Alternative Care Wellness Center

Dr. Anthony E Faro, III, BS, MS, D.C. DABCI, Certified in Acupuncture
100 S Scenic Hwy #105 Lake Wales FL 33853 - 863-676-BACK - Fax: 863-676-0698

General Information

(If more space is needed when filling in info, feel free to provide your own separate sheet.) * not recognized by FL Board.

Name: *First*_____ *Middle*_____ *Last*_____

Preferred Name:_____

Date of Birth: ____/____/____ Age: _____ Gender: □ Male □ Female

Genetic Background: □ African □ Asian □ European □ Ashkenazi □ Native American
□ Middle Eastern □ Mediterranean □ Other _____

Highest Education Level: □ High School □ Graduate □ Post-Graduate

Job Title: _____

Nature of Business: _____

Primary Address: _____ Apt. No.: _____

City: _____ *State:* _____ *Zip:* _____

Alternate Address: _____ Apt. No.: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Alternate Phone: _____

Best Time and Place to Reach You: _____

Email: _____ Fax: _____

Emergency Contact: Name_____ Phone_____

Address: _____ Apt. No.:_____

City: _____ State: _____ Zip: _____

Primary Pharmacy: Name_____ Phone_____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Fax*: _____

**It is extremely important that you list the pharmacy's fax number.*

Whom may we thank for referring you? _____

□ Primary Care □ Website □ Media □ Other _____

_____

Payment Information

Insurance plans including HMO, PPO, TRI Care, Medicaid, and Medicare do not pay for Integrative Medicine procedures. Therefore, Payment is due at time of service, no exceptions. Knowledge and awareness of insurance coverage is the sole responsibility of the patient. Therefore, procedures performed in our clinic ***are not reported to the insurance carrier*** *and do not show up on your MIB an insurance industry list of every service and diagnosis you have. This data is used to determine your insurance rates and pre existing conditions.*

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Health Concerns & Goals

Please list current and/or ongoing areas of concern you would like to address in order of priority.

What do you hope to achieve with your visits here? _____

_____

_____

When was the last time you felt exceptionally well? _____

Health Concern or Goal #1 *(Please describe as many details as you can)* _____

_____

When did you first notice symptoms appear? _____ Was there a trigger? _____

Is this condition getting: □ Better □ Worse □ About the same

What treatments have you tried? *Please list everything - home remedies to medical interventions:* _____

_____

What makes it better? _____

What makes it worse? _____

If pain is associated with your condition, please check all that apply: *Type of pain*

□ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting □ Burning

□ Tingling □ Cramps □ Stiffness □ Swelling □ Other _____

How often do you experience this condition? _____

Is it constant or does it come and go? _____

Anything else you feel is important about this condition? _____

Health Concern or Goal #2 *(Please describe as many details as you can)* _____

_____

When did you first notice symptoms appear? _____ Was there a trigger? _____

Is this condition getting: □ Better □ Worse □ About the same

What treatments have you tried? *Please list everything - home remedies to medical interventions:* _____

_____

What makes it better? _____

What makes it worse? _____

If pain is associated with your condition, please check all that apply: *Type of pain*

□ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting □ Burning

□ Tingling □ Cramps □ Stiffness □ Swelling □ Other _____

How often do you experience this condition? _____

Is it constant or does it come and go? _____

Anything else you feel is important about this condition? _____

Health Concerns & Goals *continued*

Health Concern or Goal #3 *(Please describe as many details as you can)* _____

_____

When did you first notice symptoms appear? _____ Was there a trigger? _____

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Is this condition getting: □ Better □ Worse □ About the same

What treatments have you tried? *Please list everything - home remedies to medical interventions:* _____

_____

What makes it better? _____

What makes it worse? _____

If pain is associated with your condition, please check all that apply: *Type of pain*

□ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting □ Burning

□ Tingling □ Cramps □ Stiffness □ Swelling □ Other _____

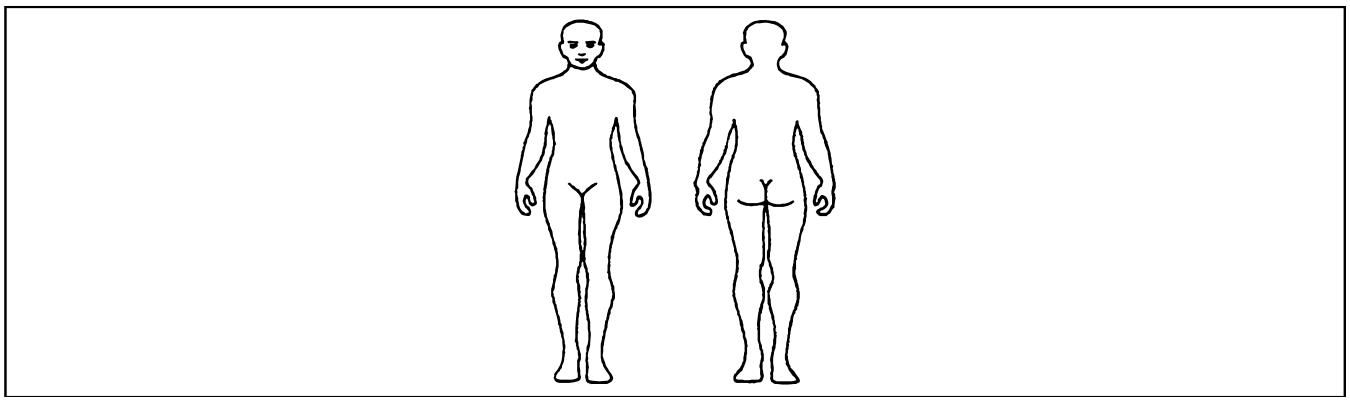
How often do you experience this condition? _____

Is it constant or does it come and go? _____

Anything else you feel is important about this condition? _____

_____

Please mark any areas of concern with as much detail as you can. Please write anywhere in the box.



Other comments you think are important _____

_____

_____

Medical History

Please list all other healthcare providers with whom you have received treatment within the last 10 years:

□ Doctor of Chiropractic *Name:* _____ *City:*_____

Treatment Focus: _____

□ M.D. / D.O. *Name:* _____ *City:*_____

Treatment Focus: _____

□ Physical Therapist *Name:* _____ *City:*_____

Treatment Focus: _____

□ Acupuncture *Name:* _____ *City:*_____

Treatment Focus: _____

□ *Other:* _____

Name: _____ *City:*_____

Treatment Focus: _____

Medical History *continued*

Hospitalizations □ None

*Date*_____ - *Reason* _____

_____ - _____

_____ - _____

_____ - _____

_____ - _____

Allergies

Medication/Supplement/Food	*Reaction*
_____	_____
_____	_____
_____	_____
_____	_____

Diseases/Diagnosis/Conditions: *Check appropriate box and provide Month/Year of onset* □ *Past Condition* □ *Ongoing Condition*

Gastrointestinal
- □ □ Irritable Bowel Syndrome ___ /____
- □ □ Inflammatory Bowel Disease ___ /____
- □ □ Crohn's ___ /____
- □ □ Ulcerative Colitis ___ /____
- □ □ Gastritis or Peptic Ulcer Disease ___ /____
- □ □ GERD *(reflux)* ___ /____
- □ □ Celiac Disease ___ /____
- □ □ Hemorrhoids ___ /____
- □ □ Other ___ /____ _____

Cardiovascular
- □ □ Heart Attack ___ /____
- □ □ Other Heart Disease ___ /____
- □ □ Stroke ___ /____
- □ □ Elevated Cholesterol ___ /____
- □ □ Arrhythmia *(irregular heart rate)* ___ /____
- □ □ Hypertension *(high blood pressure)* ___ /____
- □ □ Rheumatic Fever ___ /____
- □ □ Mitral Valve Fever ___ /____
- □ □ Other ___ /____ _____

