



**DOCTORSCHIMP.COM**

Integrative Health Solutions

# **INTEGRATIVE AND FUNCTIONAL MEDICINE**

## **PATIENT INFORMATION & INTAKE FORMS**

### **LOCATION & CONTACT INFORMATION**

937 E. SUMNER STREET

HARTFORD, WI 53027

PHONE 262.673.2341

FAX 262.673.2131

WEBSITE [WWW.DOCTORSCHIMP.COM](http://WWW.DOCTORSCHIMP.COM)

\*If you have a medical emergency dial 911 or go directly to the nearest emergency room.



Dear Patient,

Dr. Schimp and staff would like to welcome you to our integrative and functional medicine clinic. We look forward to meeting you.

### **WHAT TO EXPECT**

Please complete the attached intake forms and obtain a copy of your prior medical records (including laboratory and imaging reports). You can fax, mail or hand-deliver forms and medical records to our clinic – **Please provide your information at least 1 week (7 days) in advance of your appointment.**

### **CONSULTATIONS**

**INITIAL:** The initial consultation with Dr. Schimp will be 60 minutes. A thorough review of your medical history will be completed during this time. We will also discuss recommendations and options regarding tests that will help evaluate your health in greater detail. The purpose of testing and costs will be discussed.

**LAB VISIT:** A fasting lab draw and pertinent physical examination will be performed at a subsequent visit at the clinic. Depending on the level of care needed this visit will be 15 or 30 minutes in length with Dr. Schimp. Lab results typically return in 1-2 days but on occasion can take up to 2 weeks. Some tests will be completed at home – we will provide a kit for either urine, stool or saliva collection. A 10 hour fast is needed prior to collecting your blood samples. You should drink water during this fast and continue taking your prescription medications. Laboratory diagnostic testing helps Dr. Schimp design your personal health care program and will help uncover the root causes of your health conditions.

**FOLLOW-UP:** After the lab information is available a 30-minute review visit will be scheduled. At this visit Dr. Schimp will also discuss dietary and lifestyle recommendations, provide home-care instructions and handouts and will provide specific supplement instructions. Dr. Schimp selects the highest quality products to ensure maximum therapeutic effectiveness. These products can be purchased at the clinic. Refills can be picked-up at the clinic or shipped (\$10 flat rate shipping fee). Most patients can expect to have a working plan in place within 1-2 weeks of initiating care.

**EMAIL SUPPORT:** Dr. Schimp responds promptly to email questions when further support is needed. Additional visits can be scheduled as needed. Initial electronic contact can be made through the “contact us” page at [www.doctorschimp.com](http://www.doctorschimp.com). When necessary, repeat lab evaluations are scheduled at 1-3 month intervals (occasionally longer).

### **OBTAINING YOUR 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. A medical records release form is included for your use. Please contact your physician or other health care provider to obtain these records.

Your records should be express mailed to – Dr. David Schimp 937 E. Sumner St., Hartford, WI 53027

### **CONFIRMATION AND CANCELLATION OF APPOINTMENTS**

If you must cancel or re-schedule your appointment, please contact us at least seven (7) days prior to your appointment.

### **INSURANCE INFORMATION**

Dr. Schimp does not participate in any health insurance plans. Services through the clinic will be considered out-of-network. Payment is expected on the day of service. We will, however, submit a claim to your insurance carrier on your behalf. Health insurance plans vary considerably and coverage often cannot be determined until a claim is submitted. If your insurance company covers services then a reimbursement check will be sent directly from your insurance company. Medicare does not provide coverage for integrative and functional medicine services but secondary coverage occasionally reimburses patient for these services.

# Female Intake Questionnaire

## General Information

Name \_\_\_\_\_ Age \_\_\_\_\_ Today's Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Work) \_\_\_\_\_

Genetic Background:  African American  Hispanic  Mediterranean  Asian  
 Native American  Caucasian  Northern European  
 Other \_\_\_\_\_

When, where and from whom did you last receive medical or health care? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Work) \_\_\_\_\_

## How did you hear about our practice?

Clinic website  Web search  Referral from doctor  Referral from friend/family member  
 Social media  Other \_\_\_\_\_

## Current Health Concerns

Please rank current and ongoing health concerns in order of priority

Describe Problem	Severity	Severity			Prior Treatment/Approach	Success	Success		
		Mild	Moderate	Severe			Excellent	Good	Fair
<i>Example: Post Nasal Drip</i>		X			<i>Elimination Diet</i>		X		
1.									
2.									
3.									
4.									
5.									
7.									
8.									
9.									
9.									
10.									

## Allergies

Name of Medication/Supplement/Food:	Reaction:
1.	
2.	
3.	
4.	
5.	

