



# THE MAAS CLINIC

OSTEOPATHIC & FUNCTIONAL DIAGNOSTIC MEDICINE

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# Health History Questionnaire

## ESTABLISHING HEALTH GOALS

### Personal Message

Before we begin our journey together, I would like to discuss something very important that will have a major impact on your ability to recover and achieve maximum improvement. After many years in private practice, I have had the opportunity to work with thousands of patients and have seen many patients achieve significant improvement while others have become frustrated and failed in their attempt to get well. After careful review, I have discovered the reasons why some people succeed and why others fail. This questionnaire is about much more than eliminating your symptoms – it's about living a life of vibrant health.

I've discovered that any discussion of the correct way to achieve health and stay healthy is, in actuality, a discussion of how you have lived your life up to this point and how you will live it in the future.

Therefore, to help you make significant changes in your present health, I want to ask you a few very important questions. I want you to be honest with yourself and really dig deep inside yourself for the answers.

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

\_\_\_\_\_

If you had a magic wand and could erase three problems, what would they be?

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**Have you made the decision to change? To do what it takes to get well?**

Yes \_\_\_\_\_

No \_\_\_\_\_

I have read something interesting: ***"The definition of insanity is to keep doing the same thing and expecting different results"***. If you keep following the same course of treatment you have been following will your results really change? Have you ever wondered if you are on the right path to achieving optimal health? Sometimes it requires taking a new and improved road to reach your destination.

Most people I ask tell me they've made the decision to change. But how many people have truly decided to change? Very few! Why? Because there is a big difference between deciding something and having "reasons" to actually do it.

When you have made a decision to make a change and you know your reasons, you create an internal power that can propel you to achieving health and wellness. So now I ask:

**List up to 5 things that you have been unable to do as a result of your present symptoms. Please be specific. (Use extra pages if necessary)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_





**HAVE YOU COMPLETED THE LAST SECTION?**

**IF NOT, PLEASE GO BACK AND ANSWER ALL THE QUESTIONS!  
PLEASE NOTE THAT THE PAGES ARE BACK AND FRONT!**

**PLEASE DO NOT SKIP THIS SECTION!!**

**GIVE CAREFUL THOUGHT TO WHY YOU WANT TO GET BETTER AND  
HOW IT WOULD AFFECT YOUR LIFE!**

## GENERAL INFORMATION

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Parish \_\_\_\_\_ Country \_\_\_\_\_

Postal Code \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Place of birth \_\_\_\_\_ Gender: F \_\_\_ M \_\_\_

Occupation \_\_\_\_\_ Hours per week \_\_\_\_\_

Nature of Business \_\_\_\_\_

Genetic Background: Please check appropriate box(es):

- African American     Hispanic     Mediterranean     Asian  
 Native American     Caucasian     Northern European     Other

Right Handed: \_\_\_ Left Handed: \_\_\_ Mixed Dominance: \_\_\_

Number of Sisters: \_\_\_ (# deceased: \_\_\_) # of Brothers: \_\_\_ (# deceased: \_\_\_) Birth Order: \_\_\_

Has any other family member already been a patient at the clinic? \_\_\_\_\_

Next of Kin or other to reach in an emergency \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Primary medical physician \_\_\_\_\_

Address and phone number  
\_\_\_\_\_  
\_\_\_\_\_

How did you hear about our clinic? Book \_\_\_ Website \_\_\_ Media \_\_\_ Friend/family member \_\_\_

Other \_\_\_\_\_

## PERSONAL DESCRIPTIVE INFORMATION

**Marital status:**

- Single
  Married
  Divorced  
 Widow
  Long Term Partnership

**List Children:**

Child's Name	Age	Gender

With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)  
 Example: Wendy, age 7, sister

\_\_\_\_\_

\_\_\_\_\_

Do you have any pets or farm animals? Yes \_\_\_\_ No \_\_\_\_

If yes, where do they live? Indoors \_\_\_\_ Outdoors \_\_\_\_ Both indoors and outdoors \_\_\_\_

Have you ever lived or travelled outside of Barbados? Yes \_\_\_\_ No \_\_\_\_

If so, when and where? \_\_\_\_\_

\_\_\_\_\_

How much time have you lost from work or school in the past year?

- a. \_\_\_\_ 0-2 days                      b. \_\_\_\_ 3 –14 days                      c. \_\_\_\_ > 15 days

Previous jobs: \_\_\_\_\_

\_\_\_\_\_

Please list your highest level of education:

- High School  
 College \_\_\_\_\_ Major: \_\_\_\_\_ Year: \_\_\_\_\_  
 Graduate School \_\_\_\_\_ Field: \_\_\_\_\_ Year: \_\_\_\_\_  
 Professional School \_\_\_\_\_ Field: \_\_\_\_\_ Year: \_\_\_\_\_

Did you have learning problems? \_\_\_\_\_

# Functional Diagnostic Medicine Questionnaire

Please complete the following Functional Medicine Questionnaire to the best of your ability. You may need family members to help supply information. Your thoroughness and accuracy in answering all appropriate questions will help the physician evaluate the root cause of your health concerns and determine an effective treatment program.

Note that we are interested in so-called minor symptoms as well as major problems. We know that in many doctor's offices there is some tendency not to mention too many symptoms for fear that the doctor will take you for a hypochondriac. The rules in our office are different. We are interested in any odd or unusual message you are getting from your body, even though it may be considered irrelevant to "making a diagnosis" or it may seem to you to be of no consequence to your health. Some such symptoms are useful clues in the kind of "medical detective work" we do. Please include as much information as you can on this form.

**Please print or write legibly.**

## COMPLAINTS/CONCERNS

Please list your chief symptoms in order of decreasing severity, starting with the worst one. Please note how long each symptoms has been present.

Problem	Onset	Frequency	Severity
1. e.g. Headaches	June 2007	4 times per week	Mild / moderate / severe
2.			
3.			
4.			
5.			
6.			
7.			

What diagnosis or explanation have been given to you? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

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

\_\_\_\_\_

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

\_\_\_\_\_

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

\_\_\_\_\_

Please list all physicians you have seen for the above health conditions:

1.	4.
2.	5.
3.	6.

Please check all the Alternative Treatments you have tried for your condition(s)

- |                                       |                                      |  |   |
|---------------------------------------|--------------------------------------|--|---|
| <input type="checkbox"/> None         | <input type="checkbox"/> Massage     | <input type="checkbox"/> Yoga          | <input type="checkbox"/> Environmental medicine |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Rolwing     | <input type="checkbox"/> Hypnosis      | <input type="checkbox"/> Nutritional Therapy    |
| <input type="checkbox"/> Acupuncture  | <input type="checkbox"/> Reiki       | <input type="checkbox"/> Ayurveda      | <input type="checkbox"/> Biological Dentistry   |
| <input type="checkbox"/> Iridology    | <input type="checkbox"/> Homeopathy  | <input type="checkbox"/> Light therapy | <input type="checkbox"/> IV (chelation) therapy |
| <input type="checkbox"/> Colonics     | <input type="checkbox"/> Biofeedback | <input type="checkbox"/> Meditation    | <input type="checkbox"/> Naturopathic medicine  |

## PAST MEDICAL & SURGICAL HISTORY

Please indicate all that have affected you and the date. The "X" denotes that you cannot get the illness twice.

ILLNESSES	Date	Date	Date	Comments
Anemia				
Arthritis				
Asthma				
Bronchitis				
Cancer				
Chicken Pox		X	X	
Chronic Fatigue Syndrome				
Crohn's Disease or Ulcerative Colitis				
Diabetes				
Emphysema				
Epilepsy, convulsions				
Gallstones				
German Measles		X	X	
Gout				
Heart attack/Angina				
Heart failure				
Hepatitis				
High blood pressure				
Irritable bowel				
Kidney stones				
Measles		X	X	
Mononucleosis		X	X	
Mumps		X	X	

Pneumonia				
Rheumatic fever				
Sinusitis				
Whooping cough		X	X	

**ILLNESSES**                      **Date**                      **Date**                      **Date**                      **Comments**

Sleep apnea				
Stroke				
Thyroid disease				
Other (describe)				

**INJURIES**                      **Date**                      **Date**                      **Date**                      **Comments**

Back Injury				
Fracture				
Head Injury				
Neck Injury				
Other (describe)				

**DIAGNOSTIC STUDIES**                      **Date**                      **Date**                      **Date**                      **Comments**

Back X-rays				
Barium Enema				
Blood Tests				
Bone Density Test				
Bone scan				
Carotid Artery Ultrasound				
CAT scan of Abdomen				
CAT scan of brain				
CAT scan of spine				
Chest X-ray				
Colonoscopy				
EKG				
Liver scan				
Mammogram				
MRI				
Neck X-rays				
Sigmoidoscopy				
Upper GI Series				
Other (describe)				

**OPERATIONS**                      **Date**                      **Date**                      **Date**                      **Comments**

Appendectomy		X	X	
Dental Surgery				
Gall Bladder		X	X	
Hernia				
Hysterectomy		X	X	
Tonsillectomy		X	X	
Tubes in Ears				

Other (describe)				

## HOSPITALIZATIONS

Where Hospitalized	When	For What Reason

## PATIENT BIRTH HISTORY

Question	Yes	No	Don't Know	Comment
Were you a full term baby?				
A Premie?				
Forcep delivery?				
Cesarean section?				
Epidural used?				
Breast fed?				
Bottle fed?				