Cancer
- □ □ Lung Cancer ___ /____
- □ □ Breast Cancer ___ /____
- □ □ Colon Cancer ___ /____
- □ □ Ovarian Cancer ___ /____
- □ □ Prostate Cancer ___ /____
- □ □ Skin Cancer ___ /____
- □ □ Other ___ /____ _____

Genital & Urinary Systems
- □ □ Kidney Stones ___ /____
- □ □ Gout ___ /____
- □ □ Interstitial Cystitis ___ /____
- □ □ Frequent Urinary Tract Infections ___ /____
- □ □ Frequent Yeast Infections ___ /____
- □ □ Erectile or Sexual Dysfunctions ___ /____
- □ □ Other ___ /____ _____

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

Musculoskeletal/Pain
- □ □ Osteoarthritis ___ /____
- □ □ Fibromyalgia ___ /____
- □ □ Chronic Pain ___ /____
- □ □ Tendonitis ___ /____
- □ □ Tension Headaches ___ /____
- □ □ TMJ Problems ___ /____
- □ □ Foot Cramps ___ /____
- □ □ Joint Deformity ___ /____
- □ □ Joint Pain ___ /____
- □ □ Other ___ /____ _____

Diseases/Diagnosis/Conditions: *continued*

Inflammatory/Autoimmune
- □ □ Chronic Fatigue Syndrome ___ /____
- □ □ Autoimmune Disease ___ /____
- □ □ Rheumatoid Arthritis ___ /____
- □ □ Lupus SLE ___ /____
- □ □ Immune Deficiency Disease ___ /____
- □ □ Herpes-Genital ___ /____
- □ □ Cold Sores ___ /____
- □ □ Severe Infectious Disease ___ /____
- □ □ Poor Immune Function *(frequent infections* ___ /____
- □ □ Food Allergies ___ /____
- □ □ Environmental Allergies ___ /____

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□ □ Multiple Chemical Sensitivities ___/____
□ □ Latex Allergy ___/____
□ □ Other ___/____ _____

Respiratory Diseases

□ □ Asthma ___/____
□ □ Chronic Sinusitis ___/____
□ □ Bronchitis ___/____
□ □ Emphysema ___/____
□ □ Pneumonia ___/____
□ □ Tuberculosis ___/____
□ □ Sleep Apnea ___/____
□ □ Other ___/____ _____

Head, Eyes, & Ears

□ □ Conjunctivitis ___/____
□ □ Distorted Sense of Smell ___/____
□ □ Distorted Taste ___/____
□ □ Ear Fullness ___/____
□ □ Ear Pain ___/____
□ □ Hearing Loss ___/____
□ □ Hearing Problems ___/____
□ □ Headache ___/____
□ □ Migraine ___/____
□ □ Sensitivity to Loud Noises ___/____
□ □ Vision Problems *(other than glasses)* ___/____
□ □ Macular Degeneration ___/____
□ □ Vitreous Detachment ___/____
□ □ Retinal Detachment ___/____
□ □ Other ___/____ _____

Nails

□ □ Bitten ___/____
□ □ Brittle ___/____
□ □ Curve Up ___/____
□ □ Frayed ___/____
□ □ Fungus-Fingers ___/____
□ □ Fungus-Toes ___/____
□ □ Pitting ___/____
□ □ Ragged Cuticles ___/____
□ □ Ridges ___/____
□ □ Soft ___/____
□ □ Thickening of Finger Nails ___/____
□ □ Thickening of Toenails ___/____
□ □ White Spots/Lines ___/____
□ □ Other ___/____ _____