## Lifestyle Review

### Sleep

How many hours of sleep do you get each night on average? \_\_\_\_\_

Do you have problems falling asleep?  Yes  No      Staying asleep?  Yes  No

Do you have problems with insomnia?  Yes  No      Do you snore?  Yes  No

Do you feel rested upon awakening?  Yes  No

Do you use sleeping aids?  Yes  No

If yes, explain: \_\_\_\_\_

### Exercise

Current Exercise Program:

Activity	Type	# of Times Per Week	Time/Duration (Minutes)
Cardio/Aerobic			
Strength/Resistance			
Flexibility/Stretching			
Balance			
Sports/Leisure (e.g., golf)			
Other:			

Do you feel motivated to exercise?  Yes  A little  No

Are there any problems that limit exercise?  Yes  No

If yes, explain: \_\_\_\_\_

Do you feel unusually fatigued or sore after exercise?  Yes  No

If yes, explain: \_\_\_\_\_

## Nutrition

Do you currently follow any of the following special diets or nutritional programs? *(Check all that apply)*

- Vegetarian    Vegan    Allergy    Elimination    Low Fat    Low Carb    High Protein  
 Blood Type    Low sodium    No Dairy    No Wheat    Gluten Free  
 Other: \_\_\_\_\_

Do you have sensitivities to certain foods?    Yes    No

If yes, list food and symptoms: \_\_\_\_\_

Do you have an aversion to certain foods?    Yes    No

If yes, explain: \_\_\_\_\_

Do you adversely react to: *(Check all that apply)*

- Monosodium glutamate (MSG)    Artificial sweeteners    Garlic/onion    Cheese    Citrus foods  
 Chocolate    Alcohol    Red wine    Sulfite-containing foods (wine, dried fruit, salad bars)  
 Preservatives    Food colorings    Other food substances: \_\_\_\_\_

Are there any foods that you crave or binge on?    Yes    No

If yes, what foods? \_\_\_\_\_

Do you eat 3 meals a day?    Yes    No   If no, how many \_\_\_\_\_

Does skipping a meal greatly affect you?    Yes    No

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

Check the factors that apply to your current lifestyle and eating habits:

- |   |   |
|---|---|
| <input type="checkbox"/> Fast eater   | <input type="checkbox"/> Significant other or family members have special dietary needs |
| <input type="checkbox"/> Eat too much   | <input type="checkbox"/> Love to eat  |
| <input type="checkbox"/> Late-night eating  | <input type="checkbox"/> Eat because I have to  |
| <input type="checkbox"/> Dislike healthy foods  | <input type="checkbox"/> Have negative relationship to food                             |
| <input type="checkbox"/> Time constraints   | <input type="checkbox"/> Struggle with eating issues                                    |
| <input type="checkbox"/> Travel frequently  | <input type="checkbox"/> Emotional eater (eat when sad, lonely, bored, etc.)            |
| <input type="checkbox"/> Eat more than 50% of meals away from home                    | <input type="checkbox"/> Eat too much under stress                                      |
| <input type="checkbox"/> Healthy foods not readily available                          | <input type="checkbox"/> Eat too little under stress                                    |
| <input type="checkbox"/> Poor snack choices   | <input type="checkbox"/> Don't care to cook   |
| <input type="checkbox"/> Significant other or family members don't like healthy foods | <input type="checkbox"/> Confused about nutrition advice                                |

## Diet

Please record what you eat in a typical day:

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks \_\_\_\_\_

Fluids \_\_\_\_\_

How many servings do you eat in a typical week of these foods:

Fruits (not juice) \_\_\_\_\_ Vegetables (not including white potatoes) \_\_\_\_\_

Legumes (beans, peas, etc) \_\_\_\_\_ Red meat \_\_\_\_\_ Fish \_\_\_\_\_

Dairy/Alternatives \_\_\_\_\_ Nuts & Seeds \_\_\_\_\_ Fats & Oils \_\_\_\_\_

Cans of soda (regular or diet) \_\_\_\_\_ Sweets (candy, cookies, cake, ice cream, etc.) \_\_\_\_\_

Do you drink caffeinated beverages?  Yes  No If yes, check amounts:

Coffee (cups per day)  1  2-4  >4 Tea (cups per day)  1  2-4  >4

Caffeinated sodas—regular or diet (cans per day)  1  2-4  >4

Do you have adverse reactions to caffeine?  Yes  No

If yes, explain: \_\_\_\_\_

When you drink caffeine do you feel:  Irritable or wired  Aches or pains

## Smoking

Do you smoke currently?  Yes  No Packs per day: \_\_\_\_\_ Number of years \_\_\_\_\_

What type?  Cigarettes  Smokeless  Pipe  Cigar  E-Cig

Have you attempted to quit?  Yes  No

If yes, using what methods: \_\_\_\_\_

If you smoked previously: Packs per day: \_\_\_\_\_ Number of years \_\_\_\_\_

Are you regularly exposed to second-hand smoke?  Yes  No

## Alcohol

How many alcoholic beverages do you drink in a week? (1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits)