When your mother was pregnant with you, did she:

Smoke tobacco?				
Drink alcohol?				
Take estrogen?				

## CHILDHOOD HEALTH HISTORY

Please indicate the occupation of your parents during your childhood:

Question	Yes	No	Don't Know	Comment
Did you live in an area with soft water?				
Hard water?				

As a child, did you consume a lot of the following:

Sugar?				
Candy?				
<b>Question</b>	<b>Yes</b>	<b>No</b>	<b>Don't Know</b>	<b>Comment</b>
Soda?				
Diet soda?				
Sweet Foods?				
White bread?				
Cookies?				
Ice Cream?				
Meat, vegetable & potato/rice/pasta diet?				
Vegetarian & grain based diet with little meat?				
Vegetarian diet with milk & eggs?				
Vegetarian diet without milk & eggs?				

As a child, were there any foods that you had to avoid because they gave you symptoms? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, please name the food and symptom e.g. wheat – gas and bloating. Please don't include allergies as they are in a following section.

<b>Food</b>	<b>Symptom</b>	<b>Other comments</b>

### AGE OF ONSET OF ILLNESSES

Please indicate which, if any, of the following problems/conditions developed when you were a child (ages birth to age12) by indicating the **approximate age** of onset.

- |  |   |
|--|---|
| <input type="checkbox"/> Frequent colds or flu               | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Bronchitis                          | <input type="checkbox"/> Ear Infections             |
| <input type="checkbox"/> Measles                             | <input type="checkbox"/> Mumps                      |
| <input type="checkbox"/> Chicken Pox                         | <input type="checkbox"/> Whooping Cough             |
| <input type="checkbox"/> Strep Infections                    | <input type="checkbox"/> Seasonal allergies         |
| <input type="checkbox"/> Significant dental work             | <input type="checkbox"/> Behavior problems          |
| <input type="checkbox"/> Attention Deficit Disorder (ADD)    | <input type="checkbox"/> Hyperactivity              |
| <input type="checkbox"/> Difficulty learning:                | <input type="checkbox"/> Frequent headaches         |
| <input type="checkbox"/> High number of absences from school | <input type="checkbox"/> Upset stomach, indigestion |
| <input type="checkbox"/> Jaundice                            | <input type="checkbox"/> Colic                      |
| <input type="checkbox"/> Ear infections                      | <input type="checkbox"/> Congenital abnormalities   |
| <input type="checkbox"/> Premature at birth                  | <input type="checkbox"/> Pneumonia                  |
| <input type="checkbox"/> Fever blisters                      | <input type="checkbox"/> Parent (s) smoked          |
| <input type="checkbox"/> Abusive or alcoholic parent (s)     | <input type="checkbox"/> Skin disorders (eczema)    |

Major illness(s) that required hospitalization. If yes please make sure you have outlined the reason why in the Hospitalization section on the previous page.

## IMMUNIZATION HISTORY

Please indicate if you have been vaccinated against any of the following diseases:

- |  |   |
|--|---|
| <input type="checkbox"/> Smallpox          | <input type="checkbox"/> Mumps                    |
| <input type="checkbox"/> Tetanus           | <input type="checkbox"/> Measles                  |
| <input type="checkbox"/> Diphtheria        | <input type="checkbox"/> Rubella (German measles) |
| <input type="checkbox"/> Pertussis         | <input type="checkbox"/> Typhoid                  |
| <input type="checkbox"/> Polio (oral)      | <input type="checkbox"/> Cholera                  |
| <input type="checkbox"/> Polio (Injection) |   |

## FEMALE MEDICAL HISTORY (for women only)

### OBSTETRICS HISTORY Check box if yes and provide number of

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Pregnancies _____      | <input type="checkbox"/> Caesarean _____                    | <input type="checkbox"/> Vaginal deliveries _____ |
| <input type="checkbox"/> Miscarriage _____      | <input type="checkbox"/> Abortion _____                     | <input type="checkbox"/> Living Children _____    |
| <input type="checkbox"/> Post partum depression | <input type="checkbox"/> Toxemia                            | <input type="checkbox"/> Gestational diabetes     |
| <input type="checkbox"/> Baby over 8 pounds     | <input type="checkbox"/> Breast feeding For how long? _____ |   |

### GYNECOLOGICAL HISTORY

Age at 1<sup>st</sup> period: \_\_\_\_\_ Menses Frequency: \_\_\_\_\_ Length: \_\_\_\_\_ Pain: Yes \_\_\_ No \_\_\_

Clotting: Yes \_\_\_ No \_\_\_ Has your period skipped? \_\_\_\_\_ For how long? \_\_\_\_\_

Last Menstrual Period: \_\_\_\_\_

Do you currently use contraception? Yes \_\_\_ No \_\_\_

If yes, what type do you use?  Condom  Diaphragm  IUD  Partner vasectomy

Have you ever used hormonal contraception? Yes \_\_\_ No \_\_\_ If yes, when \_\_\_\_\_

Use of hormonal contraception:  Birth control pills  Patch  Nuva Ring: How long? \_\_\_\_\_

Are you using the pill now? Yes \_\_\_ No \_\_\_ Did taking the pill agree with you? Yes \_\_\_ No \_\_\_

In the 2<sup>nd</sup> half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)?  Yes  No

Last Mammogram \_\_\_\_\_ Breast Biopsy/Date \_\_\_\_\_

Last PAP Test: \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal \_\_\_\_\_

Date of last Bone Density: \_\_\_\_\_ Results:  High  Low  Within normal range

Are you in menopause? Yes \_\_\_ No \_\_\_ Age at Menopause \_\_\_\_\_

Do you take:  Estrogen  Ogen  Estrace  Premarin Other \_\_\_\_\_

Progesterone  Provera Other \_\_\_\_\_

How long have you been on hormone replacement? \_\_\_\_\_

# FAMILY HISTORY

(Place mark any health problem(s) your family has suffered with either now or in the past)

Check Family Members that Apply	Father	Mother	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)												
Heart Attack												
Stroke												
Uterine Cancer												
Colon Cancer												
Breast Cancer												
Ovarian Cancer												
Prostate Cancer												
Skin Cancer												
ADD/ADHD												
ALS or other Motor Neuron Diseases												
Alzheimer's												
Anemia												
Anxiety												
Arthritis												
Asthma												
Autism												
Autoimmune Diseases (such as Lupus)												
Bipolar Disease												
Bladder disease												
Blood clotting problems												
Celiac disease												
Dementia												
Depression												
Diabetes												
Eczema												
Emphysema												
Environmental Sensitivities												
Epilepsy												
Flu												
Food Allergies, Sensitivities, Intolerances												
Genetic disorders												
Glaucoma												
Headache												
Heart Disease												
High Blood Pressure												

High Cholesterol												
Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
<b>Inflammatory Arthritis</b> (Rheumatoid, Psoriatic, Ankylosing spondylitis)												
<b>Inflammatory Bowel Disease</b>												
<b>Insomnia</b>												
<b>Irritable Bowel Syndrome</b>												
<b>Kidney disease</b>												
<b>Multiple Sclerosis</b>												
<b>Nervous breakdown</b>												
<b>Obesity</b>												
<b>Osteoporosis</b>												
<b>Other</b>												
<b>Parkinson's</b>												
<b>Pneumonia/Bronchitis</b>												
<b>Psoriasis</b>												
<b>Psychiatric disorders</b>												
<b>Schizophrenia</b>												
<b>Sleep Apnea</b>												
<b>Smoking addiction</b>												
<b>Stroke</b>												
<b>Substance abuse</b> (such as alcoholism)												
<b>Ulcers</b>												

Any other family history we should know about? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please comment: \_\_\_\_\_

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## REVIEW OF SYSTEMS

Check only those items that apply to you, **past or present**. Ignore anything that does not apply to you.