Skin Diseases

□ □ 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 ___/____
□ □ Hives ___/____
□ □ Jock Itch ___/____
□ □ Lackluster Skin ___/____
□ □ Moles w/ Color/Size Change ___/____
□ □ Oily Skin ___/____
□ □ Pale Skin ___/____
□ □ Patchy Dullness ___/____
□ □ Rash ___/____
□ □ Red Face ___/____
□ □ Sensitive to Bites ___/____
□ □ Sensitive to Poison Ivy/Oak ___/____
□ □ Shingles ___/____
□ □ Skin Darkening ___/____
□ □ Strong Body Odor ___/____
□ □ Hair Loss ___/____
□ □ Vitiligo ___/____
□ □ Eczema ___/____
□ □ Psoriasis ___/____
□ □ Melanoma ___/____
□ □ Skin Cancer ___/____
□ □ Other ___/____ _____

Neurologic/Mood

□ □ Depression ___/____
□ □ Anxiety ___/____
□ □ Bipolar Disorder ___/____
□ □ Schizophrenia ___/____
□ □ Headaches ___/____
□ □ Migraines ___/____
□ □ ADD/ADHD ___/____
□ □ Autism ___/____
□ □ Mild Cognitive Impairment ___/____
□ □ Memory Problems ___/____
□ □ Parkinson's Disease ___/____
□ □ Multiple Sclerosis ___/____
□ □ ALS ___/____
□ □ Seizures ___/____
□ □ Other Neurological Problems _____

Blood Type

□ A □ B □ AB □ O □ Rh+ □ unknown

Injuries

Check box if yes and provide date/description

□ Back Injury ___/____ _____
□ Head Injury ___/____ _____
□ Neck Injury ___/____ _____
□ Broken Bones ___/____ _____
□ Other ___/____ _____

Diseases/Diagnosis/Conditions: *continued*

Female Repoductive

□ □ Breast Cysts ___/____
□ □ Breast Lumps ___/____
□ □ Breast Tenderness ___/____
□ □ Ovarian Cysts ___/____
□ □ Poor Libido ___/____
□ □ Vaginal Discharge ___/____
□ □ Vaginal Odor ___/____
□ □ Vaginal Itch ___/____
□ □ Vaginal Pain with Sex ___/____

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□ □ Other ___ /____ _____

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

Male Reproductive
□ □ Discharge from penis ___ /____
□ □ Ejaculation Problem ___ /____
□ □ Genital Pain ___ /____
□ □ Impotence ___ /____
□ □ Prostate or Urinary Infection ___ /____
□ □ Lumps in Testicles ___ /____
□ □ Poor Libido *(Sex Drive)* ___ /____
□ □ Other ___ /____ _____

Preventive Tests
Check box if yes and provide date of most recent test
□ Blood Tests ___ /____
□ Full Physical Exam ___ /____
□ X-Ray ___ /____ *Body Part?*_____
□ Dental X-Ray ___ /____
□ Bone Density ___ /____
□ Colonoscopy ___ /____
□ Cardiac Stress Test ___ /____
□ EKG ___ /____
□ Hemoccult Test (stool test for blood) ___ /____
□ MRI ___ /____
□ CT Scan ___ /____
□ Upper Endoscopy ___ /____
□ Upper GI Series ___ /____
□ Ultrasound ___ /____
□ Other ___ /____ _____

Gynecologic History *(for women only)*

Obstetric History *Check box if yes and provide relevant quantity*
□ Pregnancy____ □ Vaginal Delivery____ □ Caesarean Delivery____ □ Miscarriage____ □ Abortion____
□ Living Children____ □ Post Partum Depression____ □ Toxemia____ □ Gestational Diabetes____
□ Baby over 8 lbs. ____ □ Premature____
□ Breast Feeding____ *How long?* _____ □ Oral Contraceptives____ *How long?* _____

Menstrual History
Age at first period: _____ Menses Frequency: _____ Length: _____ Pain: □ Yes □ No
Clotting: □ Yes □ No Has you period ever skipped? □ Yes □ No How long? _____
Last Menstrual Period: _____
Do you use contraception? □ Yes □ No *If yes:* □ Condom □ Diaphragm □ IUD □ Partner Vasectomy