1-3  4-6  7-10  >10  None

Previous alcohol intake?  Yes ( Mild  Moderate  High)  None

Have you ever had a problem with alcohol?  Yes  No

If yes, when? \_\_\_\_\_

Explain the problem: \_\_\_\_\_

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

## Other Substances

Are you currently using any recreational drugs?  Yes  No

If yes, type: \_\_\_\_\_

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

**Stress**

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

How much stress do each of the following cause on a daily basis *(Rate on scale of 1-10, 10 being highest)*

Work \_\_\_\_ Family \_\_\_\_ Social \_\_\_\_ Finances \_\_\_\_ Health \_\_\_\_ Other \_\_\_\_

Do you use relaxation techniques?  Yes  No

If yes, how often? \_\_\_\_\_

Which techniques do you use? *(Check all that apply)*

Meditation  Breathing  Tai Chi  Yoga  Prayer  Other: \_\_\_\_\_

Have you ever sought counseling?  Yes  No

Are you currently in therapy?  Yes  No

If yes, describe: \_\_\_\_\_

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

What are your hobbies or leisure activities? \_\_\_\_\_

**Relationships**

Marital status:  Single  Married  Divorced  Gay/Lesbian  Long-Term Partner  Widow/er

With whom do you live? *(Include children, parents, relatives, friends, pets)* \_\_\_\_\_

Current occupation: \_\_\_\_\_

Previous occupations: \_\_\_\_\_

Do you have resources for emotional support?  Yes  No *(Check all that apply)*

Spouse/Partner  Family  Friends  Religious/Spiritual  Pets  Other: \_\_\_\_\_

Do you have a religious or spiritual practice?  Yes  No

If yes, what kind? \_\_\_\_\_

**How well have things been going for you?** *(Mark on scale of 1–10, or N/A if not applicable)*

	N/A	Poorly			Fine			Very Well			
Overall	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
At school	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
In your job	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
In your social life	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With close friends	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With sex	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your attitude	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your boyfriend/girlfriend	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your children	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your parents	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your spouse	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10

## History

### Patient's Birth/Childhood History:

You were born:  Term  Premature  Don't know

Were there any pregnancy or birth complications?  Yes  No

If yes, explain: \_\_\_\_\_

You were:  Breast-fed/How long? \_\_\_\_\_  Bottle-fed/Type of formula: \_\_\_\_\_  Don't know

Age of introduction of: Solid food: \_\_\_\_\_ Wheat \_\_\_\_\_ Dairy \_\_\_\_\_

As a child, were there any foods that were avoided because they gave you symptoms?  Yes  No

If yes, what foods and what symptoms? (Example: milk—gas and diarrhea)

\_\_\_\_\_  
\_\_\_\_\_

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

### Dental History:

Check if you have any of the following, and provide number if applicable:

Silver mercury fillings \_\_\_\_\_  Gold fillings \_\_\_\_\_  Root canals \_\_\_\_\_  Implants \_\_\_\_\_

Caps/Crowns \_\_\_\_\_  Tooth pain \_\_\_\_\_  Bleeding gums \_\_\_\_\_  Gingivitis \_\_\_\_\_

Problems with chewing \_\_\_\_\_  Other dental concerns (explain): \_\_\_\_\_

Have you had any mercury fillings removed?  Yes  No If yes, when: \_\_\_\_\_

How many fillings did you have as a kid? \_\_\_\_\_

Do you brush regularly?  Yes  No Do you floss regularly?  Yes  No

### Environmental/Detoxification History

Do any of these significantly affect you?

Cigarette smoke  Perfume/colognes  Auto exhaust fumes  Other: \_\_\_\_\_

In your work or home environment are you regularly exposed to: (Check all that apply)

Mold  Water leaks  Renovations  Chemicals  Electromagnetic radiation

Damp environments  Carpets or rugs  Old paint  Stagnant or stuffy air  Smokers

Pesticides  Herbicides  Harsh chemicals (solvents, glues, gas, acids, etc)  Cleaning chemicals

Heavy metals (lead, mercury, etc.)  Paints  Airplane travel  Other \_\_\_\_\_

Have you had a significant exposure to any harmful chemicals?  Yes  No

If yes: Chemical name, length of exposure, date: \_\_\_\_\_

Do you have any pets or farm animals?  Yes  No

If yes, do they live:  Inside  Outside  Both inside and outside



---

## Women's History

### Obstetric History: *(Check box and provide number if applicable)*

- Pregnancies \_\_\_\_\_  Miscarriages \_\_\_\_\_  Abortions \_\_\_\_\_  Living children \_\_\_\_\_  
 Vaginal deliveries \_\_\_\_\_  Cesarean \_\_\_\_\_  Term births \_\_\_\_\_  Premature birth \_\_\_\_\_

