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PATIENT INTAKE FORM

GENERAL INFORMATION

DEMOGRAPHIC INFORMATION

First Name	Middle Name (or n/a)	Last Name	Preferred name

Street Address	City	State	Zip

Home Phone	Work Phone	Mobile Phone	E-mail

Age_____ Date of Birth_____ Place of Birth_____

Gender: ☐ female ☐male

Occupation _____

Nature of Business_____

Hours per week _____

Jobs held prior to current occupation:

_____

_____

_____

☐Retired

Race/genetic background, Please check all that apply:

☐African American ☐Hispanic ☐Mediterranean ☐Asian

☐Native American ☐Caucasian ☐Northern European ☐Other

How did you hear about this practice? *(Please check all that apply)*

☐Book ☐ Internet ☐Speaker ☐ Media ☐ Friend/family member

☐Another patient ☐Doctor or other clinician who:_____

☐Other/referred by: _____

INSURANCE INFORMATION

Insurance Plan/ Policy Number: _____ Social Security Number: _____

PHARMACY INFORMATION

Pharmacy Name and Address: _____

Pharmacy Phone Number: _____

EMERGENCY CONTACT INFORMATION

Next of kin or other to reach in an emergency

_____

Name Phone Number Relationship

SOCIAL SUPPORT

Who provides your primary medical care? _____

His or her address & phone number: _____

Marital/domestic partner status:

☐Single ☐Married ☐Divorced ☐Widow ☐Long Term Partnership

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

Names	Age	Relationship

What other things about your living situation are important for us to know?

MEDICAL HISTORY

We take into account of the whole person, including body, mind, spirit and all aspects of lifestyle.

Please complete the following medical questionnaire to the best of your ability. You may need family members to help supply information. You will notice that this is a longer set of questions than you typically fill out at the doctor's office. The breadth and depth of this history form are essential to identifying the multiple and interacting factors that have contributed to your current health status. Your thoroughness in answering all these questions will help us evaluate the root cause of your health concerns and determine an effective treatment program. It will also give us more consultation time during your visit.

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Please type, print, or write legibly

All your responses are private and confidential

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
e.g. Headaches 1.	June 2007	4 times per week	Mild / moderate / severe
2.			
3.			
4.			
5.			
6.			

What diagnosis or explanations have been given to you?

When was the last time you felt really well for more than a few days at a time?

What are your thoughts about what triggered your change in health?

What makes you feel worse?

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What makes you feel better?

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

To what extent have prior treatments been helpful?

PAST MEDICAL & SURGICAL HISTORY

ILLNESSES

	Date	Date	Date	Comments
Chicken pox				
German measles				
Measles				
Mononucleosis				
Mumps				
Whooping cough				
Tonsillitis				
Anemia				
Arthritis				
Asthma				
Bronchitis				
Cancer				

Chronic fatigue syndrome				
Chronic constipation				
Crohn's disease or Ulcerative colitis				
Diabetes				
Emphysema				
Epilepsy, convulsions				
Gallstones				
Gout				
Heart attack/Angina				
Heart failure				
Hepatitis				
High blood pressure				
Irritable bowel				
Kidney stones				
Pneumonia				
Rheumatic fever				
Sinusitis				
Sleep apnea				
Stroke				
Thyroid disease				
Other (describe)				

INJURIES

	Date	Date	Date	Comments
Head injury				
Neck injury				
Back injury				
Fracture				
Other (describe)				

DIAGNOSTIC STUDIES

	Date	Date	Date	Comments
Chest X-ray				
Mammogram				
EKG				
Sigmoidoscopy				

Colonoscopy				
Upper GI series				
Barium enema				
CAT scan of abdomen				
CAT scan of brain				
CAT scan of spine				
Liver scan				
Bone scan				
Neck X-rays				
Back X-rays				
MRI				
Bone density test				
Carotid artery ultrasound				
Blood tests				
Other (describe)				

OPERATIONS

	Date	Date	Date	Comments
Tonsillectomy				
Appendectomy				
Gallbladder				
Hysterectomy				
Tubes in ears				
Hernia				
Dental surgery				
Other (describe)				

HOSPITALIZATIONS

Where Hospitalized	When	For What Reason

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PATIENT BIRTH HISTORY

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

When your mother was pregnant with you, did she:

	Yes	No	Don't Know	Comment
Smoke tobacco?				
Drink alcohol?				
Take estrogen?				