### GENERAL

- Fever
- Chills/Cold all over
- Aches/Pains
- General Weakness
- Difficulty sweating
- Excessive Sweating
- Swollen Glands
- Cold hands & Feet
- Fatigue
- Difficulty falling asleep
- Night Walker
- Nightmares
- No dream recall
- Early waking
- Daytime sleepiness
- Distorted Vision

### SKIN:

- Cuts Heal slowly
- Bruise Easily
- Rash
- Pigmentation
- Changing Moles
- Calluses
- Eczema
- Psoriasis
- Dryness
- Oiliness
- Itching
- Acne
- Boils
- Hives
- Fungus on Nails
- Peeling Skin
- Cracking skin
- Shingles
- Nails Split
- White Spots/Lines on Nails
- Crawling Sensation
- Burning on Bottom of Feet
- Athletes Foot
- Cellulite
- Bugs love to bite you
- Have bumps on the back of arms and front of thighs
- Skin Cancer
- Strong body odor

### Is your skin sensitive to the:

- Sun
- Fabrics \_\_\_\_\_
- Detergents \_\_\_\_\_

### HEAD:

- Poor Concentration
- Confusion
- Concussion
- Whiplash
- Mental Sluggishness
- Forgetfulness
- Indecisive
- Face Twitch
- Poor Memory
- Hair Loss

### Headaches:

- Daytime
- Afternoon
- After Meals
- Severe
- Migraine
- Frontal
- Occipital
- Relieved by Eating Sweets
- Relieved by: \_\_\_\_\_

### EYES:

- Feeling of Sand in Eyes
- Double Vision
- Blurred Vision
- Poor Night Vision
- Bright Flashes
- Halo around Lights
- Eye Pains
- Dark Circles under Eyes
- Strong Light Irritates
- Cataracts
- Floaters in Eyes (see floating objects)
- Visual hallucinations

### EARS:

- Aches
- Discharge/Conjunctivitis
- Pains
- Ringing
- Deafness/Hearing loss
- Itching
- Pressure
- Wear a hearing aid
- Frequent infections
- Tubes in ears
- Sensitive to loud noises
- Hearing Hallucinations

### **NOSE/SINUSES**

- Stuffy
- Bleeding
- Runny
- Discharge
- Watery Nose
- Congested
- Infection
- Polyps
- Acute smell
- Drainage
- Sneezing spells
- Post nasal drip
- No sense of smell
- Do the change of seasons tend to make your symptoms worse? Yes/No

#### **If yes, is it worse in the:**

- Spring
- Summer
- Fall
- Winter

### **MOUTH:**

- Coated Tongue (White)
- Sore Tongue
- Teeth Problems
- Bleeding Gums
- Canker Sores
- Cracked lips/ corners
- Chapped lips
- Fever blisters
- Wear dentures
- Grind teeth when sleeping
- Bad breath
- Dry mouth

### **THROAT:**

- Mucus
- Difficulty Swallowing
- Frequent Hoarseness
- Tonsillitis
- Enlarged Glands
- Constant clearing of throat
- Throat closes up

### **NECK:**

- Stiffness
- Swelling
- Lumps
- Neck glands swell

### **CIRCULATION/RESPIRATION:**

- Swollen Ankles
- Sensitive to Hot
- Sensitive to Cold
- Extremities Cold or Clammy
- Hands/Feet go to sleep/numb
- High Blood Pressure
- Chest Pain

- Pain between shoulders
- Dizziness upon standing
- Fainting Spells
- High Cholesterol
- High Triglycerides
- Wheezing
- Irregular Heartbeat
- Palpitations
- Low exercise tolerance
- Frequent coughs
- Breathing heavily
- Frequently Sighing
- Shortness of breath
- Night Sweats
- Varicose Veins
- Mitral valve prolapse
- Murmurs
- Skipped heartbeat
- Heart enlargement
- Angina pain
- Bronchitis/Pneumonia
- Emphysema
- Croup
- Frequent colds
- Heavy/tight chest
- Past Heart Attack When \_\_\_\_\_
- Phlebitis
- Spider Veins

### **KIDNEY/URINARY TRACT:**

- Burning
- Frequent Urination
- Blood in Urine
- Night time Urination
- Problem Passing Urine
- Kidney Pain
- Kidney Stones
- Painful Urination
- Bladder infections
- Kidney infections
- Syphilis
- Bedwetting
- Have trichomonas

### **GASTROINTESTINAL/DIGESTION**

- Peptic/Duodenal Ulcer
- Poor Appetite
- Excessive Appetite
- Gallstones
- Gallbladder pain
- Nervous Stomach
- Overly Full Feeling after meal
- Indigestion
- Heartburn
- Acid Reflux
- Hiatal Hernia
- Nausea
- Vomiting
- Vomiting Blood
- Abdominal Pains/Cramps
- Gas
- Diarrhea

- Constipation

#### **GASTROINTESTINAL/DIGESTION Cont**

- Changes in Bowels
- Rectal Bleeding
- Tarry Stools
- Rectal Itching
- Use laxatives
- Bloating
- Belch frequently
- Anal itching
- Anal fissures
- Bloody stools
- Undigested food in stools

#### **WOMEN'S HISTORY (for women only)**

- Fibrocystic Breasts
- Lumps in breast
- Fibroid Tumors/Breast
- Spotting
- Heavy Periods
- Fibroid Tumors/Uterus
- Painful periods
- Change in period
- Breast soreness before period
- Endometriosis
- Non-period bleeding
- Breast soreness during period
- Vaginal Dryness
- Vaginal discharge
- Had partial/total hysterectomy
- Hot Flashes
- Mood Swings
- Concentration/Memory Problems
- Breast cancer
- Ovarian cysts
- Pregnant
- Infertility
- Decreased Libido
- Heavy Bleeding
- Joint Pains
- Headaches
- Weight Gain
- Loss of Control of Urine
- Palpitations

#### **MEN'S HISTORY (for men only)**

Have you had a Prostate Specific Antigen Test (PSA) done?

Yes \_\_\_\_\_ No \_\_\_\_\_

PSA Level:

- 0 – 2
- 2 – 4
- 4 – 10
- >10
- Prostate enlargement
- Prostate infection
- Change in libido
- Impotence
- Diminished libido
- Poor libido
- Infertility

- Lumps in testicles
- Sore on penis
- Genital pain
- Hernia
- Prostate cancer
- Low sperm count
- Difficulty Obtaining Erection
- Difficulty Maintaining an Erection
- Nocturia (urination at night)
- How many times at night? \_\_\_\_\_
- Urgency/Hesitancy/Change in Urinary Stream
- Loss of Control of Urine

#### **JOINT/MUSCLES/TENDONS**

- Pain wakes me up
- Weakness in Legs and arms
- Balance problems
- Muscle cramping
- Head injury
- Muscle Stiffness in Morning
- Damp weather bothers you

#### **EMOTIONAL:**

- Convulsions
- Dizziness
- Fainting Spells
- Blackouts
- Amnesia
- Had shock therapy
- Frequently keyed up and jittery
- Shaky
- Startled by sudden noises
- Often feel suddenly scared
- Go to pieces easily
- Forgetful
- Listless
- Withdrawn feeling
- Feel "lost" in time
- Had nervous breakdown
- Had "burnout"
- Feel groggy
- Unable to concentrate
- Short attention span
- Vision changes
- Unable to reason
- Considered a nervous person
- Worried over little things
- Anxiety
- Unusual tension
- Frustration
- Numbness
- Often break out in cold sweats
- Profuse sweating
- Depressed
- Been admitted for psychiatric care
- Often awakened by frightening dreams
- Family member had nervous breakdown
- Use tranquilizers
- Aggressive
- Misunderstood by others
- Irritable

- Easily flare in anger

***EMOTIONAL CONTINUED:***

- Feeling of hostility
- Fatigue
- Hyperactive
- Restless leg syndrome
- Considered clumsy
- Unable to coordinate muscles
- Have difficulty falling asleep
- Have difficulty staying asleep
- Daytime sleepiness
- Workaholic
- Have had hallucinations
- Have considered suicide
- Have overused alcohol
- Family history of overused alcohol
- Cry often
- Feel insecure
- Have overused drugs
- Been addicted to drugs
- Extremely shy

## DENTAL HISTORY

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Have you had sore gums (gingivitis) often over the years? Yes \_\_\_\_ No \_\_\_\_

Has ringing in the ears (tinnitus) been present? Yes \_\_\_\_ No \_\_\_\_

Have TMJ (temporal mandibular joint) problems been a concern? Yes \_\_\_\_ No \_\_\_\_

Do you often have a 'metallic' taste in your mouth? Yes \_\_\_\_ No \_\_\_\_

Do you have a lot of bad breath (halitosis) or white tongue (thrush)? Yes \_\_\_\_ No \_\_\_\_

Have you worn or do you presently wear braces? Yes \_\_\_\_ No \_\_\_\_

Do you have problems chewing? Yes \_\_\_\_ No \_\_\_\_

Do you floss regularly? Yes \_\_\_\_ No \_\_\_\_

Did your mother have dental fillings prior to giving birth to you? Yes \_\_\_\_ No \_\_\_\_

Did you have fillings as a child? Yes \_\_\_\_ No \_\_\_\_

If yes, about how many fillings did you have before you were 18 yrs? \_\_\_\_\_

Did you have dental fillings as an adult? Yes \_\_\_\_ No \_\_\_\_

If yes, about how many fillings did you have after to 18 yrs? \_\_\_\_\_

How many amalgam fillings do you have now? \_\_\_\_\_

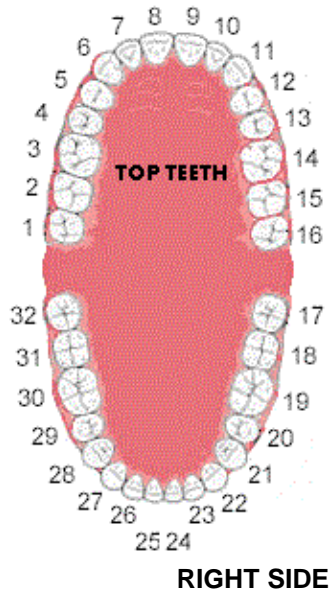
Did you play with mercury as a child or adult? Yes \_\_\_\_ No \_\_\_\_

Have you eaten a lot of fish in your life? Yes \_\_\_\_ No \_\_\_\_

List the approximate age and the type of dental work done from childhood until present:

Age	Describe Dental Work	Health Problems following dental work? (describe)

Please circle the tooth or teeth you have had or still have problems with. Please state what type of problem you have had, for example: root canal, crown, abscessed tooth, partials, etc. and indicate which teeth have fillings.



**RECORD ANSWERS:**

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## MEDICATIONS & SUPPLEMENTS

### ANTIBIOTIC USE

**Antibiotics: How often have you taken antibiotics?**

	Less than 5 times	More than 5 times
Infancy/Childhood		
Teen		
Adulthood		

### STEROID USE

**Oral Steroids: How often have you taken oral steroids (e.g. Prednisone, Cortisone, etc.)?**

	Less than 5 times	More than 5 times
Infancy/Childhood		
Teen		
Adulthood		

## MEDICATION LOG

Please indicate the type of medications you are taking now. Please include non-prescription drugs.

Medication Name	Date started	Dated Stopped	Dosage	Frequency

## SUPPLEMENT LOG

Supplements: List all vitamins, minerals and other nutritional supplements

Supplement Name/Brand	Dose	Frequency	Dated Started	Reason for use

Have your medications or supplements ever caused you unusual side effects or problems?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ALLERGIES**

Please indicate any allergies and their reactions

<b>Food/Medication/Supplement/Environmental</b>	<b>Reaction</b>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever had an allergy test done? Yes\_\_\_\_ No\_\_\_\_

Have you ever received medical treatment or hospitalization for an allergic reaction? Please describe.

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

## NUTRITION & LIFESTYLE HISTORY

Height (feet/inches) \_\_\_\_\_ Current Weight \_\_\_\_\_

Usual weight range +/- 5 lbs \_\_\_\_\_ Desired Weight range +/- 5 lbs \_\_\_\_\_

Highest adult weight \_\_\_\_\_ Lowest adult weight \_\_\_\_\_

Weight fluctuations (>10lbs) Yes \_\_\_\_\_ No \_\_\_\_\_ Body Fat % \_\_\_\_\_

How often do you weigh yourself? Daily \_\_\_\_\_ Weekly \_\_\_\_\_ Monthly \_\_\_\_\_ Rarely \_\_\_\_\_ Never \_\_\_\_\_

Have you made any changes in your eating habits because of your health? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you currently follow a special diet or nutritional program? Yes \_\_\_\_\_ No \_\_\_\_\_

*Check all that apply:*

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Low fat  | <input type="checkbox"/> Gluten restricted       | <input type="checkbox"/> The Zone Diet             |
| <input type="checkbox"/> Mixed food diet (animal and vegetable sources)           | <input type="checkbox"/> Low sodium              | <input type="checkbox"/> Total calorie restriction |
| <input type="checkbox"/> High protein   | <input type="checkbox"/> Fat restriction         | <input type="checkbox"/> Ovo-lacto diet            |
| <input type="checkbox"/> Vegetarian   | <input type="checkbox"/> Low starch/carbohydrate | <input type="checkbox"/> Diabetic                  |
| <input type="checkbox"/> Vegan  | <input type="checkbox"/> The Blood type Diet     | <input type="checkbox"/> No dairy                  |
| <input type="checkbox"/> Specific Program for Weight Loss/Maintenance Type: _____ | <input type="checkbox"/> Metabolic Typing Diet   | <input type="checkbox"/> No wheat                  |

**Please check any specific food restrictions you have:**

- |                                      |                                |                                     |
|--------------------------------------|--------------------------------|-------------------------------------|
| <input type="checkbox"/> Dairy       | <input type="checkbox"/> Wheat | <input type="checkbox"/> Eggs       |
| <input type="checkbox"/> Soy         | <input type="checkbox"/> Corn  | <input type="checkbox"/> All gluten |
| <input type="checkbox"/> Other _____ |                                |                                     |

Is there anything special about your diet that I should know?

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Do you feel you have **delayed** symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? Yes \_\_\_\_\_ No \_\_\_\_\_

If you could only eat a few foods a week, what would they be? \_\_\_\_\_

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Do you grocery Shop? Yes \_\_\_\_\_ No \_\_\_\_\_ If no, who does the shopping? \_\_\_\_\_

When you shop do you purchase the following?

- |  |  |
|--|--|
| <input type="checkbox"/> Organic Foods | <input type="checkbox"/> Hormone free and antibiotic free meat |
|--|--|

Do you read food labels? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you Cook? Yes \_\_\_\_\_ No \_\_\_\_\_ If no, who does the cooking? \_\_\_\_\_

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

Which is your biggest meal?  Breakfast  Lunch  Dinner

Check all 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 or food preferences |
| <input type="checkbox"/> Erratic eating habits  | <input type="checkbox"/> Love to eat  |
| <input type="checkbox"/> Eat too much   | <input type="checkbox"/> Eat because I have to  |
| <input type="checkbox"/> Late night eater   | <input type="checkbox"/> Have a negative relationship to food   |
| <input type="checkbox"/> Dislike health food  | <input type="checkbox"/> Struggle with eating issues  |
| <input type="checkbox"/> Time constraints   | <input type="checkbox"/> Emotional eater (eat when sad, lonely, depressed, bored)                           |
| <input type="checkbox"/> Eat more than 50% of meals away from home                    | <input type="checkbox"/> Eat too much under stress  |
| <input type="checkbox"/> Travel frequently  | <input type="checkbox"/> Eat too little under stress  |
| <input type="checkbox"/> Non-availability of healthy foods                            | <input type="checkbox"/> Don't care to cook   |
| <input type="checkbox"/> Do not plan meals or menus                                   | <input type="checkbox"/> Eating in the middle of the night  |
| <input type="checkbox"/> Reliance on convenience items                                | <input type="checkbox"/> Confused about nutritional advice  |
| <input type="checkbox"/> Poor snack choices   | <input type="checkbox"/> Diet often for weight control  |
| <input type="checkbox"/> Significant other or family members don't like healthy foods |   |

## FOOD DIARY

Place a check mark next to the food/drink that applies to your current diet.

Usual Breakfast	Usual Lunch	Usual Dinner
<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> None
<input type="checkbox"/> Bacon/Sausage	<input type="checkbox"/> Butter	<input type="checkbox"/> Beans (legumes)
<input type="checkbox"/> Bagel	<input type="checkbox"/> Coffee	<input type="checkbox"/> Brown rice
<input type="checkbox"/> Butter	<input type="checkbox"/> Eat in a cafeteria	<input type="checkbox"/> Butter
<input type="checkbox"/> Cereal	<input type="checkbox"/> Eat in restaurant	<input type="checkbox"/> Carrots
<input type="checkbox"/> Coffee	<input type="checkbox"/> Fast Food	<input type="checkbox"/> Coffee
<input type="checkbox"/> Donut	<input type="checkbox"/> Fish sandwich	<input type="checkbox"/> Fish
<input type="checkbox"/> Eggs	<input type="checkbox"/> Fried foods	<input type="checkbox"/> Green vegetables
<input type="checkbox"/> Fruit	<input type="checkbox"/> Hamburger	<input type="checkbox"/> Juice
<input type="checkbox"/> Juice	<input type="checkbox"/> Hot dogs	<input type="checkbox"/> Margarine
<input type="checkbox"/> Margarine	<input type="checkbox"/> Juice	<input type="checkbox"/> Milk
<input type="checkbox"/> Milk	<input type="checkbox"/> Leftovers	<input type="checkbox"/> Pasta
<input type="checkbox"/> Oat bran	<input type="checkbox"/> Margarine	<input type="checkbox"/> Potato
<input type="checkbox"/> Sugar	<input type="checkbox"/> Mayo	<input type="checkbox"/> Poultry
<input type="checkbox"/> Sweet roll	<input type="checkbox"/> Meat sandwich	<input type="checkbox"/> Red meat
<input type="checkbox"/> Sweetener	<input type="checkbox"/> Milk	<input type="checkbox"/> Rice
<input type="checkbox"/> Tea	<input type="checkbox"/> Pizza	<input type="checkbox"/> Salad
<input type="checkbox"/> Toast	<input type="checkbox"/> Potato chips	<input type="checkbox"/> Salad dressing
<input type="checkbox"/> Water	<input type="checkbox"/> Salad	<input type="checkbox"/> Soda
<input type="checkbox"/> Wheat bran	<input type="checkbox"/> Shake _____	<input type="checkbox"/> Sugar
<input type="checkbox"/> Yogurt	<input type="checkbox"/> Soda	<input type="checkbox"/> Sweetener
<input type="checkbox"/> Oat meal	<input type="checkbox"/> Soup	<input type="checkbox"/> Tea
<input type="checkbox"/> Protein shake _____	<input type="checkbox"/> Sugar	<input type="checkbox"/> Vinegar
<input type="checkbox"/> Slim fast	<input type="checkbox"/> Sweetener	<input type="checkbox"/> Water
<input type="checkbox"/> Carnation shake	<input type="checkbox"/> Tea	<input type="checkbox"/> White rice
<input type="checkbox"/> Other: (List below)	<input type="checkbox"/> Vegetables	<input type="checkbox"/> Yellow vegetables
	<input type="checkbox"/> Water	<input type="checkbox"/> Other: (List below)
	<input type="checkbox"/> Yogurt	
	<input type="checkbox"/> Other:	

**Check foods/drinks that you consume at least 3 days or more each week.**

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Almonds                 | <input type="checkbox"/> Deli Meats       | <input type="checkbox"/> Oyster             | <input type="checkbox"/> Walnut         |
| <input type="checkbox"/> Almond Butter           | <input type="checkbox"/> Desserts         | <input type="checkbox"/> Orange             | <input type="checkbox"/> Waffles        |
| <input type="checkbox"/> Alcohol                 | <input type="checkbox"/> Deli Sandwich    | <input type="checkbox"/> Papaya             | <input type="checkbox"/> Whitefish      |
| <input type="checkbox"/> Apples                  | <input type="checkbox"/> Dolphin          | <input type="checkbox"/> Parsley            | <input type="checkbox"/> Wheat          |
| <input type="checkbox"/> Avocado                 | <input type="checkbox"/> Eggplant         | <input type="checkbox"/> PopTarts           | <input type="checkbox"/> Yeast, Bakers  |
| <input type="checkbox"/> Asparagus               | <input type="checkbox"/> Ensure           | <input type="checkbox"/> Peanuts            | <input type="checkbox"/> Yeast, Brewers |
| <input type="checkbox"/> Bagels                  | <input type="checkbox"/> Flying fish      | <input type="checkbox"/> Peanut butter      | <input type="checkbox"/> Yogurt         |
| <input type="checkbox"/> Belly Pumpkin           | <input type="checkbox"/> Fried Foods      | <input type="checkbox"/> Peas               | <input type="checkbox"/> Yam            |
| <input type="checkbox"/> Barley                  | <input type="checkbox"/> French Fries     | <input type="checkbox"/> Peach              | <input type="checkbox"/> Zucchini       |
| <input type="checkbox"/> Banana                  | <input type="checkbox"/> French Toast     | <input type="checkbox"/> Pecan              |   |
| <input type="checkbox"/> Bacon                   | <input type="checkbox"/> Garlic           | <input type="checkbox"/> Pepper Sauce       |   |
| <input type="checkbox"/> Bread Fruit             | <input type="checkbox"/> Ginger           | <input type="checkbox"/> Perch              |   |
| <input type="checkbox"/> Bread, White            | <input type="checkbox"/> Grape            | <input type="checkbox"/> Pineapple          |   |
| <input type="checkbox"/> Bread, Wheat            | <input type="checkbox"/> Greek Food       | <input type="checkbox"/> Pancakes           |   |
| <input type="checkbox"/> Bread, Rye              | <input type="checkbox"/> Grapefruit       | <input type="checkbox"/> Protein Shakes     |   |
| <input type="checkbox"/> Biscuits                | <input type="checkbox"/> Grape nuts       |   |   |
| <input type="checkbox"/> Bean, Pinto             | <input type="checkbox"/> Haddock          | <input type="checkbox"/> Plum               |   |
| <input type="checkbox"/> Bean, String            | <input type="checkbox"/> Ham              | <input type="checkbox"/> Pork               |   |
| <input type="checkbox"/> Broccoli                | <input type="checkbox"/> Halibut          | <input type="checkbox"/> Peanut             |   |
| <input type="checkbox"/> Brazil Nuts             | <input type="checkbox"/> Herring          | <input type="checkbox"/> Potato, sweet      |   |
| <input type="checkbox"/> Brussels Sprouts        | <input type="checkbox"/> Hot Dogs, Pork   | <input type="checkbox"/> Potato, White      |   |
| <input type="checkbox"/> Blueberries             | <input type="checkbox"/> Hot Dogs, Beef   | <input type="checkbox"/> Pumpkin            |   |
| <input type="checkbox"/> Butter                  | <input type="checkbox"/> Hamburgers       | <input type="checkbox"/> Quinoa             |   |
| <input type="checkbox"/> Cabbage                 | <input type="checkbox"/> Honey            | <input type="checkbox"/> Radish             |   |
| <input type="checkbox"/> Cereal                  | <input type="checkbox"/> Italian Food     | <input type="checkbox"/> Rye                |   |
| <input type="checkbox"/> Celery                  | <input type="checkbox"/> Ice Cream        | <input type="checkbox"/> Safflower          |   |
| <input type="checkbox"/> Cantaloupe              | <input type="checkbox"/> Indian Food      | <input type="checkbox"/> Sage               |   |
| <input type="checkbox"/> Candy                   | <input type="checkbox"/> Japanese Food    | <input type="checkbox"/> Salt               |   |
| <input type="checkbox"/> Chefette                | <input type="checkbox"/> Jelly            | <input type="checkbox"/> Salmon             |   |
| <input type="checkbox"/> Chinese Food            | <input type="checkbox"/> Ketchup          | <input type="checkbox"/> Scallops           |   |
| <input type="checkbox"/> Cream                   | <input type="checkbox"/> KFC              | <input type="checkbox"/> Sausage            |   |
| <input type="checkbox"/> Cheese                  | <input type="checkbox"/> Lamb             | <input type="checkbox"/> Souse              |   |
| <input type="checkbox"/> Carrot                  | <input type="checkbox"/> Lemon            | <input type="checkbox"/> Slim Fast          |   |
| <input type="checkbox"/> Chicken                 | <input type="checkbox"/> Lentil           | <input type="checkbox"/> Sweet & Low        |   |
| <input type="checkbox"/> Chili Pepper            | <input type="checkbox"/> Lettuce          | <input type="checkbox"/> Sesame             |   |
| <input type="checkbox"/> Cinnamon                | <input type="checkbox"/> Lime             | <input type="checkbox"/> Shrimp             |   |
| <input type="checkbox"/> Clam                    | <input type="checkbox"/> Lima Beans       | <input type="checkbox"/> Snapper            |   |
| <input type="checkbox"/> Cloves                  | <input type="checkbox"/> Lobster          | <input type="checkbox"/> Soft Drinks        |   |
| <input type="checkbox"/> Cocoa-Chocolate         | <input type="checkbox"/> Mackerel         | <input type="checkbox"/> Sole               |   |
| <input type="checkbox"/> Carnation Drink         | <input type="checkbox"/> Margarine        | <input type="checkbox"/> Sour cream         |   |
| <input type="checkbox"/> Chewing gum, sweetened  | <input type="checkbox"/> Millet           | <input type="checkbox"/> Soybean            |   |
| <input type="checkbox"/> Chewing gum, sugar free | <input type="checkbox"/> Mung Bean        | <input type="checkbox"/> Spinach            |   |
| <input type="checkbox"/> Coconut                 | <input type="checkbox"/> Mushroom         | <input type="checkbox"/> Strawberry         |   |
| <input type="checkbox"/> Cod                     | <input type="checkbox"/> Mustard          | <input type="checkbox"/> Sucralose          |   |
| <input type="checkbox"/> Coffee                  | <input type="checkbox"/> Milk, Cow        | <input type="checkbox"/> Sugar              |   |
| <input type="checkbox"/> Corn                    | <input type="checkbox"/> Milk, Goat       | <input type="checkbox"/> Sunflower          |   |
| <input type="checkbox"/> Crab                    | <input type="checkbox"/> Milk, Rice       | <input type="checkbox"/> Salads             |   |
| <input type="checkbox"/> Cranberry               | <input type="checkbox"/> Milk, Almond     | <input type="checkbox"/> Sardines           |   |
| <input type="checkbox"/> Cashew                  | <input type="checkbox"/> Milk, Soy        | <input type="checkbox"/> Sweet Peppers      |   |
| <input type="checkbox"/> Cheese                  | <input type="checkbox"/> Mexican Food     | <input type="checkbox"/> Squash             |   |
| <input type="checkbox"/> Cucumber                | <input type="checkbox"/> Malt             | <input type="checkbox"/> Tea, Black         |   |
|  | <input type="checkbox"/> Nutmeg           | <input type="checkbox"/> Tea, Decaffeinated |   |
|  | <input type="checkbox"/> NutriSweet       | <input type="checkbox"/> Thai food          |   |
|  | <input type="checkbox"/> Oatmeal, Regular | <input type="checkbox"/> Tomato             |   |
|  | <input type="checkbox"/> Oatmeal, Instant | <input type="checkbox"/> Tuna               |   |
|  | <input type="checkbox"/> Olive            | <input type="checkbox"/> Turkey             |   |
|  | <input type="checkbox"/> Onion            | <input type="checkbox"/> Tangerine          |   |
|  | <input type="checkbox"/> Orange Juice     | <input type="checkbox"/> Vinegar            |   |
|  | <input type="checkbox"/> Oregano          |   |   |

**What snacks do you eat or drink between:**

Breakfast & Lunch: \_\_\_\_\_

Lunch & Dinner: \_\_\_\_\_

After Dinner: \_\_\_\_\_

**How much of the following do you consume each day/week?**

ITEM	Daily	Weekly	Favorite Type
Candy			
Cheese			
Chocolate			
Cups of caffeinated coffee			
Cups of decaffeinated coffee or tea			
Cups of hot chocolate			
Cups of caffeinated tea			
Diet sodas (12-ounce can/bottle)			
Sodas with caffeine (12-ounce can/bottle)			
Sodas without caffeine (12-ounce can/bottle)			
Energy Drinks (12-ounce can/bottle)			
Ice cream			
Salty foods			
Slices of white bread (rolls/bagels)			

**Water:** Glasses/day\_\_\_ **Type:** Tap:\_\_\_ Distilled:\_\_\_ Spring:\_\_\_ Well:\_\_\_ Reverse Osmosis:\_\_\_

Do you feel **worse** when you eat a lot of:

- |  |  |
|--|--|
| <input type="checkbox"/> High fat foods                                    | <input type="checkbox"/> Refined sugar (junk food) |
| <input type="checkbox"/> High protein foods                                | <input type="checkbox"/> Fried foods               |
| <input type="checkbox"/> High carbohydrate foods (breads, pasta, potatoes) | <input type="checkbox"/> 1 or 2 alcoholic drinks   |
|  | <input type="checkbox"/> Other _____               |

Do you feel **better** when you eat a lot of:

- |  |  |
|--|--|
| <input type="checkbox"/> High fat foods                                    | <input type="checkbox"/> Refined sugar (junk food) |
| <input type="checkbox"/> High protein foods                                | <input type="checkbox"/> Fried foods               |
| <input type="checkbox"/> High carbohydrate foods (breads, pasta, potatoes) | <input type="checkbox"/> 1 or 2 alcoholic drinks   |
|  | <input type="checkbox"/> Other _____               |

Does skipping meals greatly affect your symptoms? Yes \_\_\_\_\_ No \_\_\_\_\_

Has there ever been a food that you have craved or really "pigged out" on over a period of time?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what food(s) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are there certain foods you do not like? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what food(s) \_\_\_\_\_

\_\_\_\_\_

## TOBACCO HISTORY

Currently using tobacco? Yes \_\_\_\_\_ No \_\_\_\_\_ How many years? \_\_\_\_\_ Packs per day: \_\_\_\_\_

If yes, what type? Cigarette \_\_\_\_\_ Smokeless \_\_\_\_\_ Cigar \_\_\_\_\_ Pipe \_\_\_\_\_ Patch/Gum \_\_\_\_\_

Attempts to quit: \_\_\_\_\_

Previous smoking: How many years? \_\_\_\_\_ Packs per day: \_\_\_\_\_

Are you exposed to 2<sup>nd</sup> hand smoke? If yes, please explain: \_\_\_\_\_

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## ALCOHOL INTAKE

How many drinks currently per week? *1 drink = 5 ounces wine, 12 oz. beer, 1.5 ounces spirits*

None \_\_\_\_\_ 1-3 \_\_\_\_\_ 4-6 \_\_\_\_\_ 7-10 \_\_\_\_\_ >10 \_\_\_\_\_ *If none skip to "Other Substances"*

Previous alcohol intake? Yes \_\_\_\_\_ (Mild \_\_\_\_\_ Moderate \_\_\_\_\_ High \_\_\_\_\_)

Have you ever been told to 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 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 \_\_\_\_\_

Was your mother an alcoholic? \_\_\_\_\_ Father? \_\_\_\_\_ Other family member? \_\_\_\_\_

## OTHER SUBSTANCES

Are you currently using recreational drugs? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what types?: \_\_\_\_\_

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

If yes, what types?: \_\_\_\_\_

## EXERCISE

Current Exercise program: *Activity (list type, number of sessions/week, and duration of activity)*

Activity	Type	Frequency per week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength Training			
Other (Pilates, yoga, etc.)			
Sports or Leisure Activities (golf, tennis, rollerblading etc.)			

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

List problems that limit activity: \_\_\_\_\_

Do you feel unusually fatigued after exercise? Yes \_\_\_\_\_ No \_\_\_\_\_

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

Do you usually sweat when exercising? Yes \_\_\_ No \_\_\_

## SOCIAL HISTORY

### 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 \_\_\_\_\_

Do you spend the majority of your time and money to fulfill responsibilities and obligations?  
Yes \_\_\_\_\_ No \_\_\_\_\_

Would you describe your childhood experience as happy and secure? Yes \_\_\_\_\_ No \_\_\_\_\_

### STRESS/COPING

Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress, illness, and immune system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life it is very important that you feel safe telling us about it, so that we can support you and optimize your treatment outcomes.

Please do your best to answer the following questions:

Have you or your family recently experienced any major life changes? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please comment: \_\_\_\_\_

Have you experienced any major losses in life? Yes \_\_\_\_ No \_\_\_\_

If so, please comment: \_\_\_\_\_

Have you ever been involved in abusive relationships in your life? Yes \_\_\_\_ No \_\_\_\_

Was alcoholism or substance abuse present in your childhood home? Yes \_\_\_\_ No \_\_\_\_

Is alcoholism or substance abuse present in your relationships now? Yes \_\_\_\_ No \_\_\_\_

Have you ever sought counseling? Yes \_\_\_\_ No \_\_\_\_

Currently? Yes \_\_\_\_ No \_\_\_\_ Previously? Yes \_\_\_\_ No \_\_\_\_ If previously from \_\_\_\_ to \_\_\_\_

What kind? \_\_\_\_\_

Comments: \_\_\_\_\_

Do you feel you have an excessive amount of stress in your life? Yes \_\_\_\_ No \_\_\_\_

Do you feel you can easily handle the stress in your life? Yes \_\_\_\_ No \_\_\_\_

Daily stressors: *Rate on a scale of 1 – 10 (1 not stressful - 10 very stressful)*

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

Do you practice meditation or relaxation techniques? Yes \_\_\_\_ No \_\_\_\_ How often? \_\_\_\_\_

Check all that apply:

Yoga  Meditation  Imagery  Breathing  Tai Chi  Prayer  Other

Hobbies and leisure activities: \_\_\_\_\_

How important is religion (or spirituality) for you and your family's life?

a. \_\_\_\_ not at all important      b. \_\_\_\_ somewhat important      c. \_\_\_\_ extremely important

Have you ever been abused, a victim of a crime, or experienced a significant trauma?

Yes \_\_\_\_ No \_\_\_\_

How well have things been going for you?