Birth weight of largest baby \_\_\_\_\_ Birth weight of smallest baby \_\_\_\_\_

Did you develop any problems in or after pregnancy, for example, toxemia (high blood pressure), diabetes, post-partum depression, issues with breast feeding, etc.?  Yes  No

If yes, please explain \_\_\_\_\_

### Menstrual History:

Age at first period \_\_\_\_\_ Date of last menstrual period \_\_\_\_\_

Length of cycle \_\_\_\_\_ Time between cycles \_\_\_\_\_

Cramping?  Yes  No Pain?  Yes  No

Have you ever had premenstrual problems (bloating, breast tenderness, irritability, etc.)?  Yes  No

If yes, please describe: \_\_\_\_\_

Do you have other problems with your periods (heavy, irregular, spotting, skipping, etc.)?  Yes  No

If yes, please describe: \_\_\_\_\_

Use of hormonal birth control:  Birth control pills  Patch  Nuva ring

Other \_\_\_\_\_ How Long \_\_\_\_\_

Any problems with hormonal birth control?  Yes  No

If yes, explain \_\_\_\_\_

Use of other contraception?  Yes  No  Condoms  Diaphragm  IUD  Partner vasectomy

Are you in menopause?  Yes  No If yes, age at last period: \_\_\_\_\_

Was it surgical menopause?  Yes  No If yes, explain surgery: \_\_\_\_\_

Do you currently have symptomatic problems with menopause? *(Check all that apply)*

- Hot flashes  Mood swings  Concentration/memory problems  Headaches  Joint pain  
 Vaginal dryness  Weight gain  Decreased libido  Loss of control of urine  Palpitations

Are you on hormone replacement therapy?  Yes  No

If yes, for how long and for what reason (hot flashes, osteoporosis prevention, etc.)? \_\_\_\_\_

### Other Gynecological Symptoms: *(Check if applicable)*

- Endometriosis  Infertility  Fibrocystic breasts  Vaginal infection  Fibroids  
 Ovarian cysts  Pelvic inflammatory disease  Reproductive cancer  
 Sexually transmitted disease (describe) \_\_\_\_\_

### Gynecological Screening/Procedures: *(If applicable, provide date)*

Last Pap test: \_\_\_\_\_  Normal  Abnormal

Last mammogram: \_\_\_\_\_  Normal  Abnormal

Last bone density: \_\_\_\_\_ Results:  High  Low  Within Normal Range

Other tests/procedures (list type and dates) \_\_\_\_\_

**Family History:**

Check family members that have/had any of the following

	Mother	Father	Brother (s)	Sister (s)	Child	Child	Child	Child	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other
Age (if still alive)													
Age at death (if deceased)													
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genetic disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Medical History: Illnesses/Conditions

**Check YES** = a condition you currently have, **Check PAST** = a condition you've had in the past.

<b>Gastrointestinal</b>	<b>Yes</b>	<b>Past</b>
Irritable bowel syndrome	<input type="checkbox"/>	<input type="checkbox"/>
GERD (reflux)	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's disease/ulcerative colitis	<input type="checkbox"/>	<input type="checkbox"/>
Peptic ulcer disease	<input type="checkbox"/>	<input type="checkbox"/>
Celiac disease	<input type="checkbox"/>	<input type="checkbox"/>
Gallstones	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
<b>Respiratory</b>		
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>
Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
<b>Urinary/Genital</b>		
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>
Interstitial cystitis	<input type="checkbox"/>	<input type="checkbox"/>
Frequent yeast infections	<input type="checkbox"/>	<input type="checkbox"/>
Frequent urinary tract infections	<input type="checkbox"/>	<input type="checkbox"/>
Sexual dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Sexually transmitted diseases	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
<b>Endocrine/Metabolic</b>		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hypothyroidism (low thyroid)	<input type="checkbox"/>	<input type="checkbox"/>
Hyperthyroidism (overactive thyroid)	<input type="checkbox"/>	<input type="checkbox"/>
Polycystic Ovarian Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Infertility	<input type="checkbox"/>	<input type="checkbox"/>
Metabolic syndrome/insulin resistance	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
<b>Inflammatory/Immune</b>		
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic fatigue syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Food allergies	<input type="checkbox"/>	<input type="checkbox"/>
Environmental allergies	<input type="checkbox"/>	<input type="checkbox"/>
Multiple chemical sensitivities	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>
Immune deficiency	<input type="checkbox"/>	<input type="checkbox"/>
Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>

<b>Musculoskeletal</b>	<b>Yes</b>	<b>Past</b>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
<b>Skin</b>		
Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
Acne	<input type="checkbox"/>	<input type="checkbox"/>
Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cardiovascular</b>		
Angina	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
Heart failure	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension (high blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
High blood fats (cholesterol, triglycerides)	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Arrhythmia (irregular heart rate)	<input type="checkbox"/>	<input type="checkbox"/>
Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
<b>Neurologic/Emotional</b>		
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>
Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cancer</b>		
Lung	<input type="checkbox"/>	<input type="checkbox"/>
Breast	<input type="checkbox"/>	<input type="checkbox"/>
Colon	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>

**Medical History** *(cont.)*

<b>Diagnostic Studies</b>	<b>Date</b>	<b>Comments</b>
Bone density		
CT scan		
Colonoscopy		
Cardiac stress test		
EKG		
MRI		
Upper endoscopy		
Upper GI series		
Chest X-ray		
Other X-rays		
Barium enema		
Other:		
<b>Injuries</b>		
Broken bone(s)		
Back injury		
Neck injury		
Head injury		
Other:		
<b>Surgeries</b>		
Appendectomy		
Dental		
Gallbladder		
Hernia		
Hysterectomy		
Tonsillectomy		
Joint replacement		
Heart surgery		
Other:		
<b>Hospitalizations</b>	<b>Date</b>	<b>Reason</b>

## Symptom Review

**Please check** if these symptoms occur presently or have occurred in the last 6 months

General	Mild	Moderate	Severe
Cold hands and feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daytime sleepiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty falling asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Early waking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flushing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heat intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night waking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nightmares	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can't remember dreams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low body temperature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head, Eyes, and Ears			
Conjunctivitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted sense of smell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted taste	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear fullness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear ringing/buzzing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye crusting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyelid margin redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to loud noises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal			
Back muscle spasm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Calf cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest tightness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foot cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint deformity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle spasms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle twitches:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Around eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arms or legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Musculoskeletal (cont.)	Mild	Moderate	Severe
Neck muscle spasm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tendonitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tension headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TMJ problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood/Nerves			
Agoraphobia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Auditory hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blackouts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With judgment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness (spinning)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fearfulness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light-headedness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other phobias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paranoia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tremor/trembling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visual hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular			
Angina/chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breathlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irregular pulse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen ankles/feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Symptom Review *(cont.)*

**Please check** if these symptoms occur presently or have occurred in the last 6 months

Urinary	Mild	Moderate	Severe
Bed wetting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hesitancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leaking/incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain/burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urgency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Digestion			
Anal spasms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bad teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloating of:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whole abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloating after meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood in stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Canker sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cracking at corner of lips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dentures w/poor chewing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Farting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fissures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foods "repeat" (reflux)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intolerance to:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lactose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All dairy products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gluten (wheat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Corn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eggs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatty foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yeast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease/jaundice (yellow eyes or skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucus in stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Digestion <i>(cont.)</i>	Mild	Moderate	Severe
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Periodontal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore tongue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strong stool odor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Undigested food in stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upper abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating			
Binge eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can't gain weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can't lose weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carbohydrate craving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carbohydrate intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salt cravings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent dieting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweet cravings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caffeine dependency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory			
Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bad odor in nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough - dry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough - productive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hayfever:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Summer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Change of season	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nasal stuffiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus fullness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Snoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Winter stuffiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Symptom Review *(cont.)*

**Please check** if these symptoms occur presently or have occurred in the last 6 months

Nails	Mild	Moderate	Severe
Bitten	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brittle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Curve up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frayed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fungus - fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fungus - toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ragged cuticles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ridges	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thickening of:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Finger nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toenails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
White spots/lines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Lymph Nodes</b>			
Enlarged/neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tender/neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other enlarged/tender lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Skin, Dryness of</b>			
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any cracking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any peeling?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
And unmanageable?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any cracking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any peeling?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mouth/throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scalp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any dandruff?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin in general	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Skin Problems</b>			
Acne on back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne on chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne on face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne on shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Athlete's foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bumps on back of upper arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cellulite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dark circles under eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Skin Problems <i>(cont.)</i>	Mild	Moderate	Severe
Ears get red	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Herpes - genital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jock itch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lackluster skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moles w color/size change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oily skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pale skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patchy dullness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Red face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to bites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to poison ivy/oak	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shingles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin darkening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strong body odor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thick calluses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vitiligo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Itching Skin</b>			
Anus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear canals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nipples	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genitals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Roof of mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scalp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin in general	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Symptom Review *(cont.)*

**Please check** if these symptoms occur presently or have occurred in the last 6 months

Female Reproductive	Mild	Moderate	Severe
Breast cysts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast lumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian cyst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor libido (sex drive)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infertility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal odor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal itch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Premenstrual:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carbohydrate craving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chocolate craving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irregular periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scanty periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spotting between	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



## Medications/Supplements

### Current medications (include prescription and over-the-counter)

Medication	Dosage	Start Date (mo/yr)	Reason for Use

### Nutritional supplements (vitamins/minerals/herbs etc.)

Name and Brand	Dosage	Start Date (mo/yr)	Reason for Use

Have medications or supplements ever caused unusual side effects or problems?  Yes  No

If yes, describe: \_\_\_\_\_

Have you used any of these regularly or for a long time:

NSAIDs (Advil, Aleve, etc.), Motrin, Aspirin?  Yes  No Tylenol (acetaminophen)?  Yes  No

Acid-blocking drugs (Zantac, Prilosec, Nexium, etc.)?  Yes  No

### How many times have you taken antibiotics?

	< 5	> 5	Reason for Use
Infancy/Childhood			
Teen			
Adulthood			

Have you ever taken long term antibiotics?  Yes  No

If yes, explain: \_\_\_\_\_

### How often have you taken oral steroids (e.g., cortisone, prednisone, etc.)?

	< 5	> 5	Reason for Use
Infancy/Childhood			
Teen			
Adulthood			

---

## Readiness Assessment and Health Goals

### 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                           | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Take several nutritional supplements each day            | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Keep a record of everything you eat each day             | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Modify your lifestyle (e.g., work demands, sleep habits) | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Practice a relaxation technique                          | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Engage in regular exercise                               | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |

**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 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 follow through? \_\_\_\_\_

**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

**Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact):**

How much ongoing support (e.g., telephone consults, email correspondence) from our professional staff would be helpful to you as you implement your personal health program?

- 5    4    3    2    1

Comments \_\_\_\_\_

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## Health Goals

What do you hope to achieve in your visit with us? \_\_\_\_\_

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When was the last time you felt well? \_\_\_\_\_

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Did something trigger your change in health? \_\_\_\_\_

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What makes you feel better? \_\_\_\_\_

---

---

What makes you feel worse? \_\_\_\_\_

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---

How does your condition affect you? \_\_\_\_\_

---

---

What do you think is happening and why? \_\_\_\_\_

---

---

What do you feel needs to happen for you to get better? \_\_\_\_\_

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# Metabolic Assessment Form™

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date: \_\_\_\_\_

## PART I

Please list your 5 major health concerns in order of importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

## PART II

Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

<p><b>Category I</b></p> <p>Feeling that bowels do not empty completely      0 1 2 3</p> <p>Lower abdominal pain relieved by passing stool or gas      0 1 2 3</p> <p>Alternating constipation and diarrhea      0 1 2 3</p> <p>Diarrhea      0 1 2 3</p> <p>Constipation      0 1 2 3</p> <p>Hard, dry, or small stool      0 1 2 3</p> <p>Coated tongue or “fuzzy” debris on tongue      0 1 2 3</p> <p>Pass large amount of foul-smelling gas      0 1 2 3</p> <p>More than 3 bowel movements daily      0 1 2 3</p> <p>Use laxatives frequently      0 1 2 3</p> <p><b>Category II</b></p> <p>Increasing frequency of food reactions      0 1 2 3</p> <p>Unpredictable food reactions      0 1 2 3</p> <p>Aches, pains, and swelling throughout the body      0 1 2 3</p> <p>Unpredictable abdominal swelling      0 1 2 3</p> <p>Frequent bloating and distention after eating      0 1 2 3</p> <p>Abdominal intolerance to sugars and starches      0 1 2 3</p> <p><b>Category III</b></p> <p>Intolerance to smells      0 1 2 3</p> <p>Intolerance to jewelry      0 1 2 3</p> <p>Intolerance to shampoo, lotion, detergents, etc      0 1 2 3</p> <p>Multiple smell and chemical sensitivities      0 1 2 3</p> <p>Constant skin outbreaks      0 1 2 3</p> <p><b>Category IV</b></p> <p>Excessive belching, burping, or bloating      0 1 2 3</p> <p>Gas immediately following a meal      0 1 2 3</p> <p>Offensive breath      0 1 2 3</p> <p>Difficult bowel movements      0 1 2 3</p> <p>Sense of fullness during and after meals      0 1 2 3</p> <p>Difficulty digesting fruits and vegetables; undigested food found in stools      0 1 2 3</p> <p><b>Category V</b></p> <p>Stomach pain, burning, or aching 1-4 hours after eating      0 1 2 3</p> <p>Use of antacids      0 1 2 3</p> <p>Feel hungry an hour or two after eating      0 1 2 3</p> <p>Heartburn when lying down or bending forward      0 1 2 3</p> <p>Temporary relief by using antacids, food, milk, or carbonated beverages      0 1 2 3</p> <p>Digestive problems subside with rest and relaxation      0 1 2 3</p> <p>Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine      0 1 2 3</p> <p><b>Category VI</b></p> <p>Roughage and fiber cause constipation      0 1 2 3</p> <p>Indigestion and fullness last 2-4 hours after eating      0 1 2 3</p> <p>Pain, tenderness, soreness on left side under rib cage      0 1 2 3</p> <p>Excessive passage of gas      0 1 2 3</p> <p>Nausea and/or vomiting      0 1 2 3</p> <p>Stool undigested, foul smelling, mucus like, greasy, or poorly formed      0 1 2 3</p> <p>Frequent urination      0 1 2 3</p> <p>Increased thirst and appetite      0 1 2 3</p>	<p><b>Category VII</b></p> <p>Abdominal distention after consumption of fiber, starches, and sugar      0 1 2 3</p> <p>Abdominal distention after certain probiotic or natural supplements      0 1 2 3</p> <p>Lowered gastrointestinal motility, constipation      0 1 2 3</p> <p>Raised gastrointestinal motility, diarrhea      0 1 2 3</p> <p>Alternating constipation and diarrhea      0 1 2 3</p> <p>Suspicion of nutritional malabsorption      0 1 2 3</p> <p>Frequent use of antacid medication      0 1 2 3</p> <p>Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/ Diverticulitis, or Leaky Gut Syndrome?      Yes No</p> <p><b>Category VIII</b></p> <p>Greasy or high-fat foods cause distress      0 1 2 3</p> <p>Lower bowel gas and/or bloating several hours after eating      0 1 2 3</p> <p>Bitter metallic taste in mouth, especially in the morning      0 1 2 3</p> <p>Burpy, fishy taste after consuming fish oils      0 1 2 3</p> <p>Difficulty losing weight      0 1 2 3</p> <p>Unexplained itchy skin      0 1 2 3</p> <p>Yellowish cast to eyes      0 1 2 3</p> <p>Stool color alternates from clay colored to normal brown      0 1 2 3</p> <p>Reddened skin, especially palms      0 1 2 3</p> <p>Dry or flaky skin and/or hair      0 1 2 3</p> <p>History of gallbladder attacks or stones      0 1 2 3</p> <p>Have you had your gallbladder removed?      Yes No</p> <p><b>Category IX</b></p> <p>Acne and unhealthy skin      0 1 2 3</p> <p>Excessive hair loss      0 1 2 3</p> <p>Overall sense of bloating      0 1 2 3</p> <p>Bodily swelling for no reason      0 1 2 3</p> <p>Hormone imbalances      0 1 2 3</p> <p>Weight gain      0 1 2 3</p> <p>Poor bowel function      0 1 2 3</p> <p>Excessively foul-smelling sweat      0 1 2 3</p> <p><b>Category X</b></p> <p>Crave sweets during the day      0 1 2 3</p> <p>Irritable if meals are missed      0 1 2 3</p> <p>Depend on coffee to keep going/get started      0 1 2 3</p> <p>Get light-headed if meals are missed      0 1 2 3</p> <p>Eating relieves fatigue      0 1 2 3</p> <p>Feel shaky, jittery, or have tremors      0 1 2 3</p> <p>Agitated, easily upset, nervous      0 1 2 3</p> <p>Poor memory/forgetful      0 1 2 3</p> <p>Blurred vision      0 1 2 3</p> <p><b>Category XI</b></p> <p>Fatigue after meals      0 1 2 3</p> <p>Crave sweets during the day      0 1 2 3</p> <p>Eating sweets does not relieve cravings for sugar      0 1 2 3</p> <p>Must have sweets after meals      0 1 2 3</p> <p>Waist girth is equal or larger than hip girth      0 1 2 3</p> <p>Frequent urination      0 1 2 3</p> <p>Increased thirst and appetite      0 1 2 3</p> <p>Difficulty losing weight      0 1 2 3</p>
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<b>Category XII</b>			
Cannot stay asleep	0	1	2 3
Crave salt	0	1	2 3
Slow starter in the morning	0	1	2 3
Afternoon fatigue	0	1	2 3
Dizziness when standing up quickly	0	1	2 3
Afternoon headaches	0	1	2 3
Headaches with exertion or stress	0	1	2 3
Weak nails	0	1	2 3
<b>Category XIII</b>			
Cannot fall asleep	0	1	2 3
Perspire easily	0	1	2 3
Under a high amount of stress	0	1	2 3
Weight gain when under stress	0	1	2 3
Wake up tired even after 6 or more hours of sleep	0	1	2 3
Excessive perspiration or perspiration with little or no activity	0	1	2 3
<b>Category XIV</b>			
Edema and swelling in ankles and wrists	0	1	2 3
Muscle cramping	0	1	2 3
Poor muscle endurance	0	1	2 3
Frequent urination	0	1	2 3
Frequent thirst	0	1	2 3
Crave salt	0	1	2 3
Abnormal sweating from minimal activity	0	1	2 3
Alteration in bowel regularity	0	1	2 3
Inability to hold breath for long periods	0	1	2 3
Shallow, rapid breathing	0	1	2 3
<b>Category XV</b>			
Tired/sluggish	0	1	2 3
Feel cold—hands, feet, all over	0	1	2 3
Require excessive amounts of sleep to function properly	0	1	2 3
Increase in weight even with low-calorie diet	0	1	2 3
Gain weight easily	0	1	2 3
Difficult, infrequent bowel movements	0	1	2 3
Depression/lack of motivation	0	1	2 3
Morning headaches that wear off as the day progresses	0	1	2 3
Outer third of eyebrow thins	0	1	2 3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2 3
Dryness of skin and/or scalp	0	1	2 3
Mental sluggishness	0	1	2 3
<b>Category XVI</b>			
Heart palpitations	0	1	2 3
Inward trembling	0	1	2 3
Increased pulse even at rest	0	1	2 3
Nervous and emotional	0	1	2 3
Insomnia	0	1	2 3

<b>Category XVI (Cont.)</b>			
Night sweats	0	1	2 3
Difficulty gaining weight	0	1	2 3
<b>Category XVII (Males Only)</b>			
Urination difficulty or dribbling	0	1	2 3
Frequent urination	0	1	2 3
Pain inside of legs or heels	0	1	2 3
Feeling of incomplete bowel emptying	0	1	2 3
Leg twitching at night	0	1	2 3
<b>Category XVIII (Males Only)</b>			
Decreased libido	0	1	2 3
Decreased number of spontaneous morning erections	0	1	2 3
Decreased fullness of erections	0	1	2 3
Difficulty maintaining morning erections	0	1	2 3
Spells of mental fatigue	0	1	2 3
Inability to concentrate	0	1	2 3
Episodes of depression	0	1	2 3
Muscle soreness	0	1	2 3
Decreased physical stamina	0	1	2 3
Unexplained weight gain	0	1	2 3
Increase in fat distribution around chest and hips	0	1	2 3
Sweating attacks	0	1	2 3
More emotional than in the past	0	1	2 3
<b>Category XIX (Menstruating Females Only)</b>			
Perimenopausal	Yes	No	
Alternating menstrual cycle lengths	Yes	No	
Extended menstrual cycle (greater than 32 days)	Yes	No	
Shortened menstrual cycle (less than 24 days)	Yes	No	
Pain and cramping during periods	0	1	2 3
Scanty blood flow	0	1	2 3
Heavy blood flow	0	1	2 3
Breast pain and swelling during menses	0	1	2 3
Pelvic pain during menses	0	1	2 3
Irritable and depressed during menses	0	1	2 3
Acne	0	1	2 3
Facial hair growth	0	1	2 3
Hair loss/thinning	0	1	2 3
<b>Category XX (Menopausal Females Only)</b>			
How many years have you been menopausal?	_____ years		
Since menopause, do you ever have uterine bleeding?	Yes	No	
Hot flashes	0	1	2 3
Mental foginess	0	1	2 3
Disinterest in sex	0	1	2 3
Mood swings	0	1	2 3
Depression	0	1	2 3
Painful intercourse	0	1	2 3
Shrinking breasts	0	1	2 3
Facial hair growth	0	1	2 3
Acne	0	1	2 3
Increased vaginal pain, dryness, or itching	0	1	2 3

### **PART III**

How many alcoholic beverages do you consume per week? \_\_\_\_\_

Rate your stress level on a scale of 1-10 during the average week: \_\_\_\_\_

How many caffeinated beverages do you consume per day? \_\_\_\_\_

How many times do you eat fish per week? \_\_\_\_\_

How many times do you eat out per week? \_\_\_\_\_

How many times do you work out per week? \_\_\_\_\_

How many times do you eat raw nuts or seeds per week? \_\_\_\_\_

List the three worst foods you eat during the average week: \_\_\_\_\_

List the three healthiest foods you eat during the average week: \_\_\_\_\_

### **PART IV**

**Please list any medications you currently take and for what conditions:**

**Please list any natural supplements you currently take and for what conditions:**

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

Request for records of Dr. \_\_\_\_\_

**THE PURPOSE FOR THIS RELEASE**

You are hereby authorized to furnish and release **LABORATORY AND IMAGING RECORDS** to:

Dr. David Schimp

This authorization can be revoked in writing at any time except to the extent that disclosure made in good faith has already occurred in reliance on this authorization.

I (patient's name) \_\_\_\_\_

hereby release (doctor's name) \_\_\_\_\_

employees of or agents managing members, and the attending physician(s) from legal responsibility or liability for the release of the above information to the extent authorized. A copy of this authorization shall be as valid as the original.

Doctor's address: \_\_\_\_\_

Telephone number ( ) \_\_\_\_ - \_\_\_\_\_

Fax number ( ) \_\_\_\_ - \_\_\_\_\_

I understand that there may be a fee for this service depending on the number of pages photocopied. However; no such fee will be charged if these records are requested for continuing medical care.

Patient's Name: \_\_\_\_\_ *Please Print* D.O.B. \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_

**Express Mail or Fax Records to:**

Dr. David J Schimp

937 E. Sumner St. Hartford, WI 53027

(fax to 262-673-2131)

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