THE SPRING CENTER

Kelly K. McCann, MD

Adult Medical Questionnaire

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

Preferred Name _____

Date of Birth _____ Age _____ Gender_____

Genetic Background (circle all that apply):

☐ African ☐ European ☐ Native American ☐ Mediterranean ☐ Asian

☐ Ashkenazi ☐ Middle Eastern ☐ Other: _____

Highest Education level: _____

Job Title: _____

Nature of Business: _____

Primary Address: _____

Billing Address: _____

Preferred Phone: _____

Home Phone: _____

Cell Phone: _____

Work Phone:_____

E-mail:_____

Emergency Contact

Name _____ *Relationship* _____

Address _____ *Phone:* _____

City _____ *State* _____ *Zip* _____

Primary Care Physician

Name _____ *Phone:* _____

Address _____ *Fax :* _____

City _____ *State* _____ *Zip* _____

Pharmacy Information

Primary Pharmacy

Name _____ *Phone* _____

Address _____ *Fax** _____

City _____ *State* _____ *Zip* _____

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

Compounding/Supplement Pharmacy

Name _____ *Phone* _____

Address _____ *Fax** _____

City _____ *State* _____ *Zip* _____

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

Medical Questionnaire

Allergies

Medication/Supplement/Food	Reaction

Complaints & Concerns

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._____

When was the last time you felt well? _____

_____

Did something trigger your change in health? _____

_____

Is there anything that makes you feel worse? _____

_____

Is there anything that makes you feel better? _____

_____

Please list current and ongoing problems in order of priority

Describe Problem	Mild	Moderate	Severe	Prior Treatment/Approach	Excellent	Good	Fair
Example: Difficulty Maintaining Attention		X		*Elimination Diet*	X		

Synopsis/Health History

Please use this page or your own to write a chronological history of your health journey up to this point. Please include important details and dates, if possible, of symptoms, occurrences, exposures etc. This will greatly help our Practitioners understand your background before you come in for your first appointment.

Medical History

Check box if yes and provide date and details if applicable

Gastrointestinal

- ☐ Irritable Bowel Syndrome_____
- ☐ Inflammatory Bowel Disease_____
- ☐ Crohn's _____
- ☐ Ulcerative Colitis_____
- ☐ Gastritis or Peptic Ulcer Disease_____
- ☐ GERD (reflux) _____
- ☐ Celiac Disease_____
- ☐ Other_____

Cardiovascular

- ☐ Heart Attack_____
- ☐ Heart Disease_____
- ☐ Stroke_____
- ☐ Elevated Cholesterol_____
- ☐ Arrythmia (irregular heartrate) _____
- ☐ Hypertension (High BP) _____
- ☐ Rheumatic Fever_____
- ☐ Mitral Valve Prolapse_____
- ☐ Other_____

Metabolic/Endocrine

- ☐ Type 1 Diabetes_____
- ☐ Type 2 Diabetes_____
- ☐ Hypoglycemia_____
- ☐ Metabolic Syndrome (Insulin resistant or pre-diabetic) _____
- ☐ Hypothyroidism (low) _____
- ☐ Hyperthyroidism (overactive) _____
- ☐ Endocrine Problems_____
- ☐ PCOS_____
- ☐ Infertility_____
- ☐ Weight Gain_____
- ☐ Weight Loss_____
- ☐ Frequent Weight Fluctuations_____
- ☐ Bulimia_____
- ☐ Anorexia_____
- ☐ Binge Eating Disorder_____
- ☐ Night Eating Syndrome_____
- ☐ Eating Disorder (non-specific) _____
- ☐ Other_____

Genital and Urinary Systems

- ☐ Kidney Stones_____
- ☐ Gout _____
- ☐ Frequent Urinary Tract Infections_____
- ☐ Frequent Yeast Infections_____
- ☐ Erectile or Sexual Dysfunction_____
- ☐ Other_____

Musculoskeletal/Pain

- ☐ Arthritis_____
- ☐ Fibromyalgia_____
- ☐ Chronic Pain_____
- ☐ Other_____

Inflammatory/Autoimmune

- ☐ Chronic Fatigue Syndrome_____
- ☐ Autoimmune Disease_____
- ☐ Rheumatoid Arthritis_____
- ☐ Lupus SLE_____
- ☐ Immune Deficiency Disease_____
- ☐ Herpes-Genital_____
- ☐ Severe Infections Disease_____
- ☐ Poor Immune Function (Frequent infection) _____
- ☐ Food Allergies_____
- ☐ Environmental Allergies_____
- ☐ Multiple Chemical Sensitivities _____
- ☐ Latex Allergy_____
- ☐ Other_____

Respiratory Diseases

- ☐ Asthma_____
- ☐ Chronic Sinusitis_____
- ☐ Bronchitis_____
- ☐ Emphysema_____
- ☐ Pneumonia_____
- ☐ Tuberculosis_____
- ☐ Sleep Apnea_____
- ☐ Other_____

Cancer

- ☐ Lung Cancer_____
- ☐ Breast Cancer_____
- ☐ Colon Cancer_____
- ☐ Ovarian Cancer_____
- ☐ Prostate Cancer_____
- ☐ Skin Cancer_____
- ☐ Other_____

Skin Diseases

- ☐ Eczema_____
- ☐ Psoriasis_____
- ☐ Acne_____
- ☐ Melanoma_____
- ☐ Other_____

☐ Medical History Continued

Neurologic/Mood

- ☐ Depression_____
- ☐ Anxiety_____
- ☐ Bipolar Disorder_____
- ☐ Schizophrenia_____
- ☐ Headaches_____
- ☐ ADD/ADHD_____
- ☐ Autism_____
- ☐ Mild Cognitive Impairment_____
- ☐ Memory Problems_____
- ☐ Parkinson's Disease_____
- ☐ Multiple Sclerosis_____
- ☐ ALS_____
- ☐ Seizures_____
- ☐ Other_____

Previous Evaluations

Check box if yes and provide date and details if applicable

- ☐ Full Physical Exam_____
- ☐ Psychological Evaluations_____
- ☐ Genetic Evaluation_____
- ☐ Neurological Evaluation_____
- ☐ Vision Evaluation_____
- ☐ Osteopathic_____
- ☐ Acupuncture_____
- ☐ Physical Therapy_____
- ☐ Occupational Therapy_____
- ☐ Homeopathic_____
- ☐ Naturopathic_____
- ☐ Craniosacral_____
- ☐ Chiropractic_____
- ☐ Bone Density_____
- ☐ Colonoscopy_____
- ☐ Cardiac Stress Test_____
- ☐ EKG_____
- ☐ Hemoccult Test-Stool test for blood_____
- ☐ MRI_____
- ☐ CT Scan_____
- ☐ Upper Endoscopy_____
- ☐ Upper GI Series_____
- ☐ Ultrasound_____
- ☐ Other_____

Injuries

Check box if yes and provide date and details if applicable

- ☐ Back Injury_____
- ☐ Neck Injury_____
- ☐ Head Injury_____
- ☐ Broken Bones_____
- ☐ Other_____

Surgeries

Check box if yes and provide date and details if applicable

- ☐ Appendectomy_____
- ☐ Hysterectomy +/- Ovaries_____
- ☐ Gallbladder _____
- ☐ Hernia Repair_____
- ☐ Tonsillectomy_____
- ☐ Adenoidectomy_____
- ☐ Dental Surgery_____
- ☐ Joint Replacement_____
- ☐ Heart Surgery- Bypass/Valve_____
- ☐ Angeoplasty or Stent_____
- ☐ Pacemaker_____
- ☐ Other_____

Blood Type: ○A ○B ○AB ○0 ○Rh+ ○Unknown

Hospitalizations ☐ None

Date	Reason

Gynecologic History

Obstetric History: *Check box if yes and provide number of*

- ☐ Pregnancies _____ ☐ Caesarean _____ ☐ Vaginal deliveries _____
- ☐ Miscarriage _____ ☐ Abortion _____ ☐ Living Children _____
- ☐ Post Partum Depression ☐ Toxemia ☐ Gestational Diabetes ☐ Baby Over 8 Pounds
- ☐ Breast Feeding. If so, for how long? __

Menstural History:

Age at First Period:_____Menses Frequency:_____Length:_____Pain: ☐ Yes ☐ No Clotting: ☐ Yes ☐ No

Has your period ever skipped?_____For how long?_____

Last Menstrual Period:_____

Use of hormonal contraception such as: ☐ Birth Control Pills ☐ Patch ☐ Nuva Ring How long?_____

Do you use contraception? ☐ Yes ☐ No ☐ Condom ☐ Diaphragm ☐ IUD ☐ Partner Vasectomy

Woman's Disorders/Hormonal Imbalances

- ☐ Fibrocystic Breasts ☐ Endometriosis ☐ Fibroids ☐ Infertility
- ☐ Painful Periods ☐ Heavy periods ☐ PMS

Last Mammogram:_____ ☐ Breast Biopsy/Date:_____

Last PAP Test:_____ ☐ Normal ☐ Abnormal

Last Bone Density:_____Results: ☐ High ☐ Low ☐ Within Normal Range

Are you in menopause? ☐ Yes ☐ No

Age at Menopause_____

- ☐ Hot Flashes ☐ Mood Swings ☐ Concentration/Memory Problems ☐ Vaginal Dryness ☐ Decreased Libido
- ☐ Heavy Bleeding ☐ Joint Pains ☐ Headaches ☐ Weight Gain ☐ Loss of Control of Urine ☐ Palpitations
- ☐ Use of hormone replacement therapy. How long?_____

Men's History

Have you had a PSA done? ☐ Yes ☐ No

PSA Level: ☐ 0-2 ☐ 2-4 ☐ 4-10 ☐ >10

- ☐ Prostate Enlargement ☐ Prostate infection ☐ Change in Libido ☐ Impotence
- ☐ Difficulty Obtaining an 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

GI History

Foreign Travel ☐ Yes ☐ No Where? _____

Wilderness Camping? ☐ Yes ☐ No Where? _____

Have you ever had severe: ☐ Gastroenteritis ☐ Diarrhea

Do you feel like you digest your food well? ☐ Yes ☐ No

Do you feel bloated after meals? ☐ Yes ☐ No

Patient Birth History

☐ Term ☐ Premature

Pregnancy Complications: _____

Birth Complications: _____

☐ Breast Fed? How long? _____ ☐ Bottle Fed

Age at introduction of: Solid Foods: _____ Dairy: _____ Wheat: _____

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

Dental History

Silver Mercury Fillings? ☐ Yes ☐ No If so, how many?

☐ Gold fillings ☐ Root Canals ☐ Implants ☐ Tooth Pain ☐ Bleeding gums ☐ Gingivitis

☐ Problems with Chewing ☐ Silver Mercury Filling Removal When? _____

Do you floss regularly? ☐ Yes ☐ No

Medications

CURRENT MEDICATIONS

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

PREVIOUS MEDICATIONS *Last 10 years*

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

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

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

Have your medications or supplements ever caused you unusual side effects or problems? ☐ Yes ☐ No
Describe: _____

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ☐ Yes ☐ No

Have you had prolonged or regular use of Tylenol? ☐ Yes ☐ No

Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.) ☐ Yes ☐ No

Frequent antibiotics > 3 times/year ☐ Yes ☐ No

Long term antibiotics ☐ Yes ☐ No

Use of steroids (prednisone, nasal allergy inhalers) in the past ☐ Yes ☐ No

Use of oral contraceptives ☐ Yes ☐ No

Family History

Check Family members that apply	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunt	Uncle	Other
Age (if still alive)												
Age at death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Spondylitis)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Diseases (such as Lupus)												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												

Social History

Nutrition History:

Have you ever had a nutrition consultation? ☐ Yes ☐ No

Have you made any changes in your eating habits because of your health? ☐ Yes ☐ No Describe: _____

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

Check all that apply:

☐ Low Fat ☐ Low Carbohydrate ☐ High Protein ☐ Low Sodium ☐ Diabetic ☐ No Dairy ☐ No Wheat