Women's Disorder/Hormonal Imbalances
□ Fibrocystic Breasts □ Endometriosis □ Fibroids □ Infertility
□ Painful Periods □ Heavy Periods □ PMS
Last Mammogram: □ Breast Biopsy ___ /___ /____ □ Thermogram ___ /___ /____
Last PAP Test: □ Normal □ Abnormal
Date of Last Bone Density: ___ /___ /____ Results: □ High □ Low □ Within Normal Range
Are you in menopause? □ Yes □ No Age of onset of menopause: _____
Check box if you are experiencing
□ 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?* _____ *What hormones and dosage?* _____
_____

Men's History *(for men only)*

Have you had a PSA done? □ Yes □ No Date of last test? ___ /___ /____
Highest PSA Level: □ 0-2 □ 2-4 □ 4-10 □ >10

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Check box if you are experiencing

□ Prostate Enlargement □ Prostate Infection □ Change in Libido □ Impotence
□ Difficulty Obtaining an Erection □ Difficulty Maintaining an Erection □ Prostate Cancer
□ Nocturia *(urination at night)* How many times a night? _____
□ Urgency/Hesitancy/Change in Urinary Stream □ Loss of Control of Urine

Medications

Current Medications *(Both prescription and over-the-counter)*

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

Previous Medications*: Last 10 Years*

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

Nutritional Supplements: *(Vitamins, Minerals, Herbs, &Homeopathy) If more space is needed, please write on separate sheet.*

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

Have your medications or supplements ever caused you unusual side effects or problems? □ Yes □ No
Describe: _____
Have you had prolonged *(3 days or longer)* or regular use of NSAIDS *(i.e. Advil, Aleve, Motrin, Aspirin, etc.)*? □ Yes □ No
Have you had prolonged or regular use of Tylenol? □ Yes □ No
For what reason, and for how long, did you use pain relievers? _____
How much do you use NSAIDS now? Daily _____ Weekly _____ Monthly _____
Have you had prolonged or regular use of Acid Blocking Drugs *(i.e. Tagamet, Zantac, Prilosec, etc.)*? □ Yes □ No
Have you taken antibiotics **more than** 1 x per year? □ Yes □ No
Have you had long-term use of antibiotics? *(More than 10 days.)* □ Yes □ No
How many times have you taken antibiotics throughout your lifetime? _____
Have you ever used steroids *(i.e. prednisone, nasal allergy inhalers, skin/joint creams, etc.)*? □ Yes □ No

GI History

Foreign travel? □ Yes □ No *Where?* _____

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Wilderness Camping □ Yes □ No *Where?* _____
Have you had severe: □ Gastroenteritis □ Diarrhea
Do you feel like you digest your food well? □ Yes □ No Do you feel bloated after meals? □ Yes □ No

Patient Birth History

□ Term □ Premature *Pregnancy Complications:* _____
Birth Complications: _____
□ Breast Fed *How long?* _____ □ Bottle-fed
Age at introduction of: Solid Foods: _____ Dairy: _____ Wheat: _____
Did you eat candy or sugar as a child? □ Yes □ No

Dental History

Dental Surgery? _____
□ Silver Mercury Fillings *How many?* _____ □ Gold Fillings □ Root Canals □ Implants □ Tooth Pain
□ Bleeding Gums □ Gingivitis □ Problems with Chewing
Do you floss regularly? □ Yes □ No Do you brush regularly? □ Yes □ No
What toothpaste do you use? _____ Have you had Fluoride treatments? □ Yes □ No

Diet

Do you have known adverse food reactions, allergies, or sensitivities? □ Yes □ No *If yes, describe symptoms and list all foods:* _____
_____
Do you have an adverse reaction to caffeine? □ Yes □ No
When you drink caffeine do you feel: □ Irritable or Wired □ Aches & Pains □ Headaches
Do you adversely react to: *Check all that apply*
□ Monosodium Glutamate *(MSG)* □ Aspartame *(NutraSweet)* □ Preservatives *(ex. sodium benzoate)*
□ Cheese □ Citrus foods □ Chocolate □ Alcohol □ Red Wine □ Caffeine □ Bananas □ Garlic □ Onion
□ Sulfite containing foods *(wine, dried fruit, salad bars)* □ Other: _____

Environmental & Detoxification Assessment

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

□ Cigarette Smoke □ Perfumes/Colognes □ Auto Exhaust Fumes □ Other: _____
In your home or work environment, are you exposed to: □ Chemicals □ Electromagnetic Radiation □ Mold
How often do you use your cell phone? ____ $^{hrs}/_{day}$ How often do you use your computer? ____ $^{hrs}/_{day}$ ____ $^{hrs}/_{wk}$
Have you ever turned yellow *(jaundiced)*? □ Yes □ No
Have you ever been told you have Gilbert's syndrome or a liver disorder? □ Yes □ No
If yes, 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 (if known)* _____
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 any pets or farm animals? □ Yes □ No
What detergents/soaps do you use *(Brand names)*? _____
What deodorant? _____
What beauty products do you use *(Lotions, Hair products, Make-up, etc.)*? _____
_____

Family History

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Check family members that apply	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age *(if still alive)*												
Age at Death *(if deceased)*												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis *(Rheumatoid, Psoriatic, Ankylosing Sondylitis)*												
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 / Mood Disorder												
Other:												

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Social History

Weight Stats

Height _____*ft.* _____*in.* Current Weight _____ Usual Weight Range (*+/- 5lbs)* _____
Desired Weight Range (*+/- 5lbs)* _____ Highest Adult Weight _____ Lowest Adult Weight _____
Have you experienced weight fluctuations greater than 10lbs? □ Yes □ No Body fat % _____
Is your weight, in the recent past, increasing, decreasing, or staying the same? *If changing describe* _____
_____

Nutrition History

Have you ever had a nutrition consultant? □ Yes □ No
Have you made any changes in your eating habits because of your health? □ Yes □ No *Describe* _____
_____
Do you currently follow a special diet or nutritional program? □ Yes □ No *Check all that apply*
□ Low Fat □ Low Carbohydrate □ High Protein □ Low Sodium □ Diabetic □ No Dairy □ No Wheat
□ Gluten Restricted □ Vegetarian □ Vegan □ Ultrametabolism □ Macrobiotic □ Paleo
□ Specific Program for Weight Loss/Maintenance Type: _____ □ Other _____
How often do you weigh yourself? □ Daily □ Weekly □ Monthly □ Rarely □ Never
Have you ever had your metabolism *(resting metabolic rate)* checked? □ Yes □ No *If Yes, what was it?* _____
Do you avoid any particular foods? □ Yes □ No If yes, types & 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 eat organic foods? □ Yes □ No
What percentage of your food is organic (pesticide free, non-GMO, etc.)? _____
How many meals do you eat out per week? □ 0 – 1 □ 1 – 3 □ 3 – 5 □ >5 meals per week
Check all 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 frequency
□ Non-availability of healthy foods
□ Do not plan meals or menus
□ Reliance on convenience
□ 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: _____
_____
What foods would be the hardest to reduce or eliminate? _____

Smoking

Currently smoking? □ Yes □ No *How many years?* _____ *Packs per day:* _____ *Attempts to quit:* _____
Previous smoking? *How many years?* _____ *Packs per day:* _____ *Date quit:* _____
Secondhand smoke exposure? _____ *From where?* _____

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Social History *continued*

Alcohol Intake

How many drinks currently per week? *1 Drink = 5 oz. wine, 12 oz. beer, or 1 oz. spirit*
□ None □ 1 -3 □ 4 – 6 □ 7 – 10 □ > 10 If 'None' – Skip to 'Other Substances'
Most common beverage? _____
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 been arrested or hospitalized because of drinking? □ Yes □ No
Have you ever thought about getting help to control or stop your drinking? □ Yes □ No