CHILDHOOD ILLNESSES AND CONDITIONS

Please indicate which, if any, of the following problems/conditions developed when you were a child (ages birth to age 12) by indicating the approximate age of onset.

_____ Frequent colds or flu
_____ Bronchitis
_____ Measles
_____ Chicken pox
_____Strep infections
_____ Significant dental work
_____ADD
_____ Difficulty learning
_____ High # of absences from school
_____ Jaundice

_____ Ear infections
_____ Premature at birth
_____Fever blisters
_____Abusive or alcoholic parent(s)
_____Bedwetting
_____Tonsillitis
_____ Chronic constipation
_____ Mumps
_____ Whooping cough
_____ Seasonal allergies

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_____Behavior problems
_____Hyperactivity
_____ Frequent headaches
_____Upset stomach, indigestion
_____Colic
_____Congenital abnormalities
_____Pneumonia
_____Parent(s) smoked
_____Skin disorders (eczema)

_____Encopresis (fecal incontinence)
_____Major illness(s) that required hospitalization.

If yes, please explain your illness:
_____
_____
_____
_____

IMMUNIZATION HISTORY

☐ Smallpox
☐ Tetanus
☐ Diphtheria
☐ Pertussis
☐ Polio (oral)
☐ Polio (injection)
☐ Mumps
☐ Measles
☐ Rubella (German Measles)
☐ Typhoid
☐ Cholera
☐ Other:
_____

FEMALE MEDICAL HISTORY

OBSTETRICS HISTORY

Check box if yes and provide number:

☐ Pregnancies _____
☐ Caesarean _____
☐ Vaginal deliveries _____
☐ Miscarriages _____
☐ Abortion _____
☐ Living Children _____
☐ Breastfeeding, for how long? _____
☐ Toxemia
☐ Gestational diabetes
☐ Baby over 8 pounds
☐ Postpartum depression

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GYNECOLOGICAL HISTORY

Age at 1st period: _____

Menses Frequency: ☐Yes ☐No

Length: _____

Pain: ☐Yes ☐No

Clotting: ☐Yes ☐No

Has your period skipped?

☐Yes ☐No

For how long? _____

Last Menstrual Period:_____

Do you currently use contraception?

☐Yes ☐No

If yes, what type do you use?

☐Condom ☐Diaphragm ☐IUD ☐Vasectomy

Have you ever used hormonal contraception?

☐Yes ☐No

If yes, when _____

☐Birth control pills - How long? _____

☐Patch - How long? _____

☐Nuvaring - How long? _____

Are you using the pill now?

☐Yes ☐No

Does/did taking the pill produce side effects?

☐Yes ☐No

If yes, What were/are they?

_____

_____

In the 2nd 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 ☐Progesterone ☐Provera

☐Other_____

How long have you been on hormone replacement?

_____

FAMILY HISTORY

Please 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)												
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												

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Autism												
Autoimmune diseases (e.g. Lupus)												
Bipolar Disorder												
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 Diseases												
High Cholesterol												
Inflammatory Arthritist (rheumatoid, psoratic, ankylosing spondylitis)												
Inflammatory Bowel Disease												
Insomnia												
Irritable Bowel Disease												
Kidney Disease												
Multiple Sclerosis												
"Nervous Breakdown"												
Obesity												

Osteoporosis												
Other												
Parkinson's												
Pneumonia/Bronchitis												
Psoriasis												
Psychiatric Disorders												
Schizophrenia												
Sleep Apnea												
Smoking Addiction												
Substance Abuse (e.g. Alcoholism)												
Ulcers												

Any other family history we should know about? ☐Yes ☐No If yes, please comment:

What is the attitude of those close to you about your illness? ☐Supportive ☐Non-supportive

MEDICATIONS & SUPPLEMENTS

ANTIBIOTIC USE

Antibiotics: How often have you taken antibiotics?