	Very well	Fine	Poorly	Very poorly	Does not apply
At school					
In your job					
In your social life					
With close friends					
With sex					
With your attitude					
With your boyfriend/girlfriend					
With your children					
With your parents					
With your spouse					

Which of the following provide you emotional support? *Check all that apply*

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

## STRESS EVALUATION

This section of the questionnaire is an assessment of stressors and related stress symptoms and complaints. Check all that apply to you and indicate the duration of the symptoms. Please ignore the scoring as we will complete for you.

Symptom	Score	Duration (years)			Score
		½	1	2	
<input type="checkbox"/> Excessive Fatigue	10	½	1	2	_____
<input type="checkbox"/> Dry & Thin Skin	10	½	1	2	_____
<input type="checkbox"/> Nervous/Irritability	9	½	1	2	_____
<input type="checkbox"/> Low body temperature	8	½	1	2	_____
<input type="checkbox"/> Premenstrual tension	8	½	1	2	_____
<input type="checkbox"/> Inability to concentrate	8	½	1	2	_____
<input type="checkbox"/> Mental depression	8	½	1	2	_____
<input type="checkbox"/> Food allergies & sensitivities	7	½	1	2	_____
<input type="checkbox"/> Craving for sweets	7	½	1	2	_____
<input type="checkbox"/> Headaches	6	½	1	2	_____
<input type="checkbox"/> Alcohol intolerance	6	½	1	2	_____
<input type="checkbox"/> Poor memory	5	½	1	2	_____
<input type="checkbox"/> Heart palpitations	5	½	1	2	_____
<b>TOTAL SCORE</b>					_____

Do you have chronic pain?  Yes  No

Do you have chronic inflammation?  Yes  No

## SOCIAL READJUSTMENT RATING SCALE\*

Check YES or NO to each life event in this list that happened in the **last twelve months**.  
Please ignore the points as that will be completed for you.

Life Event	Answer		Points
Death of spouse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	100
Divorce	<input type="checkbox"/> Yes	<input type="checkbox"/> No	73
Marital separation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	65
Jail term	<input type="checkbox"/> Yes	<input type="checkbox"/> No	63
Death of close family member	<input type="checkbox"/> Yes	<input type="checkbox"/> No	63
Personal injury or illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	53
Marriage	<input type="checkbox"/> Yes	<input type="checkbox"/> No	50
Fired from work	<input type="checkbox"/> Yes	<input type="checkbox"/> No	47
Marital reconciliation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	45
Retirement	<input type="checkbox"/> Yes	<input type="checkbox"/> No	45
Change in family members health	<input type="checkbox"/> Yes	<input type="checkbox"/> No	44
Pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	40
Sex difficulties	<input type="checkbox"/> Yes	<input type="checkbox"/> No	39
Addition to family	<input type="checkbox"/> Yes	<input type="checkbox"/> No	39
Business readjustment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	39
Change in financial status	<input type="checkbox"/> Yes	<input type="checkbox"/> No	38
Death of close friend	<input type="checkbox"/> Yes	<input type="checkbox"/> No	37
Change in line of work	<input type="checkbox"/> Yes	<input type="checkbox"/> No	36
Change in # of marital arguments	<input type="checkbox"/> Yes	<input type="checkbox"/> No	35
Mortgage or loan over \$10,000	<input type="checkbox"/> Yes	<input type="checkbox"/> No	31
Foreclosure of mortgage or loan	<input type="checkbox"/> Yes	<input type="checkbox"/> No	30
Change in work responsibilities	<input type="checkbox"/> Yes	<input type="checkbox"/> No	29
Son or daughter leaving home	<input type="checkbox"/> Yes	<input type="checkbox"/> No	29
Trouble with in-laws	<input type="checkbox"/> Yes	<input type="checkbox"/> No	29
Outstanding personal achievement	<input type="checkbox"/> Yes	<input type="checkbox"/> No	28
Spouse begins or stops work	<input type="checkbox"/> Yes	<input type="checkbox"/> No	26
Starting or finishing school	<input type="checkbox"/> Yes	<input type="checkbox"/> No	26
Change in living conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	25

Revision of personal habits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	24
Trouble with boss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	23
Change in work hours, conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	20
Change in residence	<input type="checkbox"/> Yes	<input type="checkbox"/> No	20
Change in schools	<input type="checkbox"/> Yes	<input type="checkbox"/> No	20
Change in recreational habits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	19
Mortgage or loan under \$10,000	<input type="checkbox"/> Yes	<input type="checkbox"/> No	18
Change in sleeping habits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	16
Change in eating habits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	15
Vacation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	13
<b>TOTAL SCORE</b>			_____

\* Holmes, TH and Rahe, RH Booklet for Schedule of Recent Experience (SRE) Seattle, University of Washington, 1967

## TOXIC STRESS TRIGGERS

(These refer to on-going stress that has accumulated over months or years. Please mark any of the above that you have experienced in your lifetime)

- Childhood traumas
- Perfectionism
- Divorce or change in a relationship
- Care giving: *taking care of a sick family member*
- Job or career challenges
- Illness, either short-term or chronic
- Dieting: *constantly trying a new and improved diet program*
- Menopause

### DO YOU WORRY OVER?

- Home life
- Marriage
- Children
- Job
- Income

### IS YOUR LIFE:

- Satisfactory
- Boring
- Demanding
- Unsatisfactory
- Money Problems

## SLEEP/REST

Average number of hours you sleep  >10  8 – 10  6 – 8  <6

Do you have trouble falling asleep? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you feel rested upon awakening? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have problems with insomnia? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you snore? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you use sleeping aids? Yes \_\_\_\_\_ No \_\_\_\_\_ Explain: \_\_\_\_\_

## ENVIRONMENTAL INFLUENCES

There are over 70,000 chemicals commercially produced in the United States. The long-term effects of many of these chemicals have never been investigated. But many chemicals are harmful in very low doses. Unless generated by the body (formaldehyde, pentane), the body's level for chemicals should be non-detectable, and not "low level". Chemicals are widespread in our environment, and constant exposure to low levels can cause dysfunction in many systems of the body. The purpose in the following questions is to determine if any of your health problems can be a result of chemical toxicity and to measure your **TOTAL TOXIN LOAD**.

### Electromagnetic Factors

- Live or have you lived within 200 yards from high-voltage wires or transformers  
When? \_\_\_\_\_
- Live or have lived near an electric distribution substation
- Bed is close to the main electrical current
- Have a fan directly over your bed
- Have an alarm clock or radio close to your bed (plugged in)
- Live or have you lived near a television transmitter
- Sleep with an electric blanket, heating pad
- Sleep on a waterbed

### Position of your head of your bed is facing:

- North
- South
- East
- West
- Work on a computer for longer than six hours/day
- Use a screening shield over your computer screen
- Live or have you lived near a power generating station
- Live near a radio tower
- You use a cellular phone more than 2 hours per day
- Use microwave ovens
- Bed has a wooden backboard
- Have fluorescent light fixtures

### Toxin Exposure

#### Trichloroethylene/TCE

- Work close to a copy machine
- Worked in a printing shop
- Drink decaffeinated coffee
- Use typewriter correction fluid
- Use rug cleaners
- Use disinfectants
- Use carbonless paper
- Use spot removers
- Use cleaning supplies
- Use metal degreasers
- Do recreational painting

#### Formaldehyde

- Wear many dry-cleaned clothes
- Noticed changes of your health since you moved into your home
- Wear many polyester clothes and permanent press
- You use Spray Starch
- Have foam wall insulation
- Have particleboard, chip board or interior plywood
- Put up wallpaper in the last 2 years
- Have foam cushions or foam mattresses
- Live or lived in a trailer
- Worked in a laboratory
- Your home been insulated since your illness
- Had new carpets.  
When? \_\_\_\_\_
- Use waxes and polishes on your floor
- Been around resin glues and plastics
- Have exterior grade plywood on your home
- Home made of stucco, plaster or concrete
- Have a wood-burning stove
- Have draperies

- Have used acid-cured resin floor finishes
- Have fire-proof material in your home
- Smoke in your home
- Have a photography darkroom
- Use nail polish remover
- Use fingernail hardeners

**Pesticides & Herbicides**

**(Organochlorines, Organophosphate, Carbamate, Chlorinated Cyclodiene, Botanical & Microbial)**

- Use pesticides
- Use weed killer
- You use cleaning fluids, waxes
- Lived or worked at a dry cleaning plant
- Have been around wood preservatives
- Drink tap water
- Work with electrical equipment
- Have mothballs in your closets
- Gasoline fumes bother you
- Eat store bought meat
- Use insecticides
- Crop-surface sprays
- Aerosols
- Fumigants

**Volatile Organic Compounds**

**(Paradichlorobenzenes, toluene, ethers, ketones, propane, polymers, tetrachloroethylene)**

- Had home painted in the last 2 years
- Use cleaning solvents
- Have soft vinyl floors
- Handle propane and butane
- Get your clothes dry-cleaned
- Store dry-cleaned clothes in closets
- Barbecue more than 2 times per month
- Work in a "tightly sealed building"
- Work close to a laser printer
- Use moth balls
- Have nylon carpet
- Use air fresheners
- Have a workshop in the home

**Phenols**

Do you use the following?

- Household cleaners

- Nasal Sprays
- Styrofoam cups
- Cough Syrup
- Decongestants
- Hair sprays
- Scented deodorants
- Scotch tape
- Newsprint
- Lysol
- Epoxy
- Listerine
- Chloraseptic throat sprays
- Noxema
- Mildew cleaners
- Perfumes
- Air Fresheners
- Disinfectants
- Polishes
- Glues
- Waxes
- Mouthwash
- Hard saucepan handles
- Smoke in the house
- Have you been exposed to chemicals? When? \_\_\_\_\_
- Have you had your home treated for termites? When? \_\_\_\_\_
- Wash own vehicle by hand. What type of cleaners do you use? \_\_\_\_\_

**Carbon Monoxide/Nitrogen Oxide/Sulfur Dioxide**

- Have oil or gas stove
- Have water heaters
- Chimney is damaged
- Live near a busy street
- Garage attached to your home
- Smoke at home
- Have an open fireplace

**Ozone**

- Use an electrical sewing machine
- Use power tools
- Use ion generators

- Work close to a photocopier

### Carbon Dioxide

- Work in a crowded work place
- Have poor ventilation at work

### Asbestos

- Live in an old home
- Have old ceiling tiles, plaster, insulation board and heating duct tape
- Lived in a large city with many trucks, buses etc.
- Lived near a building which was torn down
- Mother exposed to any unusual chemicals or drugs during pregnancy (DES)
- Do you have acrylic nails?

### Please note the "brand" of product you use

For example: Toothpaste: Crest

Shampoo: \_\_\_\_\_

Toothpaste: \_\_\_\_\_

Hair Conditioner: \_\_\_\_\_

Makeup: \_\_\_\_\_

Lipstick: \_\_\_\_\_

Make-up Foundation: \_\_\_\_\_

Deodorant: \_\_\_\_\_

Perfume: \_\_\_\_\_

Hairspray: \_\_\_\_\_

Shaving Cream: \_\_\_\_\_

Cologne: \_\_\_\_\_

Facial Creams: \_\_\_\_\_

Body Creams: \_\_\_\_\_

Do you have hair weave ? O Yes O No  
If yes, how often? \_\_\_\_\_

Do you color your hair? O Yes O No  
If yes, was it permanent\_\_ or temporary?\_\_

### Do you use Latex products?

- Baby bottle nipples
- Balloons
- Bandages
- Diaphragms
- Hot water bottles
- Latex gloves
- Dishwashing gloves
- Rubber dams for dental work
- Tires

- Worked in a rubber industry

### General Miscellaneous

- Have basement Molds
- Home is damp
- Use a humidifier? If yes, when the last time you cleaned it? \_\_\_\_\_
- Use black hair dye (Nitrosamines)
- Worked in beauty shop.  
When? \_\_\_\_\_
- Take any illicit drugs as an adolescent/young adult?  
What type? \_\_\_\_\_
- Open your windows at home
- Work in a machine shop
- Work in a garden?
- Work or have you worked on a farm  
When? \_\_\_\_\_
- Have mercury fillings
- Had mercury fillings removed?  
When? \_\_\_\_\_
- Been exposed to radiation  
When? \_\_\_\_\_
- Have a hot tub
- Use chlorine or bromine
- Have a well
- Work around PVC pipe (Vinyl chloride)
- Home well ventilated
- Moved to a new office in the last two years
- Live in an apartment?  
How old? \_\_\_\_\_
- Eat at salad bars
- Eat raw fish (Sushi)
- Buy food from street vendors
- For Women:** Have breast implants. The implant was made of saline \_\_\_ silicone\_\_\_
- Has any type of metal been used in implants or joint replacements in your body?  
What type? \_\_\_\_\_  
Where \_\_\_\_\_
- Notice more symptoms at work than at home or vice versa?
- Symptoms worse going into a mall
- Have you ever worked in a mall?  
When? \_\_\_\_\_
- Have live plants in your home
- Have pets in your home

- Owned a new vehicle since your symptoms began
- Furniture been put in storage or possibly fumigated
- Stained furniture in the last 2 years
- Have a tool shop in your garage
- Live on or near a golf course
- Live in or near an industrial area
- Lived or traveled outside the US.  
Where? \_\_\_\_\_
- Bought new furniture?  
What type of material? \_\_\_\_\_
- Installed drop ceilings
- Painted indoors
- Sided your home
- Changed your heating system, stove, clothes dryer  
or water heater
- Lived in a brand new home
- Lived in a new office
- Noticed changes of your health since you moved into  
your home?
- Have a water purification system?
- Live near a landfill?
- Have a water filter on your shower?

### Describe the contents of your bedroom

- What type of mattress? \_\_\_\_\_
- Have hardwood floors
- Have carpeting
- Have blinds
- Have draperies
- Use a foam pillow
- Use a feather pillow
- Use a Dacron pillow
- Use wool blankets
- Use cotton blankets
- Use quilts
- Use synthetic blankets

- Use an electric blanket
- Have a ceiling fan
- Have material under your bed
- Have real plants in your bedroom
- Have artificial plants in your bedroom
- Use aromatherapy in your bedroom
- Burn scented candles in your bedroom
- Have central heat
- Have a fireplace in your room
- Have an electric baseboard
- Use gas heat
- Use an air filter in your bedroom  
What type? \_\_\_\_\_
- When was the last time you changed your filter in  
your room? \_\_\_\_\_
- Have central air conditioning
- Sleep with your windows open
- Live close to a high traffic road
- Smoke in bed
- Allow any pets in your room  
What type? \_\_\_\_\_
- Have plugged in air fresheners

### Art and Leisure Activities

- Silk-screening
- Make stained glass
- Make pottery & ceramic products
- Make jewelry
- Buy art and craft supplies
- Use airbrush and spray paints
- Do quilting and weaving
- Gardening
- Make soapstone carvings
- Use acrylic paint

## READINESS ASSESSMENT

Rate on a scale of: 5 (very willing) to 1 (not willing).

In order to improve your health, how willing are you to:

Significantly modify your diet – 5 \_\_\_\_\_ 4 \_\_\_\_\_ 3 \_\_\_\_\_ 2 \_\_\_\_\_ 1 \_\_\_\_\_

Take several nutritional supplements each day– 5 \_\_\_\_\_ 4 \_\_\_\_\_ 3 \_\_\_\_\_ 2 \_\_\_\_\_ 1 \_\_\_\_\_

Keep a record of everything you eat each day – 5 \_\_\_\_\_ 4 \_\_\_\_\_ 3 \_\_\_\_\_ 2 \_\_\_\_\_ 1 \_\_\_\_\_

Modify your lifestyle (e.g. work demands, sleep habits) – 5 \_\_\_\_\_ 4 \_\_\_\_\_ 3 \_\_\_\_\_ 2 \_\_\_\_\_ 1 \_\_\_\_\_

Practice relaxation techniques – 5 \_\_\_\_\_ 4 \_\_\_\_\_ 3 \_\_\_\_\_ 2 \_\_\_\_\_ 1 \_\_\_\_\_

Engage in regular exercise – 5 \_\_\_\_\_ 4 \_\_\_\_\_ 3 \_\_\_\_\_ 2 \_\_\_\_\_ 1 \_\_\_\_\_

Have periodic lab tests to assess progress – 5 \_\_\_\_\_ 4 \_\_\_\_\_ 3 \_\_\_\_\_ 2 \_\_\_\_\_ 1 \_\_\_\_\_

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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

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

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? – 5 \_\_\_\_\_ 4 \_\_\_\_\_ 3 \_\_\_\_\_ 2 \_\_\_\_\_ 1 \_\_\_\_\_

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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

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

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Thank you** for taking the time to complete this health history medical questionnaire.

The information derived from all of these medical forms will provide invaluable data.

Each section builds upon the other, allowing me and other physicians the opportunity to discover the “**missing key**” that will solve your health problem.

Once all the sections of this form and the questionnaires have been filled out please return them to our office and we'll make an appointment for our initial consultation.

I thank you once again and look forward to helping you achieve a “**return to health and well being.**”

Sincerely,

*The Maas Clinic*