Other Substances

Caffeine intake: □ Yes □ No Cups/day: □ Coffee □ Tea - □ 1 □ 2 – 4 □ > 4 a day
Caffeinated sodas or diet sodas intake: □ Yes □ No
12 oz. soda per day: □ 1 □ 2 – 4 □ > 4 a day Favorite soda: _____
Are you currently using any recreational drugs? □ Yes □ No *Type* _____
Have you ever used IV or inhaled recreational drugs? □ Yes □ No

Exercise

Current exercise program

Activity	Type	Frequency Per Week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength			
Other *(Yoga, Pilates, Gyrotonics, etc.)*			
Sports or Leisure Activities *(Golf, Tennis, Rollerblading, etc.)*			

Rate your level of motivation for including exercise in your life? □ Low □ Medium □ High
List your 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

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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

Social History *continued*

Stress / Coping

Have you ever sought counseling? □ Yes □ No *Describe* _____
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
How do you deal with stress? _____
Daily Stressors: *Rate on a scale of 1 – 10* Work ____ Family ____ Social ____ Finances ____ Health ____ Other ____
Do you practice meditation or relaxation technique? □ Yes □ No *How often?* _____
Check all that apply □ Yoga □ Meditation □ Imagery □ Breathing □ Tai Chi □ Prayer
□ Other: _____
Have you ever been abused, a victim of a crime, or experienced a significant trauma? □ Yes □ No
If yes, please explain _____
Do you regularly give gratitude for everything in your life? □ Yes □ No
How would you describe your overall attitude towards life? _____
Do you have a spiritual practice? □ Yes □ No *Describe* _____

Sleep / Rest

Average number of hours you sleep per night: □ > 10 □ 8 -10 □ 6 – 8 □ < 6
What time do you typically go to sleep? _____:_____ $^{AM}/_{PM}$ Do you have trouble going to sleep? □ Yes □ No
Do you feel rested upon awakening? □ Yes □ No Do you have problems with insomnia? □ Yes □ No
Do you snore? □ Yes □ No Do you use sleeping aids? □ Yes □ No *Explain:* _____

Roles / Relationship

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

List Children:

Child's Name	Age	Gender

Who is living in your Household? *Number* _____ *Names* _____
Their Employment/Occupation: _____
Resources for emotional support? *Check all that apply*
□ Spouse □ Family □ Friends □ Religious/Spiritual □ Pets □ Other: _____

How well have things been going for you?	Very Well	Fine	Poorly	Does Not Apply
Overall				
At School				
In your job				
In your social life				
With close friends				

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With sex				
With your attitude				
With your boyfriend/girlfriend				
With your children				
With your parents				
With your spouse				

Readiness Assessment

In order to improve your health, how willing are you to: *Rate on a scale of: 5 (very willing) to 1 (not willing)*

Significantly improve your diet _____ □ 5 □ 4 □ 3 □ 2 □ 1
Take several nutritional supplements each day _____ □ 5 □ 4 □ 3 □ 2 □ 1
Start preparing your own meals _____ □ 5 □ 4 □ 3 □ 2 □ 1
Modify your lifestyle _____ □ 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
Get regular bodywork such as chiropractic or massage _____ □ 5 □ 4 □ 3 □ 2 □ 1
Setting regular appointments _____ □ 5 □ 4 □ 3 □ 2 □ 1
Read books or articles to learn about your health and solutions _____ □ 5 □ 4 □ 3 □ 2 □ 1
Be fully responsible for your own healing _____ □ 5 □ 4 □ 3 □ 2 □ 1

Comments: _____
_____

How confident are you of your ability to organize and follow through on the above health related activities?
Rate on a scale of: 5 (very confident) to 1 (not confident at all) □ 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?* _____
_____

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

How much ongoing support and contact *(office visits)* from the Doctor would be helpful to you as you implement your personal health program? *Rate on a scale of: 5 (very frequent) to 1 (very infrequent contact)* □ 5 □ 4 □ 3 □ 2 □ 1
Please list how often you would be willing to make appointments if needed _____
Comments: _____
_____

4-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 4 consecutive days including one weekend day. You will find a convenient 4-day diary at the end of this packet. Please feel free to carry it with you as it is often easier to write down what you consume shortly after you consume it, rather than wait until the end of the day.

