Name: _____Email Address:_____

Phone #:_____ Reason for Consultation:_____

Do you follow a special diet? or use special guidelines to choose foods? How long? _____

_____

Vitamin, Mineral Supplements – check those that you are currently using, if more space is needed, continue on the back of this page __Multivitamin – mineral ?with iron __Fish Oil ___Vit C
__Calcium __Vit D ___Magnesium Other:_____

Herbal Supplements: please list, including brand name, amount, reason

_____

if more space is needed, please continue on the back of this page

In the last 6 months have you had blood tests for the following? If yes, do we have a copy in your files?_____ Please note those that were above or below normal range:
Folate ___ B12 ___ Iron___ Cholesterol__ Blood Sugar ___Vit D_____ Blood Pressure_____

- Do you use any of the following on a regular basis per day: laxatives antacids
- Amount of caffeine containing beverages do you drink per day?____
- If one drink equals one beer or glass of wine, how much do you drink at an average sittings?_____ per week?___
- How many packs of cigarettes do you smoke per day___
- How many days per week do you use marijuana, cocaine, etc?____

How would you describe your sleep? ___Restful ___awake several time per evening
__ difficulty falling asleep ___do you wake up feeling rested? __How many hours do you ideally require?___

Do you have a glucometer? Y / N If yes, how often and what time of day/night do you check your blood sugar levels? What are the average levels?_____

Do you check your blood pressure outside of the doctor's office? Y/N, if yes how often?

Age: ____ Ht: ____ Wt: _____ Desired Weight: ____ Last time you were this weight:___
Do you gain weight easily? _____
Using a separate sheet of paper, please chart your weight for the last 5 – 10 years. Note any significant event around changes in your weight, including surgeries and pregnancies.
Is there a family history of weight problems?_____

Who else lives in your home? Please list their first name, relationship to you & approximate age:_____

_____

_____

- Who does the grocery shopping in your household? _____
- How often you eat at home? ____per week With others? ____per week
- What kind of beverages (and the amount) do you drink daily? _____

Physical Activity and Movement:

Please list any physical disabilities_____

Please circle all activities that you enjoy and how often you do them

Aerobics
Basketball
Biking
Bowling
Canoeing
or Rowing
Chair Exercises
Dancing – what kind
Frisbee
Golf
Hiking
Jogging
Kick Boxing
Martial Arts
Skating
Running
Skiing
Soccer
Stretching Exercises
Swimming
Tennis
Volleyball
Walking
Walking your dog
Weight Lifting
Yoga
Team Sports:____
Other:_____

Please *check* all that you <u>used to enjoy</u> and are no longer able to due to disability, time, availability of facilities or equipment, etc.

Hobbies: _____**Computer Usage** – non-work related use per day: ____(including handheld computer games) **How many hours per day do you watch TV?**_____

Rate your family's support of possible lifestyle changes in your diet and physical activities:
High Medium Low

Rate your motivation level for these changes: High Medium Low

P9lease circle all foods that you eat, noting an "**A**" by those that cause allergic reactions and "**FS**" that cause food sensitivity reactions:

Fruits	Vegetables	Grains	Nuts/Seeds	Dairy or Substitutes
Apples Apricots Avocado Bananas Blueberries Cantaloupe Cherries Cranberries Dried fruit Eggplant Figs Grapes – green or red Grapefruit Honeydew Kiwi Kumquats Lemon/Limes Mango Olives Oranges Papaya Passion fruit Pears Pineapple Plums Raisins Raspberries Star fruit Strawberries Watermelon	Artichoke Asparagus Beets Broccoli Cabbage Carrots Cauliflower Celery Corn Cucumbers Eggplant Fennel Greens: Collard Chard Kale Spinach Green Beans Leeks Lettuce Mushrooms Okra Onions Peas Peppers – green, red, yellow Potatoes – white Pumpkin Radishes String Beans Squash Sweet potatoes Tomatoes Zucchini	Amaranth Barley Buckwheat Corn Kamut Millet Oats Quinoa Rice – White Brown Rye Spelt Teff Wheat	Almond Brazil Cashew Hazelnut Peanut Pecan Pistachio Poppy seed Pumpkin seed Sesame Sunflower seed Walnut	Milk – Cow Goat Do you use milk substitutes? If yes, please list: Cheese- specify- Yogurt – specify Cottage cheese
If one serving = ½ cup, how many servings per day do you eat?	If one serving = ½ cup, how many servings per day do you eat?	If one serving = ½ cup how many servings per day do you eat?	If one serving = 1 tablespoon, how many servings do you eat per day?	If one serving = ½ cup milk or 1 oz cheese, how many servings per day do you eat?