	< 5 times	> 5 times
Infancy/Childhood		
Teen		
Adulthood		

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STEROID USE

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

	< 5 times	> 5 times
Infancy/Childhood		
Teen		
Adulthood		

Indicate any medications you're currently taking or have taken in the last month:

- ☐ Acid blocking drugs
- ☐ Anti-anxiety medications
- ☐ Diuretics
- ☐ Estrogen or progesterone (pharmaceutical)
- ☐ Antibiotics
- ☐ Anticonvulsants
- ☐ Antidepressants
- ☐ Antifungals
- ☐ Aspirin/Ibuprofen
- ☐ Asthma inhalers
- ☐ Beta blockers
- ☐ Cholesterol lowering medications
- ☐ Cortisone/steroids
- ☐ Diabetic medications/insulin prescription)
- ☐ Estrogen or progesterone (natural)
- ☐ Heart medications
- ☐ High blood pressure medications
- ☐ Laxatives
- ☐ Relaxants/sleeping pills
- ☐ Testosterone (natural or prescription)
- ☐ Ulcer medications
- ☐ Sildenafil citrate (Viagra or similar)
- ☐ Thyroid medication
- ☐ Acetaminophen (Tylenol
- ☐ Birth control pills/implant contraceptives
- ☐ Chemotherapy

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MEDICATION LOG

Please indicate the specific medications you are taking now, including non-prescription drugs.

Medication Name	Date Started	Date Stopped	Dosage	Times per day

SUPPLEMENT LOG

Supplements: List all vitamins, minerals and other nutritional supplements

Supplement Name/Brand	Dose	Frequency	Date Started	Reason for Use

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

☐Yes ☐No

If yes, please describe_____

ALLERGIES

Medication/Supplement/Food	Reaction

LIFESTYLE HISTORY

SOCIAL HISTORY

GENERAL

Do you have any pets or animals? ☐Yes ☐No

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

Have you ever lived or travelled outside the United States? ☐Yes ☐No

If so, when and where?

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Please describe your level of formal education:

Attended	Type	Major	Year
Y	High School		
Y	College		
Y	Graduate School		
Y	Professional School		

Did you have any learning problems? ☐Yes ☐No

Explain below:

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 yes, please comment:

How much time have you lost from work or school due to illness or other difficulties in the past year?

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

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Have you had any of the following experiences? *Please check*

- ☐ Been a combat soldier
- ☐ Lived in a war zone
- ☐ Been the victim of a serious crime
- ☐ Been in a serious car accident
- ☐ Suffered a sexual assault
- ☐ Endured traumatic illness or medical intervention
- ☐ Lost a family member or close friend to murder
- ☐ Lost a family member or close friend suicide

Have you had any of the following adverse childhood experiences (between 0-18 years of age)?

- ☐ Physical abuse (beating or harsh physical punishment)
- ☐ Emotional abuse (threats or humiliation)
- ☐ Sexual abuse (actual contact)
- ☐ Witnessing domestic violence
- ☐ Growing up in a household with substance abusers
- ☐ Mental illness in a family member
- ☐ Separation or divorce
- ☐ Having an incarcerated family member
- ☐ Physical neglect
- ☐ Emotional neglect

SPIRITUALITY

I have faith in an established religion: ☐Yes ☐No Religion:_____

A higher entity is watching over us all: ☐Yes ☐No ☐Maybe

I pray:

- ☐ Routinely
- ☐ When I need to
- ☐ From time to time
- ☐ Rarely
- ☐ Never

My prayers are answered:

- ☐ Routinely
- ☐ When I need to
- ☐ From time to time
- ☐ Rarely
- ☐ Never

I would like to spend more of my time studying spirituality: ☐Yes ☐No ☐Maybe

TOBACCO HISTORY

Currently using tobacco? ☐Yes ☐No

How many years?_____

Packs per day: _____

If yes, what type?_____

Attempts to quit: _____

Previous smoker? ☐Yes ☐No

How many years?_____

Packs per day:_____

☐Smokeless ☐Cigar ☐Pipe ☐Patch/Gum

Are you exposed to 2nd hand smoke? ☐Yes ☐No 3rd hand smoke (smell or residue)? ☐Yes ☐No

If yes, please explain:

_____

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

Past alcohol intake? ☐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 ever drink in the morning? ☐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? ☐Yes ☐No Father? ☐Yes ☐No Other family member? ☐Yes ☐No

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? _____

SLEEP

Number of hours of sleep per night on average?_____Do you feel rested upon awakening? ☐Yes ☐No

Sleep Quality Problems: (Check all that apply) Other Sleep Issues: (Check all that apply)

☐ Trouble falling asleep

☐ Snoring

☐ Waking in the middle of the night and having trouble going back to sleep?

☐ Sleep Apnea

☐ Waking up too early and having trouble going back to sleep?

☐ Restless Legs

☐ Daytime Sleepiness

☐ Moving around a lot in bed or sleepwalking

Do you use CPAP? ☐Yes ☐No

Do you nap? ☐Yes ☐No

Frequency_____

Duration_____

Do you feel refreshed after your nap? ☐Yes ☐No

Do you use sleeping aids? ☐Yes ☐No

If yes, please specify type, frequency and duration:

Have you ever had a Sleep Study? ☐Yes ☐No

If yes, when and where?

What were the results?

SEXUALITY

I am sexually attracted to:

☐Men ☐Women ☐Both ☐Would rather discuss in person ☐Prefer not to say

I enjoy having sex:

☐Very Much ☐Yes ☐No ☐Not at All ☐Would rather discuss in person ☐Prefer not to say

I engage in masturbation:

☐Frequently ☐Sometimes ☐Never ☐Would rather discuss in person ☐Prefer not to say

I currently have more than one sexual partner:

☐ Yes ☐ No ☐Would rather discuss in person ☐Prefer not to say

My sexual activity is with someone I love dearly:

☐Every time ☐Most of the time ☐Sometimes ☐Not anymore ☐Would rather discuss in person ☐Prefer not to say

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EXERCISE

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

Activity	Type	Frequency/week	Duration (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

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STRESS MANAGEMENT

Do you meditate? ☐Yes ☐No

How often/for how long?_____

Do you practice other relaxation exercise?

☐Yes ☐No

How often?_____

How many weeks of vacation do you take each year?

_____

How stressful do you consider your life to be?

☐High ☐Moderate ☐Slight ☐Very Relaxed

LEISURE

What activities bring you joy? _____

When was the last time you laughed as hard as you can? _____

How often do you get time to take care of yourself? _____

What do you do to take care of yourself? _____

NUTRITIONAL HISTORY

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:

- ☐ Low fat
- ☐ Mixed food diet (animal and vegetable sources)
- ☐ High protein
- ☐ Vegetarian
- ☐ Vegan
- ☐ Gluten restricted
- ☐ Low sodium
- ☐ Fat restriction
- ☐ Low starch/carbohydrate
- ☐ The Blood type diet
- ☐ Metabolic Typing diet
- ☐ The Zone diet

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- ☐ Total calorie restriction
- ☐ Ovo-lacto diet
- ☐ Diabetic
- ☐ No dairy
- ☐ No wheat
- ☐ Specific program for weight loss/maintenance

Type:_____

Please check any specific food restrictions you have:

- ☐ Dairy
- ☐ Soy
- ☐ Wheat
- ☐ Corn
- ☐ Eggs
- ☐ All gluten
- ☐ Other _____

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

_____

_____

Height (feet/inches) _____

Current weight _____

Usual weight range +/- 5 lbs _____

Desired weight range +/- 5 lbs_____

Highest adult weight _____

Lowest adult weight _____

Body fat % _____

Weight fluctuations (>10bs) ☐Yes ☐No

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

EATING PATTERNS

Are there any foods that you avoid because they give you symptoms? ☐Yes ☐No

If yes, please name the food and symptom e.g. wheat – gas and bloating

Food	Symptom	Other comments

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? _____

When you shop do you purchase the following?

☐Organic Foods ☐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

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

- ☐ Fast eater
- ☐ Erratic eating habits
- ☐ Eat too much
- ☐ Late night eater
- ☐ Dislike health food
- ☐ Time constraints
- ☐ Eat more than 50% of meals away from home
- ☐ Travel frequently
- ☐ Non-availability of healthy foods
- ☐ Do not plan meals or menus
- ☐ Reliance on convenience items
- ☐ Poor snack choices
- ☐ Significant other or family members don't like healthy foods
- ☐ Significant other or family members have special dietary needs of food preferences
- ☐ Love to eat
- ☐ Eat because I have to