☐ Gluten Restricted ☐ Vegetarian ☐ Vegan ☐ Ultrametabolism

☐ Specific Program for WeightLoss/Maintenance Type:_____ ☐ Other_____

Height (feet/inches)_____	Current Weight_____
Usual Weight Range +/- 5 lbs _____	Desired Weight Range +/- 5 lbs_____
Highest Adult Weight_____	Lowest Adult Weight_____
Weight Fluctuations (> 10 lbs) ☐ Yes ☐ No	Body Fat% _____

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

Have you ever had your metabolism (resting metabolic rate) checked? ☐ Yes ☐ No If yes, what was it? _____

Do you avoid any particular foods? ☐ Yes ☐ No If yes, types andreason _____

_____

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

_____

Do you grocery shop? ☐ Yes ☐ No If no, who does the shopping? _____

Do you 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 meals per week

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

- ☐ Fast eater
- ☐ Erratic eating pattern
- ☐ Eat toomuch
- ☐ Late night eating
- ☐ Dislike healthy food
- ☐ Time constraints
- ☐ Eat more than 50% meals away from home
- ☐ Travel frequently
- ☐ Non-availability of healthyfoods
- ☐ 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 or food preferences
- ☐ Love toeat
- ☐ Eat because I have to
- ☐ Have a negative relationship to food
- ☐ Struggle with eatingissues
- ☐ Emotional eater (eat when sad, lonely, depressed, bored)
- ☐ Eat too much under stress
- ☐ Eat too little under stress
- ☐ Don't care to cook
- ☐ Eating in the middle of the night
- ☐ Confused about nutrition advice

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

_____

Smoking:

Currently Smoking? ☐ Yes ☐ No

If Yes: ☐ Cigarettes ☐ Cigars ☐ Vaping ☐ Marijuana

How many years?_____How many/much per day: _____Attempts to quit: _____

Previous Smoking: Howmany years?_____Quantity per day? _____

Second Hand Smoke Exposure? _____

Alcohol Intake

How many drinks currently per week? *1 drink = 5 ounces wine, 12 ounces 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) ☐ None

Have you ever been told you should cut down your alcohol intake? ☐ Yes ☐ No Do you get annoyed when people ask you about your drinking? ☐ Yes ☐ No

Do you ever feel guilty about your alcohol consumption? ☐ Yes ☐ No

Do you ever take an eye-opener/"hair of the dog"? ☐ Yes ☐ No

Do you notice a tolerance to alcohol (can you "hold" more than others)? ☐ Yes ☐ No

Have you ever been unable to remember what you did during a drinking episode? ☐ Yes ☐ No Do you get into arguments or physical fights when you have been drinking? ☐ Yes ☐ No

Have you ever been arrested or hospitalized because of drinking? ☐ Yes ☐ No

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

Other substances

Caffeine Intake: ☐ Yes ☐ No | Coffee cups/day: ☐ 1 ☐ 2-4 ☐ >4 | Tea cups/day: ☐ 1 ☐ 2-4 ☐ >4

Caffeinated Sodas or Diet Sodas Intake: ☐ Yes ☐ No

12-ounce can/bottle ☐ 1 ☐ 2-4 ☐ > 4 per day

List favorite type (Ex. Diet Coke, Pepsi, etc.): _____

Are you currently using any recreational drugs? ☐ Yes ☐ No Type_____

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

Exercise

Current Exercise Program: *(List type of activity, number of sessions/week, and duration)*

Activity	Type	Frequency Per Week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength			
Other (yoga, pilates, gyrotonics, etc.)			
Sports or Leisure Activities (golf, tennis, rollerblading, etc.)			

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

List problems that limit activity: _____

Do you feel unusually fatigued after exercise? ☐ Yes ☐ No

If yes, please describe: _____

Do you usually sweat when exercising? ☐ Yes ☐ No

Psychosocial

Do you feel significantly less vital than you did a year ago? ☐ Yes ☐ No

Are you happy? ☐ Yes ☐ No

Do you feel your life has meaning and purpose? ☐ Yes ☐ No

Do you believe stress is presently reducing the quality of your life? ☐ Yes ☐ No

Do you like the work you do? ☐ Yes ☐ No

Have you ever experienced major losses in your life? ☐ Yes ☐ No

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

Would you describe your experience as a child in your family as happy and secure? ☐ Yes ☐ No

Stress and Coping

Have you ever sought counseling? ☐ Yes ☐ No

Are you currently in therapy? ☐ Yes ☐ No Describe:_____

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

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

Daily Stressors: Rate on scale of 1-10

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: _____

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

Sleep and Rest

Average number of hours you sleep per night: ☐ >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:_____

Rolles and Relationships

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

List Children: Child's Full Name	Age	Gender

Who is Living in Household? Number:_____ Names:_____

Their Employment/Occupations: _____

Resources for emotional support?

Check all that apply: ☐ Spouse ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other: _____

Are you satisfied with your sex life? ☐ Yes ☐ No

How well have things been going for you?	Very Well	Fine	Poorly	N/A
Overall				
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				

Environmental and Detoxification Assessment

Do you have known adverse food reactions or sensitivities? ☐ Yes ☐ No If yes, describe symptoms:

_____

Do you have any food allergies or sensitivities? ☐ Yes List all:_____ ☐ No

Do you have an adverse reaction to caffeine? ☐ Yes ☐ No

When you drink caffeine do you feel: ☐ Irritable or Wired ☐ Aches & Pains Do you adversely react to (*Check all that apply):*

☐ Monosodium glutamate (MSG) ☐ Aspartame (Nutrasweet) ☐ Caffeine ☐ Bananas ☐ Garlic ☐ Onion

☐ Cheese ☐ Citrus Foods ☐ Chocolate ☐ Alcohol ☐ Red Wine

☐ Sulfite Containing Foods (wine, dried fruit, salad bars) ☐ Preservatives (ex. sodium benzoate)

☐ Other:_____

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

☐ Cigarette Smoke ☐ Perfumes/Colognes ☐ Auto Exhaust Fumes ☐ Other: _____

In your work or home environment, are you exposed to: ☐ Chemicals ☐ Electromagnetic Radiation ☐ Mold

Have you ever turned yellow (jaundiced)? ☐ Yes ☐ No

Have you ever been told you have Gilbert's syndrome or a liver disorder? ☐ Yes ☐ No

Explain:_____

Do you have a known history of significant exposure to any harmful chemicals such as the following:

☐ Herbicides ☐ Insecticides (frequent visits of exterminator) ☐ Pesticides ☐ Organic Solvents

☐ Heavy Metals ☐ Other _____

Chemical Name, Date, Length of Exposure: _____

Do you dry clean your clothes frequently? ☐ Yes ☐ No

Do you or have you lived or worked in a damp or moldy environment or had other mold exposures? ☐ Yes ☐ No

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

Symptom Review

Please check all current symptoms occurring or present in the past 6 months

GENERAL

- ☐ Cold Hands & Feet
- ☐ Cold Intolerance
- ☐ Low Body Temperature
- ☐ Low Blood Pressure
- ☐ Daytime Sleepiness
- ☐ Difficulty Falling Asleep
- ☐ Early Waking
- ☐ Fatigue
- ☐ Fever
- ☐ Flushing
- ☐ Heat Intolerance
- ☐ Night Waking
- ☐ Nightmares
- ☐ No Dream Recall

HEAD, EYES & EARS

- ☐ Conjunctivitis
- ☐ Distorted Sense of Smell
- ☐ Distorted Taste
- ☐ Ear Fullness
- ☐ Ear Pain
- ☐ Ear Ringing/Buzzing
- ☐ Lid Margin Redness
- ☐ Eye Crusting
- ☐ Eye Pain
- ☐ Hearing Loss
- ☐ Hearing Problems
- ☐ Headache
- ☐ Migraine
- ☐ Sensitivity to Loud Noises
- ☐ Vision problems (other than glasses)
- ☐ Macular Degeneration
- ☐ Vitreous Detachment
- ☐ Retinal Detachment

MUSCULOSKELETAL

- ☐ Back Muscle Spasm
- ☐ Calf Cramps
- ☐ Chest Tightness
- ☐ Foot Cramps
- ☐ Joint Deformity
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Stiffness
- ☐ Muscle Pain
- ☐ Muscle Spasms
- ☐ Muscle Stiffness
- ☐ Muscle Twitches:
  - ☐ Around Eyes
  - ☐ Arms or Legs
- ☐ Muscle Weakness
- ☐ Neck Muscle Spasm
- ☐ Tendonitis
- ☐ Tension Headache
- ☐ TMJ Problems