Please circle all foods that you like to eat, noting those that you are allergic to:

Protein Foods		Beverages/Miscellaneous
Meat/Poultry Beef Lamb Pork Chicken Turkey Other Poultry:	Fish, please list- Shellfish, please list-	Coffee Tea Soda Caffeine
Eggs- Chicken- Other	Miscellaneous Whey Protein Pea, Rice or Hemp Protein	Miscellaneous: Sugar Substitute- please list- Food Colorings Allergies – please list-
Dried Beans Adzuki Black Fava Garbanzo Kidney-red, black Black-eyed pea Other:	 Lima Lentils Mung Navy Pinto Soy	Lecithin MSG Cinnamon
If one serving = 1 oz or ¼ cup, how many servings do you eat per day?		How cups do you drink per day of juice?____ Water?_____ Tea or Coffee? _____Soda?_____

Do you add salt at the table? Yes/No/Sometimes

Do you cook with salt? Yes/No/Sometimes

Other Comments or information I should know:

_____

_____

_____

_____

Initial Symptom Survey

Date:	Patient Name:	Practitioner:

INSTRUCTIONS: Score every symptom based on your experience **OVER THE PAST MONTH**. Using the SCALE OF SYMPTOM POINTS listed below, FILL IN the appropriate score to the left of EVERY symptom listed. Write the "Grand Total" at the top. Also note the number of missed work days you have had in the last month due to illness.

SCALE OF SYMPTOM POINTS

IF you did not suffer from the symptom ever or almost never, leave it blank.

1 = **OCCASIONALLY** (less than 2 times per week) and symptom **was MILD**
2 = **FREQUENTLY** (2 or more times per week) and symptom **was MILD**
3 = **OCCASIONALLY** (less than 2 times per week) and symptom **was SEVERE**
4 = **FREQUENTLY** (2 or more times per week) and symptom **was SEVERE**

Grand Total:	**# Missed Work Days**

	CONSTITUTIONAL
	Fatigue (sluggish, tired)
	Hyperactive (nervous energy)
	Restless (can't relax/sit still)
	Daytime sleepiness
	Insomnia at night
	Malaise (feeling lousy)
	Seizures
	TOTAL (0-28)
	EMOTIONAL/MENTAL
	Depression
	Anxiety (fears, uneasiness)
	Mood swings (rapid changes)
	Irritability
	Forgetfulness
	Lack of concentration/Brain fog
	Low sex drive
	TOTAL (0-28)
	HEAD/EARS
	Headache (not migraine)
	Migraine
	Earache
	Ear infection
	Ringing in ears
	Itchy ears
	Discharge from ears
	Sensitivity to sound
	TOTAL (0-32)
	SKIN
	Blemishes, acne
	Rashes or hives
	Eczema or psoriasis
	"Rosy" cheeks
	Flushing
	Itchy skin
	TOTAL (0-24)

	NASAL/SINUS
	Post nasal drip
	Sinus pain
	Runny nose
	Stuffy nose
	Sneezing
	TOTAL (0-20)
	MOUTH/THROAT
	Sore throat
	Swollen throat
	Swelling/burning lips/tongue
	Gagging/throat clearing
	Canker sores
	Difficulty swallowing
	TOTAL (0-24)
	LUNGS
	Wheezing
	Chest congestion
	Dry cough
	Wet cough
	Shortness of breath
	TOTAL (0-20)
	EYES
	Red or swollen eyes
	Watery eyes
	Itchy eyes
	Dark circles or "bags"
	Sensitivity to light
	Aura
	TOTAL (0-24)
	GENITOURINARY
	Increased urinary frequency
	Painful urination
	Bladder pain
	Bedwetting
	TOTAL (0-16)

	MUSCULOSKELETAL
	Joint pains
	Stiff joints
	Muscle aches
	Stiff muscles
	Tics (facial or otherwise)
	Muscle spasms
	Muscle cramps
	TOTAL (0-28)
	CARDIOVASCULAR
	Irregular heartbeat
	High blood pressure
	TOTAL (0-8)
	DIGESTIVE
	Heartburn/reflux
	Stomach pains/cramps
	Intestinal pains/cramps
	Constipation
	Diarrhea
	Bloating sensation
	Gas (of any kind)
	Nausea
	Vomiting
	Painful elimination
	TOTAL (0-40)
	WEIGHT MANAGEMENT
	Current weight:
	Fluctuating weight
	Food cravings
	Water retention
	Binge eating or drinking
	Purging (all methods)
	TOTAL (0-20)
	LIST OTHER SYMPTOMS: