

**GENERAL INFORMATION**

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name:		Height:		Weight:			
Preferred Name:			Date:				
Age:		Date of birth		Place of birth:			
Gender: <input type="checkbox"/> Male	<input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single	<input type="checkbox"/> Partnered	<input type="checkbox"/> Married	<input type="checkbox"/> Separated	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
Occupation:		Hours per week:		Date of last physical exam:			
Address:							
City:		State:	Zip Code:		Home Phone:		
Work Phone:		Cell Phone:		E-mail:			
Next of kin or other to reach in an emergency:							
Relationship:		Phone:		Address:			
GENETIC BACKGROUND: Please check appropriated box (es):							
<input type="checkbox"/> African American		<input type="checkbox"/> Hispanic		<input type="checkbox"/> Mediterranean		<input type="checkbox"/> Asian	
<input type="checkbox"/> Native American		<input type="checkbox"/> Caucasian		<input type="checkbox"/> Northern European		<input type="checkbox"/> Other	
Who is your primary medical physician?							
Primary medical physician address & office phone #:							
How did you hear about my practice?		<input type="checkbox"/> Book	<input type="checkbox"/> Website	<input type="checkbox"/> Friend/Family member	<input type="checkbox"/> Other		
Describe:							
<input type="checkbox"/> Other Hospitalizations		<input type="checkbox"/> Have you ever had a blood transfusion?		<input type="checkbox"/> Yes <input type="checkbox"/> No			

**PERSONAL HEALTH HISTORY**

<b>Childhood Illness:</b>	<input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio
<b>Immunization and dates:</b>	<input type="checkbox"/> Tetanus <input type="checkbox"/> Pneumonia <input type="checkbox"/> Hepatitis <input type="checkbox"/> Shingles <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Influenza <input type="checkbox"/> MMR <i>Measles Mumps Rubella</i>

**List any medical problems that other doctors have diagnosed**

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**SURGERIES**

Year	Reason	Hospital

**OTHER HOSPITALIZATIONS**

Year	Reason	Hospital

**FUNCTIONAL DIAGNOSTIC MEDICINE QUESTIONNAIRE**

Please indicate the type of medications you are taking now (prescription and non-prescription drugs)

Medication Name	Dose	Frequency	Date Started	Reason for Use



**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 me evaluate the root cause of your health concerns and determine an effective treatment program.

**COMPLAINTS / CONCERNS**

Please list your chief symptoms in order of decreasing severity, starting with the worst one.

Problem	On set	Frequency	Severity
1.			
2.			
3.			
4.			
5.			
6.			
7.			

What diagnosis or explanation was given to you?

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When was the last time that you felt well?

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Did something trigger your change in health?

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What makes you feel **worse**?

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What makes you feel **better**?

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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"/> Rolfing	<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/Neurofeedback	<input type="checkbox"/> Meditation	<input type="checkbox"/> Naturopathic Medicine

**FEMALE MEDICAL HISTORY (FOR WOMEN ONLY)**

**OBSTETRICAL HISTORY**

Check box if yes and provide number of

<input type="checkbox"/> Pregnancies	<input type="checkbox"/> Caesarean Births	<input type="checkbox"/> Vaginal Deliveries
<input type="checkbox"/> Miscarriages	<input type="checkbox"/> Abortions	<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 first period:	Menses Frequency:	Length:	Pain: <input type="checkbox"/> Yes <input type="checkbox"/> No
Clotting: <input type="checkbox"/> Yes <input type="checkbox"/> No	Has your period skipped? <input type="checkbox"/> Yes <input type="checkbox"/> No	For how long?	
Last Menstrual Period:			
Do you currently use contraception: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what type do you use?			
<input type="checkbox"/> Condom	<input type="checkbox"/> Diaphragm	<input type="checkbox"/> IUD	<input type="checkbox"/> Partner Vasectomy
Have you ever used hormonal contraception? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when?			
Use of hormonal contraception:	<input type="checkbox"/> Birth Control Pills	<input type="checkbox"/> Patch	<input type="checkbox"/> NuvaRing How long?
Are you using the pill now? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did/does taking the pill agree with you? <input type="checkbox"/> Yes <input type="checkbox"/> No		
In the 2 <sup>nd</sup> half of your cycle, do you have symptoms of breast tenderness, water retention, food cravings, or irritability (PMS)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Last Mammogram	Breast Biopsy/Date?		
Last PAP Test:	Normal	Abnormal	
Date Of Last Bone Density:	Results: <input type="checkbox"/> High <input type="checkbox"/> Low <input type="checkbox"/> Within normal range		
Are you in Menopause? <input type="checkbox"/> Yes <input type="checkbox"/> No	Age at Menopause:		
Do you Take:	<input type="checkbox"/> Estrogen	<input type="checkbox"/> Ogen	<input type="checkbox"/> Estrace
	<input type="checkbox"/> Progesterone	<input type="checkbox"/> Provera	<input type="checkbox"/> Premarin
		<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
How long have you been on hormonal replacement?			