MOOD/NERVES

- ☐ Agoraphobia
- ☐ Anxiety
- ☐ Auditory Hallucinations
- ☐ Black-out
- ☐ Depression

Difficulty:

- ☐ Concentrating
- ☐ With Balance
- ☐ With Thinking
- ☐ With Judgment
- ☐ With Speech
- ☐ With Memory

- ☐ Dizziness (Spinning)
- ☐ Fainting
- ☐ Fearfulness
- ☐ Irritability
- ☐ Light-headedness
- ☐ Numbness
- ☐ Other Phobias
- ☐ Panic Attacks
- ☐ Paranoia
- ☐ Seizures
- ☐ Suicidal Thoughts
- ☐ Tingling
- ☐ Tremor/Trembling
- ☐ Visual Hallucinations

EATING

- ☐ Binge Eating
- ☐ Bulimia
- ☐ Can't Gain Weight
- ☐ Can't Lose Weight
- ☐ Can't Maintain Healthy Weight
- ☐ Frequent Dieting
- ☐ Poor Appetite
- ☐ Salt Cravings
- ☐ Carbohydrate Craving
- ☐ Sweet Cravings
- ☐ Chocolate Cravings
- ☐ Caffeine Dependency

DIGESTION

- ☐ Anal Spasms
- ☐ Bad Teeth
- ☐ Bleeding Gums

Bloating of:

- ☐ Lower Abdomen
- ☐ Whole Abdomen
- ☐ Bloating After Meals

- ☐ Blood in Stools
- ☐ Burping
- ☐ Canker Sores
- ☐ Cold Sores
- ☐ Constipation
- ☐ Cracking at Corner of Lips
- ☐ Cramps
- ☐ Dentures w/Poor Chewing
- ☐ Diarrhea
- ☐ Alternating Diarrhea and Constipation
- ☐ Difficulty Swallowing
- ☐ Dry Mouth
- ☐ Excess Flatulence/Gas
- ☐ Fissures
- ☐ Foods "Repeat" (Reflux)
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Upper Abdominal Pain
- ☐ Vomiting
- ☐ Intolerance to:
  - ☐ Lactose
  - ☐ All Dairy Products
  - ☐ Wheat
  - ☐ Gluten (Wheat, Rye, Barley)
  - ☐ Corn
  - ☐ Eggs
  - ☐ Fatty Foods
  - ☐ Yeast
- ☐ Liver Disease/Jaundice
- ☐ Abnormal Liver Function Tests
- ☐ Lower Abdominal Pain
- ☐ Mucus in Stools
- ☐ Periodontal Disease
- ☐ Sore Tongue
- ☐ Strong Stool Odor
- ☐ Undigested Food in Stools

SKIN PROBLEMS

- ☐ Acne on Back
- ☐ Acne on Chest
- ☐ Acne on Face
- ☐ Acne on Shoulders
- ☐ Athlete's Foot
- ☐ Bumps on Back of Upper Arms
- ☐ Cellulite
- ☐ Dark Circles Under Eyes
- ☐ Ears Get Red
- ☐ Easy Bruising
- ☐ Lack Of Sweating
- ☐ Eczema
- ☐ Hives
- ☐ Jock Itch
- ☐ Lackluster Skin
- ☐ Moles w/Color/Size Change
- ☐ Oily Skin
- ☐ Pale Skin
- ☐ Patchy Dullness
- ☐ Rash
- ☐ Red Face
- ☐ Sensitivity to Bites
- ☐ Sensitivity to Poison Ivy/Oak
- ☐ Shingles
- ☐ Skin Darkening
- ☐ Strong Body Odor
- ☐ Hair Loss
- ☐ Vitiligo

ITCHING SKIN

- ☐ Skin in General
- ☐ Anus
- ☐ Arms
- ☐ Ear Canals
- ☐ Eyes
- ☐ Feet
- ☐ Hands
- ☐ Legs
- ☐ Nipples
- ☐ Nose
- ☐ Penis
- ☐ Roof of Mouth
- ☐ Scalp
- ☐ Throat