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- Do not change your eating behavior at this time, as the purpose of this food record is to analyze your present eating habits.
- Record information as soon as possible after the food has been consumed.
- Describe the food or beverage as accurately as possible e.g., milk – what kind? (whole, 2%, or nonfat); toast – (whole wheat, white, buttered); chicken - (fried, baked, or breaded); coffee – (decaffeinated w/ sugar & ½ 'n' 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 in 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.)

MSQ – Medical Symptom / Toxicity Questionnaire

Name: _____ *Date:* _____

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

POINT SCALE:
0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have, effect is significant
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is very significant

Digestive Tract
___ Nausea or vomiting
___ Diarrhea
___ Constipation
___ Bloated feeling
___ Belching or passing gas
___ Heartburn
___ Intestinal/stomach pain
Total _____

Ears
___ Itchy ears total
___ Earaches, ear infection
___ Drainage from ear
___ Ringing in ears, hearing loss
Total _____

Emotions
___ Mood swings
___ Anxiety, irritability, or aggressiveness
___ Depression
Total _____

Energy/Activity
___ Fatigue, sluggishness
___ Apathy, lethargy
___ Hyperactivity
___ Restlessness
Total _____

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

Head
___ Headaches
___ Faintness
___ Dizziness
___ Insomnia
Total _____

Heart
___ Irregular or skipped heartbeat
___ Rapid or pounding heartbeat
___ Chest pain
Total _____

Joints/Muscles
___ Pain or aches in joints
___ Arthritis
___ Stiffness or limitation of movement
___ Pain or aches in muscles
___ Feeling of weakness or tiredness
Total _____

Lungs
___ Chest congestion
___ Asthma, bronchitis
___ Shortness of breath
___ Difficulty breathing
Total _____

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

Mouth/Throat
___ Chronic coughing
___ Gagging, frequent throat clearing
___ Sore throat, hoarseness, loss of voice
___ Swollen/discolored tongue, gun, lips
___ Canker sores
Total _____

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

Skin
___ Acne
___ Hives
___ Hair loss
___ Flushing or hot flashes
___ Excessive sweating
Total _____

Weight
___ Binge eating
___ Craving certain foods
___ Excessive weight
___ Compulsive eating
___ Water retention
___ Underweight
Total _____

Other
___ Frequent illness
___ Frequent or urgent urination
___ Genital itch or discharge
Total _____

Grand Total _____

Diet Diary: *Name* _____ *Date* _____

Day 1

Meal	Time	Food / Beverage / Amount	Comments

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Breakfast			
Lunch			
Dinner			
Snacks & Other			

Bowel movements *(#, form, color)* _____

Stress/Mood/Emotions _____

Other Comments _____

Day 2

Meal	Time	Food / Beverage / Amount	Comments
Breakfast			
Lunch			
Dinner			
Snacks & Other			

Bowel movements *(#, form, color)* _____

Stress/Mood/Emotions _____

Other Comments _____

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Day 3

Meal	Time	Food / Beverage / Amount	Comments
Breakfast			
Lunch			
Dinner			
Snacks & Other			

Bowel movements *(#, form, color)* _____

Stress/Mood/Emotions _____

Other Comments _____

Day 4

Meal	Time	Food / Beverage / Amount	Comments
Breakfast			
Lunch			
Dinner			
Snacks & Other			

Bowel movements *(#, form, color)* _____

Stress/Mood/Emotions _____

Other Comments _____