**MALE MEDICAL HISTORY (FOR MEN ONLY)**

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, number of times: _____	
Do you feel pain or burning during the urination?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had any kidney, bladder or prostate infections within the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last or prostate exam:	

**PAST MEDICAL AND FAMILY HISTORY**

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

Check family members that apply	Father	Mother	Brothers (s)	Sister (s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Self
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 (like Lupus)												
Bipolar Disease												
Bladder Disease												
Blood Clotting Problems												
Celiac Disease												
Dementia												
Depression												
Diabetes												
Eczema												
Emphysema												
Environmental Sensitivities												
Epilepsy												



Do you believe stress is presently reducing the quality of your life?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you like the work you do?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you experienced major loses in your life?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you spend the majority of your time and money to fulfill responsibilities and obligations?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**MENTAL HEALTH**

Is stress a major problem for you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have problems with eating or your appetite	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you frequently experience anxiety?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you suffer from mood swings?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have difficulty getting motivated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you frequently experience feelings of agitation, anger, fear, or worry?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a family history of divorce as you were growing up?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a childhood history or any history of trauma in your past (such as rape, violence, natural disaster, bullying)? If yes, describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Were there any substance abuse problems in your family as you grew up? If yes, describe	<input type="checkbox"/> Yes <input type="checkbox"/> No
When you were growing up, did anyone in the family, including a parent, suffer from a chronic disease, or a mental disease? If yes, describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Overall, did you feel safe as a child and securely bonded to your parents? Did you feel you could completely trust your parents/parent to take care of you?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you feel less able to handle stress or experience more stress now than in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Check off from this list the things you do to handle daily stress:	
<input type="checkbox"/> Exercise	<input type="checkbox"/> Regular Vacations
<input type="checkbox"/> Play with pets	



<input type="checkbox"/> Baths/Jacuzzi/Saunas	<input type="checkbox"/> Comfort Eat / Cook	<input type="checkbox"/> Get body work (massages, facials, etc)
<input type="checkbox"/> Long walks / Hikes / Nature	<input type="checkbox"/> Talk with family / Friends	<input type="checkbox"/> Other:
<input type="checkbox"/> Read	<input type="checkbox"/> Watch tv / Movies	
<input type="checkbox"/> Meditate / Yoga / Taiichi	<input type="checkbox"/> Sleep	
Are you having any sexual problems?		<input type="checkbox"/> Yes <input type="checkbox"/> No

**DIET AND GASTROINTESTINAL HEALTH**

Do you consume at least five servings of fruits and vegetables per day?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you on any structured diet at this time?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you dieted many times in the past? If yes, what diets were you on?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you dieting now? If yes, what is it?	<input type="checkbox"/> Yes <input type="checkbox"/> No
# of meals you eat in an average day _____	
Do you drink at least 4-6 glasses of water or equivalent beverages per day?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been diagnosed with a chronic GI condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you typically snack on chips, cookies, crackers or granola bars?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you regularly consume soft drinks or fruit juices?	<input type="checkbox"/> Yes <input type="checkbox"/> No
How many regular sodas do you consume per day?	
Do you have frequent sugar cravings?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you eat within three hours of bedtime?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you regularly eat at restaurants or consume processed foods from the grocery store?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you experience frequent heartburn, burping, gas, pain, constipation/diarrhea, or bloating?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you regularly have less than one or more than three bowel movements per day?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you take a laxative more than twice a month?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you used antibiotic medications within the last two years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you consume alcohol, antacids or anti-inflammatory/pain killer drugs regularly?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has there been a period when you consumed more alcohol than you presently do?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been diagnosed with anemia or any other nutrient deficiency?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been placed on a heartburn medication/acid blocker (proton pump inhibitor (PPI) or H2 blocker)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you frequently experience indigestion?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you experience poor memory, difficulty concentrating or brain fog?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been diagnosed with depression, anxiety, ADD or ADHD?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you suffer from multiple food sensitivities?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**OVERALL IMMUNE AND INFLAMMATORY BALANCE**

Do you tend to catch colds and respiratory diseases easily or recover slowly from illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been diagnosed with a recent or chronic infection (such as Lyme disease, Epstein-Barr, Candidiasis, and Herpes Simplex)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you have unexplained rashes, redness or itching?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you suffer now or have in the past from chronic fatigue, chronic pain, fibromyalgia or migraine headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you suffer from any auto-immune condition such as MS, lupus, or rheumatoid arthritis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you suffer from food allergies and seasonal allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you suffer from hives, eczema, rosacea, or psoriasis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you tend to put people and family and situations first and your needs and goals second?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**ENVIRONMENTAL FACTORS IN HEALTH**

Do you use sleeping aids? If yes, explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel rested upon awakening most mornings?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any physical or mental abuses issues in your life that you would like to discuss?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you sensitive to smells and fragrances?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Most nights, how many times do you awake? _____	
Do you have regular exposure to exhaust fumes, tobacco smoke, pesticides, commercial chemicals, paint, cleaning chemicals, or volatile fumes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
How many hours of sleep do you get most nights? _____	
Most nights are you able to fall asleep within 15 minutes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you suffer from light cycle disruption or shift work issues?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you frequently feel drowsy throughout the day?	<input type="checkbox"/> Yes <input type="checkbox"/> No
How many root canals do you currently have in your mouth: _____	
How many silver fillings do you currently have in your mouth: _____	
Have you been told by your dentist that you have gum disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What kind of water do you drink on a regular basis? <input type="checkbox"/> plastic bottled <input type="checkbox"/> tap water <input type="checkbox"/> well water <input type="checkbox"/> purified water system in the home <input type="checkbox"/> filtered water from refrigerator or small counter filter	
Do you use weed killers, pesticides, commercial cleaners in and around the home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
How long is your commute time to work (if applicable)? _____	
Has anyone told you that you snore loudly?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you sleep in a totally dark bedroom?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you smoke now? If yes, what kind of smoking and how much?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did you ever smoke in the past? If yes, how much and for how long?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use commercial personal care products? (lotion, shampoo, cosmetics, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Women:</b> Do you have breast implants? If yes, what kind?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any metal devices implanted in your body? If so, describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use artificial sweeteners? If yes, what kind?	<input type="checkbox"/> Yes <input type="checkbox"/> No
How often do you barbeque meat on a grill? _____	
Have you ever had a venereal disease? If yes, what?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any history of recreational or street drugs and/or drug addiction? If yes, explain	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever given yourself street drugs with a needle?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you always wear a seatbelt when driving and as a passenger?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is any litigation pending regarding a medical condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
How many cat scans have you had in your life:	<input type="checkbox"/> Yes <input type="checkbox"/> No
What part of the body were they done on?	