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- ☐ Have a negative relationship to food
- ☐ Struggle with eating issues
- ☐ Emotional eater (eat when sad, lonely, depressed, bored, anxious)
- ☐ Eat too much under stress
- ☐ Eat too little under stress
- ☐ Don't care to cook
- ☐ Eating in the middle of the night
- ☐ Confused about nutritional advice
- ☐ Diet often for weight control

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

Usual Breakfast	Usual Lunch	Usual Dinner
□None	□None	□None
□Bacon/sausage	□Butter	□Beans (legumes)
□Bagel	□Coffee	□Brown rice
□Butter	□Eat in a cafeteria	□Butter
□Cereal	□Eat in a restaurant	□Carrots
□Coffee	□Fish sandwich	□Coffee
□Donut	□Fried foods	□Fish
□Eggs	□Hamburger	□Green vegetables
□Fruit	□Hot dogs	□Juice
□Juice	□Juice	□Margarine
□Milk	□Leftovers	□Milk
□Oat bran	□Margarine	□Potato

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□Sugar	□Mayo	□Poultry
□Sweet roll	□Meat sandwich	□Red meat
□Sweetener	□Milk	□Rice
□Tea	□Pizza	□Salad
□Toast	□Potato chips	□Salad dressing
□Water	□Salad	□Soda
□Wheat bran	□Soda	□Sugar
□Yogurt	□Soup	□Sweetener
□Oatmeal	□Sugar	□Tea
□Milk protein shake	□Sweetener	□Vinegar
□Slim fast	□Tea	□Water
□Carnation shake	□Tomato	□White rice
□Soy protein	□Vegetables	□Yellow vegetables
□Whey protein	□Water	□Other (list below):
□Rice protein	□Yogurt	
□Other (list below):	□Slim fast or Carnation Shake	
	□Protein shake	
	□Other (list below):	

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Check foods/drinks that you consume a minimum of 3 days or more each week.

□ Almonds	□ Cod	□ Mung Bean	□ Sage
□ Alcohol	□ Crab	□ Mushroom	□ Salt
□ Apples	□ Cranberry	□ Mustard	□ Salmon
□ Avocado	□ Cashew	□ Milk, Cow	□ Scallops
□ Asparagus	□ Cheese	□ Milk, Goat	□ Sausage
□ Bagels	□ Cucumber	□ Milk, Rice	□ Slim Fast
□ Barley	□ Deli Meats	□ Milk, Almond	□ Sweet and Low
□ Banana	□ Desserts	□ Milk, Soy	□ Sesame
□ Burger King	□ Eggplant	□ Mexican Food	□ Shrimp
□ Bacon	□ Ensure	□ Malt	□ Snapper
□ Bean, lima	□ Flounder	□ Nutmeg	□ Soft Drinks
□ Bread, white	□ Fried Foods	□ NutraSweet	□ Sole
□ Bean, pinto	□ French Fries	□ Oatmeal, Regular	□ Sour Cream
□ Bread, wheat	□ French Toast	□ Oatmeal, Instant	□ Soybean
□ Bread, rye	□ Garlic	□ Olive	□ Spinach
□ Bagels	□ Ginger	□ Onion	□ Strawberry
□ Biscuits	□ Grape	□ Orange Juice	□ Sucralose
□ Broccoli	□ Grits	□ Oregano	□ Sugar
□ Brazil nuts	□ Greek Food	□ Oyster	□ Sunflower
□ Brussel Sprouts	□ Grapefruit	□ Orange Juice	□ Salad Bar
□ Blueberries	□ Grape Nuts	□ Papaya	□ Sardines
□ Butter	□ Haddock	□ Parsley	□ Squash
□ Cabbage	□ Ham	□ Pop Tarts	□ Taco Bell
□ Cereal, Special K	□ Halibut	□ Peanuts	□ Tea, Black
□ Cereal, Bran Flakes	□ Herring	□ Peanut Butter	□ Tea, Decaffeinated
□ Cereal, Corn Flakes	□ Hot Dogs, Pork	□ Peas	□ Thai Food

□ Cereal	□ Hot Dogs, Beef	□ Peach	□ Tomato
□ Celery	□ Hamburgers	□ Pecan	□ Trout
□ Cantaloupe	□ Honey	□ Pepper	□ Tuna
□ Candy	□ Italian Food	□ Pepper, Green	□ Turker
□ Chinese food	□ Ice Cream	□ Perch	□ Tangerine
□ Cream	□ Indian Food	□ Pineapple	□ Vinegar
□ Cheese	□ Japanese Food	□ Pancakes	□ Walnut
□ Carrot	□ Jelly	□ Protein Shakes, Soy	□ Waffles
□ Chicken	□ Ketchup	□ Protein Shakes, Milk	□ Whitefish
□ Chili Pepper	□ Lamb	□ Protein Shakes, Whey	□ Wheat
□ Cinnamon	□ Lemon	□ Protein Shakes	□ Wendy's
□ Clam	□ Lentil	□ Potato, White	□ Yeast
□ Cloves	□ Lettuce	□ Potato, Sweet	□ Yogurt
□ Cocoa- Chocolate	□ Lime	□ Pumpkin	□ Yam
□ Carnation Drink	□ Lobster	□ Plum	□ Zucchini
□ Chewing gum, sweetened	□ Margarine	□ Pork	
□ Chewing gum, sugar free	□ Mackerel	□ Quinoa	
□ Coffee	□ McDonald's	□ Radish	
□ Corn	□ Millet	□ Safflower	

What snacks do you eat or drink between:

Breakfast & Lunch:	
Lunch & Dinner:	
After Dinner	

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

ITEM	Daily	Weekly	Type/Note
Candy			
Cheese			
Chocolate			
Cups of Coffee			
Cups of Decaf Coffee or Tea			
Cups of Tea			
Cups of Hot Chocolate			
Diet Sodas (12 oz)			
Sodas with Caffeine (12 oz)			
Decaf Sodas (12 oz)			
Energy Drinks (12 oz)			
Ice Cream			
Salty Foods			
Slices of White Bread (rolls/bagels)			

Water Intake(bottles/day) Tap_____ Distilled_____ Spring_____ Well_____

Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc.? ☐Yes ☐No

If yes, are these symptoms associated with a particular food or supplement(s)? ☐Yes ☐No

If yes, please name the food and symptom e.g. wheat – gas and bloating

Food	Symptom	Other comments

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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.?

Do you feel worse when you eat a lot of:

- ☐ High fat foods
- ☐ High protein foods
- ☐ High carbohydrate foods (breads, pasta, potatoes)
- ☐ Refined sugar (junk food)
- ☐ Fried foods
- ☐ 1 or 2 alcoholic drinks
- ☐ Other

Do you feel better when you eat a lot of:

- ☐ High fat foods
- ☐ High protein foods
- ☐ High carbohydrate foods (breads, pasta, potatoes)
- ☐ Refined sugar (junk food)
- ☐ Fried foods
- ☐ 1 or 2 alcoholic drinks
- ☐ Other

Does skipping meals greatly affect your symptoms? ☐Yes ☐No

Has there ever been a food that you have craved over a period of time? ☐Yes ☐No

If yes, what food(s):

Do you have an aversion to certain foods? ☐Yes ☐No

If yes, what food(s):

The most important thing I should change about my diet to improve my health is:

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RELATIONSHIPS

My most loving relationship is with my spouse/significant other. ☐Yes ☐No

I have relationships that I cherish. ☐Yes ☐No

I have relationships that I regret. ☐Yes ☐No

I am willing to work on ALL my relationships. ☐Yes ☐No

My relationships are the most important aspect of my life. ☐Yes ☐No

LOVE

Do you make friends easily? ☐Yes ☐No ☐Sometimes

I feel unconditional love from others: ☐Yes ☐No ☐Sometimes

I am quick to give unconditional love to others: ☐Yes ☐No ☐Sometimes

I believe that love is the most powerful healing force in the universe: ☐Yes ☐No ☐Maybe

An example of above:

_____

_____

_____

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ADDITIONAL INFORMATION

Thank you for taking the time to complete this form. Your responses will be the basis for our work together. Please include below any additional information about you or your health that you feel would be important for us to know.

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CERTIFICATION

I certify that the information is true and correct to the best of my knowledge. It is my responsibility to inform my physician if there are any changes in any of the information contained in this form.

Patient Signature Date

Guarantor Signature (if not patient) Date