SKIN, DRYNESS OF

- ☐ Eyes
- ☐ Feet
  - ☐ Any Cracking?
  - ☐ Any Peeling?
- ☐ Hair
  - ☐ And Unmanageable?
- ☐ Hands
  - ☐ Any Cracking?
  - ☐ Any Peeling?
- ☐ Mouth/Throat
- ☐ Scalp
  - ☐ Any Dandruff?
- ☐ Skin In General

LYMPH NODES

- ☐ Enlarged/neck
- ☐ Tender/neck
- ☐ Other Enlarged/Tender
- ☐ Lymph Nodes

NAILS

- ☐ Bitten
- ☐ Brittle
- ☐ Curve Up
- ☐ Frayed
- ☐ Fungus-Fingers
- ☐ Fungus-Toes
- ☐ Pitting
- ☐ Ragged Cuticles
- ☐ Ridges
- ☐ Soft Thickening of:
  - ☐ Fingernails
  - ☐ Toenails
- ☐ White Spots/Lines

RESPIRATORY

- ☐ Bad Breath
- ☐ Bad Odor in Nose
- ☐ Cough-Dry
- ☐ Cough-Productive
- ☐ Hoarseness
- ☐ Sore Throat Hay Fever:
  - ☐ Spring
  - ☐ Summer
  - ☐ Fall
  - ☐ Change Of Season
- ☐ Nasal Stuffiness
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Fullness
- ☐ Sinus Infection
- ☐ Snoring
- ☐ Wheezing
- ☐ Winter Stuffiness

CARDIOVASCULAR

- ☐ Angina/chest pain
- ☐ Breathlessness
- ☐ Heart Murmur
- ☐ Irregular Pulse
- ☐ Palpitations
- ☐ Phlebitis
- ☐ Swollen Ankles/Feet
- ☐ Varicose Veins

URINARY

- ☐ Bed Wetting
- ☐ Hesitancy (trouble getting started)
- ☐ Infection
- ☐ Kidney Disease
- ☐ Leaking/Incontinence
- ☐ Pain/Burning
- ☐ Prostate Infection
- ☐ Urgency

MALE REPRODUCTIVE

- ☐ Discharge from Penis
- ☐ Ejaculation Problem
- ☐ Genital Pain
- ☐ Impotence
- ☐ Prostate or Urinary Infection
- ☐ Lumps in Testicles
- ☐ Poor Libido (Sex Drive)

FEMALE REPRODUCTIVE

- ☐ Breast Cysts
- ☐ Breast Lumps
- ☐ Breast Tenderness
- ☐ Ovarian Cyst
- ☐ Poor Libido (Sex Drive)
- ☐ Vaginal Discharge
- ☐ Vaginal Odor
- ☐ Vaginal Itch
- ☐ Vaginal Pain with Sex

Premenstrual:

- ☐ Bloating
- ☐ Breast Tenderness
- ☐ Carbohydrate Cravings
- ☐ Chocolate Cravings
- ☐ Constipation
- ☐ Decreased Sleep
- ☐ Diarrhea
- ☐ Fatigue
- ☐ Increased Sleep
- ☐ Irritability

Menstrual:

- ☐ Cramps
- ☐ Heavy Periods
- ☐ Irregular Periods
- ☐ No Periods
- ☐ Scanty Periods
- ☐ Spotting Between

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 d a y	☐ 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 a relaxation technique	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Engage in regular exercise	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐1
Have periodic lab tests to assess your progress	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

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 (very unsupportive):

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

Comments_____

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

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

☐5 ☐4 ☐3 ☐2 ☐1

Comments_____

MSQ Medical Symptom/ Toxicity Questionnaire

The Toxicity and Symptom screening questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps track your progress overtime. Rate each of the following symptoms based up on your health profile for the past 30 days.