<b>HEALTH HABITS AND PERSONAL SAFETY</b>
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All questions contained in this questionnaire are optional and will be kept strictly confidential

<b>Exercise</b>	<input type="checkbox"/> Sedentary (no exercise)	
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)	
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min)	
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)	
<b>Diet</b>	<input type="checkbox"/> Are you dieting?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> If yes, are you on a physician prescribed medical diet?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	# Of meals you eat in an average day?	
	Rank salt intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low
	Rank fat intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low
<b>Caffeine</b>	<input type="checkbox"/> None	<input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola or other caffeinated beverage
	# Of cups/cans per day?	
<b>Alcohol</b>	Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?	
	How many drinks per week?	
	Are you concerned about the amount you drink?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you considered stopping?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever experienced blackouts?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you prone to "binge" drinking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you drive after drinking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Tobacco</b>	Do you use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks/day	<input type="checkbox"/> Chew - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Pipe - #/day
<b>Sex</b>	Are you sexually active?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Any discomfort with intercourse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Personal</b>	Do you live alone?	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Safety</b>	Do you have frequent falls?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have an Advanced Directing or Living Will?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Would you like information on the preparation of these?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Physical and/or mental abuse has also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**STRESS / COPING**

Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributor to chronic stress, illness, and immunes 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 ever been involved in an abusive relationship in your life?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Is alcoholism or substance abuse present in your relationships now?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever sought counseling?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Currently? <input type="checkbox"/> Yes <input type="checkbox"/> No	Previously? <input type="checkbox"/> Yes <input type="checkbox"/> No	If previously from _____ To: _____
What kind?		
Comments:		
Do you feel you have any excessive amount of stress in your life?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Daily stressors: Rate in a scale from 1 - 10 (1 not stressful – 10 very stressful)		
Work	Family	Social
Finances	Health	Other
Do you practice meditation or relaxation techniques?		<input type="checkbox"/> Yes <input type="checkbox"/> No
		How often?
Check all that apply:		
<input type="checkbox"/> Yoga	<input type="checkbox"/> Meditation	<input type="checkbox"/> Imagery
<input type="checkbox"/> Breathing	<input type="checkbox"/> Tai Chi	<input type="checkbox"/> Prayer
Other		
Hobbies and leisure activities:		

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

a. <input type="checkbox"/> Not at all important	b. <input type="checkbox"/> Somewhat important	c. <input type="checkbox"/> Extremely important
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<b>How well have things been going for you?</b>					
	<b>Very well</b>	<b>Fine</b>	<b>Poorly</b>	<b>Very Poorly</b>	<b>Does not apply</b>
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					

# WELLNESS EVOLUTIONS

## ELIZABETH W. BORG, Ph.D., N.D.

With your spouse					
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Do you experience mental foginess or have trouble concentrating?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
In the last 6 months, have you unintentionally lost or gained 10 or more pounds?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Do you wake up feeling unrested or depend on caffeine to keep you going throughout the day?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Do you feel overly stressed most days?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Generally speaking, do you enjoy exercising?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
In the last month, how many exercise sessions did you complete? _____					
What is the average length of time of your exercise sessions? _____					
Is your job: <input type="checkbox"/> active or <input type="checkbox"/> sedentary?					
How many hours a day are you sitting down (include travel time)?					
What kind of exercise and activity do you mostly do? Include gardening, housework, yard work, recreational activities, etc?					
Which of the following provide you emotional support? <i>Check all that apply.</i>					
<input type="checkbox"/> Spouse	<input type="checkbox"/> Family	<input type="checkbox"/> Friends	<input type="checkbox"/> Religious/Spiritual	<input type="checkbox"/> Pets	Other:

### 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	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
Take several nutritional supplements each day	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
Keep a record of everything you eat each day	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
Modify your lifestyle	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
Practice relaxation techniques	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
Engage in regular exercises	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
Have periodic lab tests to assess progress	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
Comments:					

Rate on a scale of: **5** (very confident) to **1** (not confident)

How confident are you of your ability to organize and follow through on the above health related activities?	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
If you not are 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?	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
Comments:					

**WELLNESS EVOLUTIONS**  
**ELIZABETH W. BORG, Ph.D., N.D.**

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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 me would be helpful for you as you implement your personal health program?	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
Comments:					

**Thank you for taking the time to complete this health history medical questionnaire. The information derived from these form will provide invaluable data we will use to support your needs.**  
**Thank you once again and we look forward to helping you achieve true balanced health and wellness.**