	☐ Family or Friend
	☐ PCP	☐ CC Physician	☐ Other	

ALLERGIES

Medication / 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 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 Check appropriate box and provide date of onset

Past Condition	*Ongoing Condition*	
		GASTROINTESTINAL
☐	☐	Irritable Bowel_____
☐	☐	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_____
☐	☐	Crohn's_____
☐	☐	Hypoglycemia_____
☐	☐	Metabolic Syndrome_____
		(Insulin Resistance or Pre-Diabetes)
☐	☐	Hypothyroidism (low thyroid)_____
☐	☐	Hyperthyroidism (overactive thyroid)_____
☐	☐	Endocrine Problems_____
☐	☐	Polycystic Ovarian Syndrome (POCS)_____
☐	☐	Infertility_____
☐	☐	Weight Gain_____
☐	☐	Weight Loss_____
☐	☐	Frequent Weight Fluctuations_____
☐	☐	Bulimia_____
☐	☐	Anorexia_____
☐	☐	Binge Eating Disorder_____
☐	☐	Night Eating Syndrome_____
☐	☐	Other_____
		CANCER
☐	☐	Lung Cancer_____
☐	☐	Breast Cancer_____
☐	☐	Colon Cancer_____
☐	☐	Ovarian Cancer_____
☐	☐	Prostate Cancer_____
☐	☐	Skin Cancer_____
☐	☐	Other_____

Past Condition	*Ongoing Condition*	
		GENITAL AND URINARY SYSTEM
☐	☐	Kidney Stones_____
☐	☐	Gout_____
☐	☐	Interstitial Cystitis_____
☐	☐	Frequent Urinary Tract Infections_____
☐	☐	Frequent Yeast Infections_____
☐	☐	Erectile Dysfunction_____
		Or Sexual Dysfunction
☐	☐	Other_____
		MUSCULOSKELETAL/PAIN
☐	☐	Osteoarthritis_____
☐	☐	Fibromyalgia_____
☐	☐	Chronic Pain_____
☐	☐	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 DISEASES
☐	☐	Asthma_____
☐	☐	Chronic Sinusitis_____
☐	☐	Bronchitis_____
☐	☐	Emphysema_____
☐	☐	Pneumonia_____
☐	☐	Tuberculosis_____
☐	☐	Sleep Apnea_____
☐	☐	Other_____
		SKIN DISEASES
☐	☐	Eczema_____
☐	☐	Psoriasis_____
☐	☐	Acne_____
☐	☐	Melanoma_____
☐	☐	Skin Cancer_____
☐	☐	Other_____

MEDICAL HISTORY (continued)

Past Condition	Ongoing Condition	NEUROLOGICAL
☐	☐	Depression
☐	☐	Anxiety
☐	☐	Bipolar Disorder
☐	☐	Schizophrenia
☐	☐	Headaches
☐	☐	Migraines
☐	☐	ADD/ADHD
☐	☐	Autism

Past Condition	Ongoing Condition	
☐	☐	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

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

BLOOD TYPE:

- ☐ A
- ☐ AB
- ☐ Rh+
- ☐ B
- ☐ O
- ☐ Unknown

HOSPITALIZATION ☐ **None**

Date	*Reason*

COMMENTS

GYNECOLOGICHISTORY(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?_____

MENSTRUALHISTORY

Age at First Period:_____Menses Frequency:_____Length:_____Pain: ☐Yes ☐No Clotting: ☐Yes ☐No

Has you period ever skipped?_____For how long?_____

Last Menstrual Period_____

Use of hormonal contraception such as: ☐ 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 ☐ 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 many 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 your food well? ☐ Yes ☐ No

Do you feel bloated after meals? ☐ Yes ☐ No

PATIENT BIRTHHISTORY

☐ 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

MEDICATIONS

CURRENT MEDICATIONS

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

PREVIOUS MEDICATIONS (*Last10 years)*

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

Supplement & Brand	Dose	Frequency	Start Date (month/year)	Reason For Use

Have your medications or supplement sever 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 use of Tylenol? ☐ Yes ☐ No

Have you had prolonged or regular use of acid blocking drugs (Tagamet, Zantac, Prilosec, etc.) ☐ Yes ☐ No

Frequent antibiotics ☐ 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

FAMILYHISTORY

Check family members that apply	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grand mother	Maternal Grand father	Paternal Grand mother	Paternal Grand father	Aunt	Uncle	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, Anky losing 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												

SOCIAL HISTORY

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 ☐ Ultra metabolism

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

Height (feet/inches)_____	Current Weight_____
Usual Weight Range +/- 5 lbs_____	Desired Weight Range +/- 5 lbs_____
Highest Adult Weight_____	Lowest Adult Weight_____
Weight Fluctuations (>10lbs) ☐ 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 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% meals away from home
☐ Travel frequently
☐ 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 members have special Dietary needs or food preferences
☐ Love to eat
☐ Eat because I have to
☐ Have a negative relationship to 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
☐ 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 If yes, how many years?_____Packs per day_____

Attempts to quit:_____

Previous Smoking: How many years?_____Packs per day_____

Second Hand Smoke Exposure?_____

ALCOHOL INTAKE

How many drinks currently per week? *1 drink=5 ounces wine, 12 ounces 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 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

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 thought about getting help to control or stop your drinking? ☐ Yes ☐ No

OTHER SUBSTANCES

Caffeine Intake: ☐ Yes ☐ No |Coffee cups/day: ☐ 1 ☐ 2-4 ☐ >4 | Tea cups/day: ☐ 1 ☐ 2-4 ☐ >4

Caffeinated Sodasor Diet Sodas Intake: ☐ Yes ☐ No

12-ounce can/bottle: ☐ 1 ☐ 2-4 ☐ >4

List favorite type (Ex. Diet Coke, Pepsi, etc):_____

Are you currently using any recreational drugs? ☐ Yes ☐ No If yes, type:_____

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

EXERCISE

Current Exercise Program:(*List type of activity, number of sessions/week, and duration)*

Activity	Type	Frequency Per Week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength			
Other (yoga, pilates, gyrotonics, etc.)			
Sports or Leisure Activities (golf, tennis, roller blading, etc.)			

Rate your level of motivation for including exercise in your life? ☐ Low ☐ Medium ☐ H i g h

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 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 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 sleeper night: ☐ >10 ☐ 8-10 ☐ 6-8 ☐ <6

Do you have trouble falling asleep? ☐ Yes ☐ No

Do you feel rested up on 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 ☐ Long term partnership ☐ Widow

List Children: Child's Full Name	Age	Gender

Who is Living in Household? Number:_____Name:_____

Their Employment/Occupations:_____

Resources for emotional support?

Check all that apply: ☐ 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	N/A
- 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 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 ☐ Perfumes/Colognes ☐ Auto Exhaust Fumes ☐ Other:_____

In your work or home environment, are you exposed 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 exposure? ☐ Yes ☐ No

Do you have 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
- ☐ 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

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
- ☐ Muscle Twitches – Arms or Legs
- ☐ Muscle Weakness
- ☐ Tendonitis
- ☐ Tension Headache
- ☐ TMJ Problems

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

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, pasta)
- ☐ Sweet Cravings (candy, cookies, cakes)
- ☐ Chocolate Cravings
- ☐ Caffeine Dependency

DIGESTION

- ☐ Anal Spasms
- ☐ Bad Teeth
- ☐ Bleeding Gums
- ☐ Bloating of Lower Abdomen
- ☐ Bloating of 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
- ☐ 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 (yellow eyes/ skin)
- ☐ Abnormal Liver Function Tests
- ☐ Lower Abdominal Pain
- ☐ Mucus in Stools
- ☐ Periodontal Disease
- ☐ Sore Tongue Strong Stool
- ☐ Odor Undigested Food in Stools

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

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
- ☐ Hair Unmanageable?
- ☐ Hands
  - ☐ Any Cracking?
  - ☐ Any Peeling?
- ☐ Mouth/Throat
- ☐ Scalp
  - ☐ 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 fingernails
- ☐ Thickening of 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
- ☐ Breathlessness
- ☐ Heart Murmur
- ☐ Irregular Pulse
- ☐ Palpitation
- ☐ Phlebitis
- ☐ Swollen Ankles/Feet
- ☐ Varicose Veins

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

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 nutrition 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

Comment:_____

_____

_____

Rate on a scale of 5 (very confident) to 1 (not confident at all):

How confident are your of your ability to organize and follow through on the above health related activities?

☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to 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 (very frequent contact) to 1 (very infrequent contact):

How much on-going 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 ☐ 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.

- 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 and 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 – DAY 1

Name:_____ Date:_____

Daily Exercise (Type of Activity / Time of Day / Duration) :_____

_____

Daily Bowel Movements: _____

TIME	FOOD/ BEVERAGE / AMOUNT	COMMENTS

DIET DIARY – DAY 2

Name:_____ Date:_____

Daily Exercise (Type of Activity / Time of Day / Duration) :_____

_____

Daily Bowel Movements: _____

TIME	FOOD/ BEVERAGE / AMOUNT	COMMENTS

DIET DIARY – DAY 3

Name:_____ Date:_____

Daily Exercise (Type of Activity / Time of Day / Duration) :_____

_____

Daily Bowel Movements: _____

TIME	FOOD/ BEVERAGE / AMOUNT	COMMENTS

OTHER COMMENTS / QUESTIONS / CONCERNS:_____

Medical Symptoms Questionnaire

Name:_____ **Date:**_____

Rate each of the following symptoms based upon your typical health profile for the p*ast 30 days*

Point Scale

0 - *Never* or *almost never* have the symptom
1 - *Occasionally* have it, effect is *not severe*
2 - *Occasionally* have it, effect is *severe*
3 - *Frequently* have it, effect is *not severe*
4 - *Frequently* have it, effect is *severe*

HEAD	_____	Headaches	
	_____	Faintness	
	_____	Dizziness	
	_____	Insomnia	Total: 0
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: 0
EARS	_____	Itchy ears	
	_____	Earaches, ear infections	
	_____	Drainage from ear	
	_____	Ringing in ears, hearing loss	Total: 0
NOSE	_____	Stuffy nose	
	_____	Sinus problems	
	_____	Hay fever	
	_____	Sneezing attacks	
	_____	Excessive mucus formation	Total: 0
MOUTH/THROAT	_____	Chronic coughing	
	_____	Gagging, frequent need to clear throat	
	_____	Sore throat, hoarseness, loss of voice	
	_____	Swollen or discolored tongue, gums, lips	
	_____	Canker sores	Total: 0
SKIN	_____	Acne	
	_____	Hives, rashes, dry skin	
	_____	Hair loss	
	_____	Flushing, hot flashes	
	_____	Excessive sweating	Total: 0
HEART	_____	Irregular or skipped heartbeat	
	_____	Rapid or pounding heartbeat	
	_____	Chest pain	Total: 0

LUNGS	_____	Chest congestion	
	_____	Asthma, bronchitis	
	_____	Shortness of breath	
	_____	Difficulty breathing	Total: 0
DIGESTIVE TRACT	_____	Nausea, vomiting	
	_____	Diarrhea	
	_____	Constipation	
	_____	Bloated feeling	
	_____	Belching, passing gas	
	_____	Heartburn	
	_____	Intestinal/stomach pain	Total: 0
JOINTS / MUSCLE	_____	Pain or aches in joints	
	_____	Arthritis	
	_____	Stiffness or limitation of movement	
	_____	Pain or aches in muscles	
	_____	Feeling of weakness or tiredness	Total: 0
WEIGHT	_____	Binge eating/drinking	
	_____	Craving certain foods	
	_____	Excessive weight	
	_____	Compulsive eating	
	_____	Water retention	
	_____	Underweight	Total: 0
ENERGY/ACTIVITY	_____	Fatigue, sluggishness	
	_____	Apathy, lethargy	
	_____	Hyperactivity	
	_____	Restlessness	Total: 0
MIND	_____	Poor memory	
	_____	Confusion, poor comprehension	
	_____	Poor concentration	
	_____	Poor physical coordination	
	_____	Difficulty in making decisions	
	_____	Stuttering or stammering	
	_____	Slurred speech	
	_____	Learning disabilities	Total: 0
EMOTIONS	_____	Mood swings	
	_____	Anxiety, fear, nervousness	
	_____	Anger, irritability, aggressiveness	
	_____	Depression	Total: 0
OTHER	_____	Frequent illness	
	_____	Frequent or urgent urination	
	_____	Genital itch or discharge	Total: 0

GRAND TOTAL **TOTAL : 0**