Point Scale

0= Never or almost never have the Symptom
1= Occasionally have it, effect is not severe
2= Occasionally have it, effect is severe
3= Frequently have I, effect is not severe
4= Frequently have it, effect is severe

Digestive Tract
___Nausea or Vomitiing
___Diarrhea
___Constipation
___Belching or passing gas
___Heartburn
___Intestinal/Stomach pain
*Total*_____

Ears
___Itchy ears
___Earaches, ear infections
___Drainage from ear
___Ringing in ears, hearing loss
*Total*_____

Emotions
___Mood swings
___Anxiety, fear or nervousness
___Anger, irritability or aggressiveness
___Depression
*Total*_____

Energy/Activity
___Fatigue, sluggishness
___Apathy, lethargy
___Hyperactivity
___Restlessness
*Total*_____

Eyes
___Watery or itchy eyes
___Swollen, reddened or sticky eyelids
___Bags or dark circles under eyes
___Blurred or tunnel vision (does not include near or far-sightedness)
*Total*_____

Head
___Headaches
___Faintness
___Dizziness
___Insomnia
*Total*_____

Heart
___Irregular or skipped heartbeat
___Rapid or pounding heartbeat
___Chest pain
*Total*_____

Joints/Muscles
___Pain or aches in joints
___Arthritis
___Stiffness or limitation of movement
___Pain or aches in muscles
___Feeling of weakness or tiredness
*Total*_____

Lungs
___Chest congestion
___Asthma, bronchitis
___Shortness of breath
___Difficult breathing
*Total*_____

Mind
___Poor Memory
___Confusion, poor comprehension
___Poor concentration
___Poor physical coordination
___Difficulty in making decisions
___Stuttering or stammering
___Slurred speech
___Learning disabilities
*Total*_____

Mouth/Throat
___Chronic coughing
___Gagging, frequent need to clear throat
___Sore throat, hoarseness, loss of voice
___Swollen/discolored tongue, gum lips
___Canker sores
*Total*_____

Nose
___Stuffy nose
___Sinus problems
___Hay fever
___Sneezing attacks
___Excessive mucus formation
*Total*_____

Skin
___Acne
___Hives, rashes or dry skin
___Flushing or hot flushes
___Excessive sweating
*Total*_____

Weight
___Binge eating/drinking
___Craving certain foods
___Excessive weight
___Compulsive eating
___Water retention
___Underweight
*Total*_____

Other
___Frequent illness
___Frequent/urgent urination
___Genital itch or discharge
*Total*_____

Grand Total _____

Key to Questionnaire – *Add individual scores and total each group. Add each group score and give a grand total*

• Optimal is less than 10 • Mild Toxicity: 10-50 • Moderate Toxicity: 50-100 • Severe Toxicity: over 100

3-DAY DIET DIARY INSTRUCTIONS

It is important to keep an accurate record of your usual food and beverage intake as a part of your treatment plan. Please complete this Diet Diary for 3 consecutive days including one weekend day.

- Describe the food or beverage as accurately as possible e.g., milk - what kind? (whole, 2%, nonfat); toast (whole wheat, white, buttered); chicken (fried, baked, breaded); coffee (decaffeinated with sugar and ½ & ½).
- Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, ½ cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.
- Record all beverages, including water, coffee, tea, sports drinks, sodas/diet sodas, etc.
- Include any additional comments about your eating habits on this form (ex. craving sweet, skipped meal and why, when the meal was at a restaurant, etc).
- Please note all bowel movements and their consistency (regular, loose, firm, etc.)

DIET DIARY DAY 1

Name: _____ Date: _____

Daily Exercise (Type of Activity / Time of Day / Duration): _____

_____

Daily Bowel Movements: _____

TIME	FOOD / BEVERAGE / AMOUNT	COMMENTS

DIET DIARY DAY 2

Name:_____ Date: _____

Daily Exercise (Type of Activity / Time of Day / Duration): _____

_____

Daily Bowel Movements:_____

TIME	FOOD / BEVERAGE / AMOUNT	COMMENTS

DIET DIARY DAY 3

Name:_____ Date: _____

Daily Exercise (Type of Activity / Time of Day / Duration): _____

_____

Daily Bowel Movements:_____

TIME	FOOD / BEVERAGE / AMOUNT	COMMENTS

DIET DIARY DAY 3 *Continued*

TIME	FOOD / BEVERAGE / AMOUNT	COMMENTS

OTHER COMMENTS / QUESTIONS / CONCERNS: