

Dr. Deborah L. McFarland, Chiropractic Physician

Dr. Brent Zerkle, Chiropractic Physician

7021 Old Troy Pike

Huber Heights, Oh 45424

(330) 447-9680

**Introductory class is free and mandatory prior to starting treatment**

**15 minute complimentary consult available upon request**

**Extensive examination and Report of Findings: $79**

**Non-refundable: Must be paid at the time appointment is set.**

**What you are doing up to this point is not working,**

**or you wouldn’t be filling out this paperwork.**

**If you are SERIOUS and willing to do whatever it takes:**

* Commitment of time and money
* Take supplements/essential oils
* Substantial diet and/or lifestyle changes
* Exercise as tolerated

**Consultation and Exam (approx. 1 hour):**

There is a $79, non-refundable, fee that MUST be paid at the time the one on one appointment with the doctor is made. If you wish to mail a check, cash, or call in a credit card payment, an appointment can be scheduled at that time.

A separate date/time will be scheduled for a Report of Findings. The fee for this service IS included in the consult/exam fee.

If an appointment is scheduled and the client is a “no show” or cancellation notice is not given within 24 hours of your appointment time, you will be contacted and given the chance to reschedule. If you fail to reschedule or “no show” a second time, the fee paid will be forfeited.

By scheduling an appointment, you agree to the guidelines as stated above ☺

**If you are looking for a QUICK fix, this program is NOT for you.**

**This program is primarily elective healthcare, which is largely not covered by insurance. Any services rendered, other than chiropractic services, by Holistic Endocrinology maybe be sought after for independent reimbursement, but this will not be billed, or be the responsibility to follow up on, by this office. If your program participation is based solely upon your insurance coverage, this program is probably not for you.**

**Instructions:**

1. Please fill out this form COMPLETELY. Yes, it is very comprehensive, but it is vital that we have all of your health information during your consultation.
2. Return the form upon completion to one of the following:
	1. Email: HolisticEndocrinology@gmail.com
	2. Mail: 7021 Old Troy Pike, Huber Heights, Ohio 45424
	3. If your appointment is within 4 days and you are unable to send via fax / email, bring this with you to the consultation.

You MUST have this paperwork for your consultation.

1. Go to www.reallyhatediabetes.com then click on and watch the “Introductory Video”, preferably with your spouse/significant other. This video is provided to help you become familiar with:
	1. Information on our approach to health care
	2. Office policies
	3. What to expect at your first visit
2. Read handout provided titled: What to expect on your first visit.
3. It is STRONGLY recommended that your spouse or significant other attend the consultation as there is a commitment of time and money involved as well as acting as a significant support team.

**COMPREHENSIVE CONFIDENTIAL HEALTH HISTORY**

Thank you for choosing our office to assist you with your health care. Our ability to draw effective conclusions about your current state of health and how to optimize its improvement depends largely on the accuracy of the information in which you provide, including symptoms that you may consider minor. Health issues may be influenced by many factors; therefore, it is important that you carefully consider the questions asked in this form as well as those posed by the doctor during your consultation. This will assist our goal to provide you with an optimal plan of health care, enhance our efficiency, and will provide effective use of your scheduled time.

Date: Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of friend/family member joining you for this healthcare journey: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Name: Middle: Last:

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_ Zip Code

Home Phone (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_-\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you able to receive text message? Y N

Because of the generous amount of time that will be blocked out on our schedule to give you the best service, we routinely pre-confirm appointment times. What is the best way to reach you?\_\_\_\_\_\_\_\_\_\_\_\_

Best time? \_\_\_\_\_\_\_\_\_\_am/pm Do we have permission to leave a message? Y N

Do we have permission to put you on our mailing list / text messages? Y N

Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_\_ Place of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: Female\_\_Male\_\_\_

 City or town & country, if not US

Referred by:

Primary care physician: Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address & phone number

Marital Status: Single\_\_\_\_ Married\_\_\_\_ Divorced\_\_\_\_ Widowed\_\_\_\_ Long Term Partnership\_\_\_\_

Emergency Contact:

 Relationship Name Phone

 Address

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

Nature of Business

|  |
| --- |
| \_\_\_I understand that Holistic Endocrinology doctors do not treat disease, nor should any healthcare provider for that matter. Disease is a manifestation of imbalance, toxins and altered pathways. Our doctors help to detect the underlying cause(s) and help empower you to know how to help bring these factors back into balance.\_\_\_I understand that not everyone is a good candidate for the Intense Program. It’s ok. Go ahead and complete the paperwork. There are many things we offer at different levels that may be of great benefit. What are you hoping happens as a result of your consultation with the doctor? How serious do you feel your problem is? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**For Diabetics:**Highest your blood sugar gets with NO medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Lowest your blood sugar gets with NO medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Highest your blood sugar gets with medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Lowest your blood sugar gets with medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Blood Sugar Readings** (if applicable)What was your lowest reading in the past 3 months? \_\_\_\_\_\_\_\_\_\_\_\_\_\_What was your highest reading in the past 3 months? \_\_\_\_\_\_\_\_\_\_\_\_\_What was your blood sugar level today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_What was your last Hemoglobin A1C level? \_\_\_\_\_\_\_\_\_\_\_\_ Date Checked: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Do you have kids?** Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age: \_\_\_\_\_ General health: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age: \_\_\_\_\_ General health: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age: \_\_\_\_\_ General health: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age: \_\_\_\_\_ General health: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age: \_\_\_\_\_ General health: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age: \_\_\_\_\_ General health: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**CURRENT HEALTH STATUS/CONCERNS**Please provide us with current and ongoing problems |
|  |
| **Problem** | **Date of Onset** | **Severity/Frequency** | **Treatment Approach** | **Success** |
| **Example:** Headaches | May 2006 | 2 times per week | Acupuncture/Aspirin | Mild improvement |
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What diagnosis or explanation(s), if any, have been given to you for these concerns?

What do you believe your problem(s) are?

When was the last time that you felt well?

What seems to trigger your symptoms?

What seems to worsen your symptoms?

What seems to make you feel better?

What physician or other health care provider (including alternative or complimentary practitioners) have you seen for these conditions?

How much time have you lost from work or school in the past year due to these conditions?

|  |  |  |
| --- | --- | --- |
| **SURGERIES** | **WHEN** | **COMMENTS** |
| Appendectomy |  |  |
| Dental Surgery |  |  |
| Gall Bladder |  |  |
| Hernia |  |  |
| Hysterectomy |  |  |
| Tonsillectomy |  |  |
| Tubes in Ears |  |  |
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**Hospitalizations**

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| --- | --- | --- | --- |
| Date  | Length of stay | Hospitalization other than pregnancy: Reason | Result: Better/worseSame  |
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**MEDICATIONS**

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| --- | --- | --- | --- |
| **How often have you taken antibiotics?** | **Less than 5 times** | **More than 5 times** | **Comments** |
| Infancy/Childhood |  |  |  |
| Teen |  |  |  |
| Adulthood |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **How often have you taken oral steroids? (e.g. Prednisone, Cortisone, etc)** | **Less than 5 times** | **More than 5 times** | **Comments** |
| Infancy/Childhood |  |  |  |
| Teen |  |  |  |
| Adulthood |  |  |  |

**Current Medications** (prescribed and over-the-counter)

|  |  |  |  |
| --- | --- | --- | --- |
| Medication name | Dose | Reason | Results:  |
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Are you having any side effects? Y □ N □ Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Supplements/Vitamins** (prescribed and over-the-counter)

|  |  |  |  |
| --- | --- | --- | --- |
| Supplement | Brand | Reason | Results |
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**Allergies**

YES\_\_ NO \_\_ Are you allergic to any medications, foods, essential oils (i.e. cinnamon, peppermint…)

If yes, list names and type of reaction.

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

YES\_\_ NO \_\_Have you ever been tested for food allergies?

YES\_\_ NO \_\_Do you have any known food allergies (i.e., gluten, sulfites, lactose, peanuts, dairy, fish)?

What foods? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_Do any foods bother you such as give you heart burn, headache, just don’t feel right:

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

YES\_\_ NO \_\_Do you have any environmental/seasonal/latex/other types of allergies?

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

**CHILDHOOD HISTORY**

Please answer to the best of your knowledge.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Yes** | **No** | **Don’t Know** | **Comment** |
| Where you a full term baby? |  |  |  |  |
|  A premature birth? (‘preemie’) |  |  |  |  |
|  Breast fed? |  |  |  |  |
|  Bottle fed? |  |  |  |  |
| When pregnant with you, did your mother: |  |
|  Smoke tobacco? |  |  |  |  |
|  Use recreational drugs? |  |  |  |  |
|  Drink alcohol? |  |  |  |  |
|  Use estrogen? |  |  |  |  |
|  Other prescription or non-prescription medications? |  |  |  |  |

**CHILDHOOD DIET**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Was your childhood diet high in: | **Yes** | **No** | **Don’t Know** | **Comment** |
| Sugar? (Sweets, Candy, Cookies, etc) |  |  |  |  |
| Soda? |  |  |  |  |
| Fast food, pre-packaged foods, artificial sweeteners? |  |  |  |  |
| Milk, cheeses, other dairy products? |  |  |  |  |
| Meat, vegetables, & potato diet? |  |  |  |  |
| Vegetarian diet?  |  |  |  |  |
| Diet high in white breads? |  |  |  |  |

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

If yes, please explain: (Example: milk – diarrhea)

**CHILDHOOD ILLNESSES**

Please indicate which of the following problems/conditions you experienced as a child (ages birth to 12 years) and the approximate age of onset.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **YES** | **AGE** |  |  | **YES** | **AGE** |
| ADD (Attention Deficient Disorder) |  |  | Mumps |  |  |
| Asthma |  |  | Pneumonia |  |  |
| Bronchitis |  |  | Seasonal allergies |  |  |
| Chicken Pox |  |  | Skin disorders (e.g. dermatitis) |  |  |
| Colic |  |  | Strep infections |  |  |
| Congenital problems |  |  | Tonsillitis |  |  |
| Ear infections |  |  | Upset stomach, digestive problems |  |  |
| Fever blisters |  |  | Whooping cough |  |  |
| Frequent colds or flu |  |  | Other (describe) |  |  |
| Frequent headaches |  |  | Other (describe) |  |  |
| Hyperactivity |  |  | Measles |  |  |
| Jaundice |  |  |  |  |  |

**Please list any type of healthcare provider you have sought care including endocrinologist, internal medicine, chiropractic, nutritionist, homeopathic, massage, etc.**

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| --- | --- | --- | --- |
| Health care provider | Type of doctor | Type of care provided to you | Phone number |
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As a child did you: Have a high absence from school? Yes\_\_\_ No\_\_\_

 If yes, why?

 Experience chronic exposure to second hand smoke in your home? Yes\_\_\_ No\_\_\_

 Experience abuse Yes\_\_\_ No\_\_\_

 Have alcoholic parents? Yes\_\_\_ No\_\_\_

**DIAGNOSTIC TESTING**

Last PAP test :\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Normal: Abnormal

Last Mammogram\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Breast biopsy? Date:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

Date of last bone density\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Results: High\_\_\_\_ Low\_\_\_\_ Within normal range\_\_\_\_

**FAMILY HEALTH HISTORY**

Please indicate current and past history to the best of your knowledge

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Check Family Members that Apply** | **Father** | **Mother** | **Brother(s)** | **Sister(s)** | **Children** | **Maternal****Grandmother** | **Maternal Grandfather** | **Paternal Grandmother** | **Paternal Grandfather** |
| Age (if still living) |  |  |  |  |  |  |  |  |  |
| Age at death (if deceased) |  |  |  |  |  |  |  |  |  |
| Heart Attack |  |  |  |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |  |  |  |
| Uterine Cancer |  |  |  |  |  |  |  |  |  |
| Colon Cancer |  |  |  |  |  |  |  |  |  |
| Breast Cancer |  |  |  |  |  |  |  |  |  |
| Ovarian Cancer |  |  |  |  |  |  |  |  |  |
| Prostate Cancer |  |  |  |  |  |  |  |  |  |
| Skin Cancer |  |  |  |  |  |  |  |  |  |
| ADD/ADHD |  |  |  |  |  |  |  |  |  |
| ALS or other Motor Neuron Diseases |  |  |  |  |  |  |  |  |  |
| Alzheimer’s |  |  |  |  |  |  |  |  |  |
| Anemia |  |  |  |  |  |  |  |  |  |
| Anxiety |  |  |  |  |  |  |  |  |  |
| Arthritis |  |  |  |  |  |  |  |  |  |
| Asthma |  |  |  |  |  |  |  |  |  |
| Autism |  |  |  |  |  |  |  |  |  |
| Autoimmune Diseases (such as Lupus) |  |  |  |  |  |  |  |  |  |
| Bipolar Disease |  |  |  |  |  |  |  |  |  |
| Bladder disease |  |  |  |  |  |  |  |  |  |
| Blood clotting problems |  |  |  |  |  |  |  |  |  |
| Celiac disease |  |  |  |  |  |  |  |  |  |
| Dementia |  |  |  |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |  |  |  |
| Eczema |  |  |  |  |  |  |  |  |  |
| **Check Family Members that Apply** | **Father** | **Mother** | **Brother(s)** | **Sister(s)** | **Children** | **Maternal****Grandmother** | **Maternal Grandfather** | **Paternal Grandmother** | **Paternal Grandfather** |
| Emphysema |  |  |  |  |  |  |  |  |  |
| Environmental Sensitivities |  |  |  |  |  |  |  |  |  |
| Epilepsy |  |  |  |  |  |  |  |  |  |
| Flu |  |  |  |  |  |  |  |  |  |
| Genetic Disorders |  |  |  |  |  |  |  |  |  |
| Glaucoma |  |  |  |  |  |  |  |  |  |
| Headache |  |  |  |  |  |  |  |  |  |
| Heart Disease |  |  |  |  |  |  |  |  |  |
| High Blood Pressure |  |  |  |  |  |  |  |  |  |
| High Cholesterol |  |  |  |  |  |  |  |  |  |
| Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing spondylitis) |  |  |  |  |  |  |  |  |  |
| Inflammatory Bowel Disease |  |  |  |  |  |  |  |  |  |
| Insomnia |  |  |  |  |  |  |  |  |  |
| Irritable Bowel Syndrome |  |  |  |  |  |  |  |  |  |
| Kidney disease |  |  |  |  |  |  |  |  |  |
| Multiple Sclerosis |  |  |  |  |  |  |  |  |  |
| Nervous breakdown |  |  |  |  |  |  |  |  |  |
| Obesity |  |  |  |  |  |  |  |  |  |
| Osteoporosis |  |  |  |  |  |  |  |  |  |
| Other |  |  |  |  |  |  |  |  |  |
| Parkinson’s |  |  |  |  |  |  |  |  |  |
| Pneumonia/Bronchitis |  |  |  |  |  |  |  |  |  |
| Psoriasis |  |  |  |  |  |  |  |  |  |
| Psychiatric disorders |  |  |  |  |  |  |  |  |  |
| Schizophrenia |  |  |  |  |  |  |  |  |  |
| Sleep Apnea |  |  |  |  |  |  |  |  |  |
| Smoking addiction |  |  |  |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |  |  |  |
| Substance abuse (such as alcoholism) |  |  |  |  |  |  |  |  |  |
| Ulcers |  |  |  |  |  |  |  |  |  |

**REVIEW OF SYMPTOMS**

**Check** **(√)** those items that applied to you in the ***past***. **Circle** those that ***presently*** apply

What time of day do you have the most energy? \_\_\_\_\_\_\_\_\_\_\_\_ am/pm to \_\_\_\_\_\_\_\_\_\_\_am/pm

What time of day do you have the least energy? \_\_\_\_\_\_\_\_\_\_\_\_ am/pm to \_\_\_\_\_\_\_\_\_\_\_am/pm

What is your normal energy level? Low 1□ 2□ 3□ 4□ 5□ 6□ 7□ 8□ 9□ 10□ High

What was your energy level 1 year ago? Low 1□ 2□ 3□ 4□ 5□ 6□ 7□ 8□ 9□ 10□ High

What was your energy level 5 years ago? Low 1□ 2□ 3□ 4□ 5□ 6□ 7□ 8□ 9□ 10□ High

How would you rate your endurance? Poor 1□ 2□ 3□ 4□ 5□ 6□ 7□ 8□ 9□ 10□ Best

How is your short term memory? Poor 1□ 2□ 3□ 4□ 5□ 6□ 7□ 8□ 9□ 10□ Best

**A** = ache **B**= burning **N**=numbness **S**= stiffness **T**=tingling **Z**=sharp/shooting

 Right Side Back Front Left side

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| --- | --- |
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**General**

YES\_\_ NO \_\_ Are you forgetful? How big of a problem is it? Mild □ Moderate □ Severe □

YES\_\_ NO \_\_ Do you get brain fog? When does it seem to be the worst? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_ Do you suffer from fevers?

YES\_\_ NO \_\_ Do you just feel “hot” or sweat when there appears to be no reason?

YES\_\_ NO \_\_ Do you frequently experience chills?

YES\_\_ NO \_\_ Do you have difficulty sweating.

YES\_\_ NO \_\_ Do you have excessive sweating?

YES\_\_ NO \_\_ Do you feel any generalized weakness?

YES\_\_ NO \_\_ Are you slow to heal after cuts?

 YES\_\_ NO \_\_ Were you vaccinated?

YES\_\_ NO \_\_ Are you slow to heal after cuts?

 YES\_\_ NO \_\_ Have you ever had cancer? Type(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 YES\_\_ NO \_\_ Were you vaccinated?

YES\_\_ NO \_\_ Sexually transmitted disease – Please feel free to answer this one on one with the doctor.

**Have you ever had any of these diseases**? (Circle all that apply)

 Chicken Pox Mumps Measles TB Malaria Rheumatic fever Lyme’s Mono

 Strept throat MRSA H. Pylori Meningitis C-Diff Chronic Fatigue syndrome

 Shingles Toxic Shock Syndrome West Nile Virus Mono

 **Weight/Height History**

Current Height: \_\_\_\_\_\_ feet \_\_\_\_\_\_\_ inches

Current Weight \_\_\_\_\_\_\_\_ lbs. Weight 1 year ago \_\_\_\_\_\_\_\_lbs. Weight 5 years ago \_\_\_\_\_\_\_\_\_lbs.

YES\_\_ NO \_\_ Weight gain How much over the last year? \_\_\_\_ Highest non pregnancy weight \_\_\_\_\_

YES\_\_ NO \_\_ Weight loss How much over the last year? \_\_\_\_\_\_ Lowest adult weight \_\_\_\_\_\_\_\_\_\_\_\_

Can you explain your weight changes? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much weight would you like to lose in 6 months? Be realistic. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Eyes/Vision**

YES\_\_ NO \_\_Do you ever get blurred vision? When (Ex: computer, high blood sugars, etc.)? \_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_Do you ever get double vision? When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_Do you wear glasses or contacts?

YES\_\_ NO \_\_ Do you have problems with driving at night?

YES\_\_ NO \_\_ Do you have an eye disease (i.e., glaucoma, cataracts, retinopathy)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_ Have you had any eye injuries? Type and date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_ Do you have dry eyes?

YES\_\_ NO \_\_ Do you have circles under your eyes?

**Ears/Nose/Mouth/Throat**

YES\_\_ NO \_\_ Did you or do you suffer from chronic sinus problems

YES\_\_ NO \_\_ Do you have swollen glands in the neck?

YES\_\_ NO \_\_ Was any testing performed?

YES\_\_ NO \_\_ Do you have any difficulty swallowing?

YES\_\_ NO \_\_ Does food get stuck in your throat?

YES\_\_ NO \_\_ Do you have any hearing loss?

YES\_\_ NO \_\_ Hearing aids?

YES\_\_ NO \_\_ Did you or do you suffer from any ringing in the ears?

YES\_\_ NO \_\_ Do you get ear aches or drainage? How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_ Do you have sensitive hearing?

YES\_\_ NO \_\_ Do you have a normal sense of smell?

YES\_\_ NO \_\_ Do you have a normal sense of taste?

YES\_\_ NO \_\_ Do you have sneezing spells?

YES\_\_ NO \_\_ Do you have a chronic cough?

YES\_\_ NO \_\_ Do you get a stuffy or runny nose?

YES\_\_ NO \_\_ Do you have post nasal drip?

YES\_\_ NO \_\_ Do you get frequent nose bleeds?

YES\_\_ NO \_\_ Do you have mouth sores?

YES\_\_ NO \_\_ Do you have bleeding gums?

YES\_\_ NO \_\_ Do you have gingivitis?

YES\_\_ NO \_\_ Do you have bad breath?

YES\_\_ NO \_\_ Do you have a coated tongue?

YES\_\_ NO \_\_ Do you have missing teeth?

YES\_\_ NO \_\_ Have you had an unexplained voice change?

YES\_\_ NO \_\_ Do you get frequent hoarseness? How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_ Do you get sore throats? How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Blood/Lymphatic**

YES\_\_ NO \_\_ Are you anemic?

YES\_\_ NO \_\_ Do you bleed easily?

YES\_\_ NO \_\_ Have you ever had any blood clots? Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_ Do you have phlebitis or peripheral artery disease?

YES\_\_ NO \_\_ Have you ever had a blood transfusion? Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_ Do you have any bleeding disorders?

**Cardiovascular System**

YES\_\_ NO \_\_Do you have high blood pressure? What is the highest: \_\_\_\_/\_\_\_\_

YES\_\_ NO \_\_Do you have low blood pressure? What is the lowest: \_\_\_\_\_/\_\_\_\_\_

YES\_\_ NO \_\_Diagnosed with heart disease? Diagnos(es)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_Have you ever had chest pains? Date(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_EKG performed? Last date: \_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_Stress test performed? Last date: \_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_Heart Cath? Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_Do you ever get heart palpitations? How often? \_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_Have you ever been told you have mitral valve prolapse (MVP)?

YES\_\_ NO \_\_Do your feet or ankles swell? How often? \_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_Do you bruise easily?

YES\_\_ NO \_\_Do you get shortness of breath? When? (i.e., exertion, stairs, laying down)\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_Do you have varicose veins?

YES\_\_ NO \_\_Do you have spider veins?

YES\_\_ NO \_\_Have you ever been diagnosed with an aortic aneurysm?

YES\_\_ NO \_\_Do you have plaque build-up in your carotid arteries? Known percentage: L\_\_\_\_ R\_\_\_\_

YES\_\_ NO \_\_Have you ever spit up blood? When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_Does your heart rate get really high? How high \_\_\_\_\_\_\_ How often \_\_\_\_\_\_\_\_

YES\_\_ NO \_\_Does your heart rate get really low? How low \_\_\_\_\_\_\_\_ How often \_\_\_\_\_\_\_\_

YES\_\_ NO \_\_Have you ever been told you have atrial fibrillation?

YES\_\_ NO \_\_Have you ever been told you have poor circulation?

YES\_\_ NO \_\_Have you ever had cardiac ablation? How many \_\_\_\_\_\_ Last one \_\_\_\_\_\_\_\_\_\_\_\_

**Sleep Habits**

What time do you normally go to sleep? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many hours would you like to sleep? \_\_\_\_\_\_

How many hours of sleep do you normally get at night (your night for shift workers) \_\_\_\_\_\_\_\_

YES\_\_ NO \_\_ Do you nap during the day? How often\_\_\_\_\_\_\_\_\_\_ How long? \_\_\_\_\_\_\_

YES\_\_ NO \_\_ Do you feel rested when you wake up?\_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_ Do you get out of bed besides to go to the bathroom for any reason?

YES\_\_ NO \_\_ Do you have trouble falling asleep? How many hours of sleep do you get each night? \_\_\_\_\_\_

YES\_\_ NO \_\_ Do you dream?

YES\_\_ NO \_\_ Do you have frequent nightmares?

YES\_\_ NO \_\_ Do you have frequent changes in the amount of sleep you are able to get or the times?

YES\_\_ NO \_\_ Are you like tired most of the day then WHAM, wide awake when it is time to sleep?

YES\_\_ NO \_\_ Have you been How long before you feel that you are “Awake” in the morning? \_\_\_\_\_\_\_\_\_\_\_\_\_

**Mental status:**

YES\_\_ NO \_\_ Do you get anxiety or panic attacks? Mild / Moderate / Severe

YES\_\_ NO \_\_ Do you feel depressed? Sometimes □ Do you feel this is significant? Y □ N □

YES\_\_ NO \_\_ Does your mind race?

YES\_\_ NO \_\_Are you easily irritated?

YES\_\_ NO \_\_ Do you have any eating disorders? Which one: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_ Have you ever sought counseling? Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_ Have you been diagnoses with a mental disorder? Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_ Do you feel overwhelmed at this point in your life? Reasons:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Urinary / Kidneys**

YES\_\_ NO \_\_ Do you have to urinate often? About how many times during the day \_\_\_\_\_\_\_\_\_\_\_

 How often to you wake up to urinate at night? \_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_ Do you have a discharge with urination?

YES\_\_ NO \_\_ Is there non-menstrual blood in your urine?

YES\_\_ NO \_\_ Does your urine come out weaker than it used to?

YES\_\_ NO \_\_ Does it feel like your bladder does not completely empty?

YES\_\_ NO \_\_ Do you “leak” urine with coughing, laughing or straining?

YES\_\_ NO \_\_ Do you have burning or painful urination?

YES\_\_ NO \_\_ Do you have any urinary incontinence?

YES\_\_ NO \_\_ Do you wear bladder protection?

YES\_\_ NO \_\_ Have you had kidney stones?

What color is your urine? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Males Only**

YES\_\_ NO \_\_ Do you have a decrease in libido / desire?

YES\_\_ NO \_\_ Do you have any difficulty in achieving erections or maintaining an erection?

YES\_\_ NO \_\_ Have you ever been diagnosed with erectile dysfunction (ED)?

 How long have you had difficulty with erections? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_ Are you on medications for ED? Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_ Do the meds help?

 YES\_\_ NO \_\_ Do you avoid sexual activity because of physical problems?

 YES\_\_ NO \_\_ Is your prostate enlarged?

 YES\_\_ NO \_\_ Have you had your PSA checked?

 YES\_\_ NO \_\_ Have you had a prostate digital exam? Date of last exam: \_\_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_

 YES\_\_ NO \_\_ Do you or have you used testosterone creams/supplements?

 YES\_\_ NO \_\_ Does your partner use hormone replacement therapy? Y □ N □

**Gastrointestinal**

YES\_\_ NO \_\_ Do you get belly aches or stomach pain?

 If yes, how many times? per week: \_\_\_\_\_\_ per month: \_\_\_\_\_\_\_ Mild □ Moderate □ Severe □

YES\_\_ NO \_\_Do you get bloated after you eat?

 How long after you eat do you notice the bloating? \_\_\_\_\_\_\_mins/hours

 How long does it take to go away? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 How long has this been happening? \_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_ Do you pass gas? Often? YES\_\_ NO \_\_ Foul smelling? YES\_\_ NO \_\_

YES\_\_ NO \_\_ Burping/belching? How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_ Do you get heartburn/gastric reflux?

YES\_\_ NO \_\_ Have you ever had hemorrhoids? Did they bleed? YES\_\_ NO \_\_

YES\_\_ NO \_\_ Have you ever been told you have a hiatal hernia? Y □ N □

YES\_\_ NO \_\_ Have you ever had ulcers? Do they bleed? YES\_\_ NO \_\_

YES\_\_ NO \_\_ Do you get nausea often? Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_ Do you have any vomiting? Is there any blood? YES\_\_ NO \_\_

YES\_\_ NO \_\_ Have you ever had a liver problem? Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_ Have you ever had hepatitis? If yes, type: A B C D

YES\_\_ NO \_\_ Have you ever had gallbladder problems?

YES\_\_ NO \_\_ Have you ever had any colon problems? Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_ Have you ever had appendicitis?

YES\_\_ NO \_\_ Have you ever had pancreatitis?

YES\_\_ NO \_\_ Have you ever noticed a loss in your appetite? When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_ Have you ever noticed an increase in your appetite? When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_ Do you feel hungry all of the time?

**Bowel Movements**

How many bowel movements do you have? \_\_\_\_\_ per day/week

 YES\_\_ NO \_\_ Well formed?

YES\_\_ NO \_\_ Not formed?

YES\_\_ NO \_\_ Hard?

YES\_\_ NO \_\_ Small marble size?

 YES\_\_ NO \_\_ Runny?

 YES\_\_ NO \_\_ Do they sink?

 YES\_\_ NO \_\_ Do they float?

 YES\_\_ NO \_\_ Have you ever had blood in your stool? If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_ Are bowel movements painful? How often? \_\_\_\_\_\_\_\_ per week \_\_\_\_\_\_\_\_\_\_ per month

YES\_\_ NO \_\_ Do you have a difficulty making it on time to the bathroom?

 What is the color of the stools? Clay □ Lt. Brown □ Med. Brown □ Dark Brown □ Black □ Tan □ Red □

 What was the color of the blood? \_\_Bright red \_\_Dark Red \_\_Almost black \_\_Black and tarry

 Shape of the stools, circle all that apply on a frequent basis: Runny Solid Ribbon-shaped Pencil-looking

**Respiratory/Lungs**
YES\_\_ NO \_\_ Do you have a chronic cough?

YES\_\_ NO \_\_ Do you spit up blood?

YES\_\_ NO \_\_ Have you had pneumonia? # of times: \_\_\_\_\_\_\_\_\_\_ Last episode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_ Do you have wheezing attacks?

YES\_\_ NO \_\_ Have you had pleurisy (inflammation of the lung lining)?

YES\_\_ NO \_\_ Do you have difficulty breathing?

YES\_\_ NO \_\_ Do you have asthma?

YES\_\_ NO \_\_ Have you ever been diagnosed with emphysema or COPD?

**Endocrine/Hormonal**

YES\_\_ NO \_\_ Do you have any parathyroid gland problems?

YES\_\_ NO \_\_ Have you ever been told you have a goiter or nodule on your thyroid?

YES\_\_ NO \_\_ Do you have excessive thirst?

YES\_\_ NO \_\_ Does the heat bother you?

YES\_\_ NO \_\_ Does cold weather bother you?

YES\_\_ NO \_\_ Do your hands and feet get cold?

YES\_\_ NO \_\_ Do you startle easily or do loud noises make you jump?

YES\_\_ NO \_\_ Do you have dry skin?

YES\_\_ NO \_\_ Do you have any swollen glands? Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_ Have you been told you do or may have any of these diseases

 Rheumatoid Sjorgen’s syndrome Celiacs Multiple Sclerosis Diabetes Type 1

**Muscles / Bone**

YES\_\_ NO \_\_ Do you have a spinal curvature or scoliosis?

YES\_\_ NO \_\_ Do you have arthritis? If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 What is your pain level? Best 1□ 2□ 3□ 4□ 5□ 6□ 7□ 8□ 9□ 10□ Worst

YES\_\_ NO \_\_ Do you have joint pain? What joints? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 What is your pain level? Best 1□ 2□ 3□ 4□ 5□ 6□ 7□ 8□ 9□ 10□ Worst

YES\_\_ NO \_\_ Does your joint pain move around (i.e., from knees to shoulder)?

YES\_\_ NO \_\_ Do you have muscle pain? Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_ Do you get muscle cramps? Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you cramp when active? What activity? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_ Do you cramp when resting (i.e., in bed)?

YES\_\_ NO \_\_ Do you have any muscle/joint weakness?

YES\_\_ NO \_\_ Do you have difficulty walking? If yes, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 YES\_\_ NO \_\_ Have you had any broken bones? Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Neurologic**

 YES\_\_ NO \_\_ Do you have headaches? If yes, how often? \_\_\_\_\_

 YES\_\_ NO \_\_ Do you get migraine headaches? If yes, how often? \_\_\_\_\_\_\_\_\_

 When do you get headaches: \_\_Morning \_\_With loud noise \_\_With bright lights \_\_With stress

 \_\_In the evenings \_\_With driving

\_\_With certain smells: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_When using these products: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 YES\_\_ NO \_\_ Have you ever had a seizure?

 YES\_\_ NO \_\_Do you feel you have lost coordination?

 YES\_\_ NO \_\_ Do you experience numbness or tingling? Where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 YES\_\_ NO \_\_Do you feel you have tremors?

 YES\_\_ NO \_\_ Have you ever had a head injury? Cause:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_ Concussion/Whiplash Cause: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 YES\_\_ NO \_\_ Do you get dizzy? How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 YES\_\_ NO \_\_ Do you get lightheaded? How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 YES\_\_ NO \_\_ Do you have fainting spells? How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 YES\_\_ NO \_\_ Have you ever had a stroke or TIA?

 YES\_\_ NO \_\_ Do you have a face / eye twitch

YES\_\_ NO \_\_ Have you had trigeminal neuralgia

 YES\_\_ NO \_\_ Have you had Bell’s Palsy

YES\_\_ NO \_\_ Do you have Autism, Asperger’s, ADHD, or Tourette’s syndrome?

YES\_\_ NO \_\_ Do you have difficulty concentrating?

YES\_\_ NO \_\_ Do you have restless leg syndrome?

**FEMALE MEDICAL HISTORY**

*(For women only)*

**Females Only** (Please fill out completely)

Age and year periods began (Onset of menarche) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date of LMP (Last Menstrual Period)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 How many days does(did) your period last? \_\_\_\_\_\_\_\_\_\_

 YES\_\_ NO \_\_ Is/has this been the norm?

 YES\_\_ NO \_\_ Is (was) your cycle regular? Y □ N □ Not Always □

 YES\_\_ NO \_\_ Do (did) you pass any clots? mild □ moderate □ or severe □

 Is (was) the flow: Heavy □ Medium □ Light □

 How many pads \_\_\_\_\_ tampons \_\_\_\_\_ are/were used on heavy days?

 YES\_\_ NO \_\_Do you have cramps BEFORE your period?

 YES\_\_ NO \_\_Do you have cramps DURING period?

 YES\_\_ NO \_\_ Do you have spotting (bleeding between periods)?

 YES\_\_ NO \_\_ Are you pregnant now?

 YES\_\_ NO \_\_ Any change in breast size during period? Y □ N □

 YES\_\_ NO \_\_ Do you experience tender breasts? If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 YES\_\_ NO \_\_ Do you have any non nursing nipple discharge?

 YES\_\_ NO \_\_ Do you do breast self-exams? How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 YES\_\_ NO \_\_ Do you have hot flashes? #times during day \_\_\_\_\_ Mild □ Moderate □ Severe □

YES\_\_ NO \_\_ Do you have night sweats? # during night \_\_\_\_ Mild □ Moderate □ Severe □

 YES\_\_ NO \_\_ Have you ever taken estrogen or hormone replacement therapy (HRT)?

 Name of hormone Dosage Pill or Cream

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

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

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

 Approximate age and year of estrogen/HRT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For how many years? \_\_\_\_\_\_\_\_

 YES\_\_ NO \_\_ Are you still on HRT?

YES\_\_ NO \_\_ Does your partner use HRT? What kind: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date of last pelvic/gynecological exam \_\_\_\_\_\_\_\_ Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date of last pap test \_\_\_\_\_\_\_\_Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 YES\_\_ NO \_\_ Do you experience itching or burning of the vaginal area?

 YES\_\_ NO \_\_ Do you get yeast infections? If yes, how often?\_\_\_\_\_\_\_\_ Date of last one: \_\_\_\_\_\_\_\_\_\_\_\_

 YES\_\_ NO \_\_ Do you have pain/discomfort with sexual intercourse?

 YES\_\_ NO \_\_ Do you experience non menstrual vaginal discharge?

 Amount \_\_\_\_\_\_\_\_\_ Color \_\_\_\_\_\_\_\_\_\_\_\_\_ When did this begin?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Approximate age and year of menopause (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Have you ever had (circle all that apply)

 Fibrocystic breasts Uterine Fibroids Endometriosis Genital Warts HPV

Pelvic Inflammatory Disease Herpes Poly Cystic Ovarian syndrome

**Birth Control Methods & Pregnancy History** (females only)**:**

 Have you used an IUD? YES\_\_ NO \_\_ If yes, what type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Describe any problems with IUD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 YES\_\_ NO \_\_ Have you used any form of Birth Control? Please indicate which type & how long:

What type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How long? \_\_\_\_\_\_\_\_\_\_

How old were you when you started birth control? \_\_\_\_

How many total years on birth control? \_\_\_\_\_

 Describe any problems while on Birth Control (i.e., weight gain)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 YES\_\_ NO \_\_ Do you find your present birth control method satisfactory for your health?

 YES\_\_ NO \_\_ Have you ever been pregnant? Number of Pregnancies: \_\_\_\_\_\_\_\_

 YES\_\_ NO \_\_ Did you have diabetes when you were pregnant / Gestational Diabetes?

YES\_\_ NO \_\_ Did you breastfeed? If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 YES\_\_ NO \_\_ Do you have a decreased sexual desire?

YES\_\_ NO \_\_ Any complications with pregnancies/deliveries? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_ Did your health change dramatically after delivering any of your children?

**You don’t have to answer these but important for the emotional component of chronic illness:**

Choose to skip. (you can always answer these privately)

YES\_\_ NO \_\_Have you been raped / molested? Did you conceive as a result? YES\_\_ NO \_\_

YES\_\_ NO \_\_Have you had an abortion(s)?

YES\_\_ NO \_\_Are you an abortion survivor/did your mother/father want to /attempted to abort you?

 **Skin / Breast tissue (Male and female)**

 YES\_\_ NO \_\_ Do you have any rashes? Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 YES\_\_ NO \_\_ Do you have an itching or crawling sensation? Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Do you have any of the following on your body? (Circle all that apply)

 Hives Eczema Psoriasis Open Wounds Skin Ulcers Cellulitis

 YES\_\_ NO \_\_ Do you have any changes in skin color?

 YES\_\_ NO \_\_ Is your hair thinning?

 YES\_\_ NO \_\_ Do you have fungus on your toenails or finger nails/Athlete’s foot?

 YES\_\_ NO \_\_ Do you have brittle nails (nails that break easy)?

YES\_\_ NO \_\_ Do you have strong body odor?

YES\_\_ NO \_\_ Do you bruise easily?

YES\_\_ NO \_\_ Do you have changing moles?

YES\_\_ NO \_\_ Do you have dry, cracking skin?

YES\_\_ NO \_\_ Do you have white spots/ lines on your nails?

YES\_\_ NO \_\_ Do you have a crawling sensation on your skin?

Is your skin sensitive to: Sun Fabrics Detergents Lotions Creams Touch

**LIFESTYLE HISTORY**

 **Tobacco**

 YES\_\_ NO \_\_ Do you currently use tobacco? How often? \_\_\_\_\_\_\_ Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_ Have you ever tried to quit the use of tobacco? How many times? \_\_\_\_\_\_\_\_\_\_

YES\_\_ NO \_\_ Did you ever use tobacco? When? \_\_\_\_\_\_\_ How long? \_\_\_\_\_\_\_\_ How much? \_\_\_\_\_\_\_\_

YES\_\_ NO \_\_ Were you (or are you) exposed to second-hand smoke?

 YES\_\_ NO \_\_ Do you use recreational drugs (i.e, marijuana, cocaine, etc.)?

**Beverages – Liquids:**

 Water: How many ounces of water (by itself) do you drink per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 What type of water? Circle - Filtered City / Well Spring Distilled Reverse Osmosis Alkaline

 YES\_\_ NO \_\_ Do you drink milk? Circle Skim 1% 2% Whole Organic Hemp Rice Soy Almond Coconut

 YES\_\_ NO \_\_ Do you drink any caffeinated beverages? How many cups? \_\_\_\_\_\_\_\_ Day

 YES\_\_ NO \_\_ Do you drink Tea? Type: \_\_\_\_\_\_\_\_\_ How many cups? \_\_\_\_\_\_\_\_\_Day

 YES\_\_ NO \_\_ Do you drink Soda/Diet Soda: How many ounces? \_\_\_\_\_\_\_\_\_\_Day \_\_\_\_\_\_\_\_\_\_Week

 Name of soda: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 YES\_\_ NO\_\_ Do you consume any alcoholic beverages?

YES\_\_ NO \_\_ Are you an alcoholic?

 Type # per Day # Per Week # Per Month # Per Year

 Beer \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

 Wine \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

 Mixed Drinks \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

 **Dietary Patterns:**

YES\_\_ NO \_\_ As a child did you eat a “healthy diet”

YES\_\_ NO \_\_ As a child how often did you drink pop? \_\_\_\_\_\_\_\_\_\_\_/day/week

 YES\_\_ NO \_\_ Standard American Pizza, Ice cream, Boxed foods, Drive thru, Mac and Cheese, etc?

YES\_\_ NO \_\_ Vegetarian What restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 YES\_\_ NO \_\_ Do you follow a low-fat diet?

YES\_\_ NO \_\_ Do you eat a PALEO diet?

YES\_\_ NO \_\_ Do you follow a RAW diet?

YES\_\_ NO \_\_ Have you/are you juicing?

How many meals do you eat per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What time of day is your “big meal? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Typical breakfast: Time: \_\_\_\_\_\_\_ Food: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Typical lunch: Time: \_\_\_\_\_\_\_ Food: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Typical dinner: Time: \_\_\_\_\_\_\_ Food: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Typical snacks and time of day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you describe your eating habits:

\_\_\_Grazer: Small amounts all day long \_\_\_Need that mid morning junk food snack

\_\_\_No control \_\_\_Need that mid afternoon junk food snack

\_\_\_Just one big meal. \_\_\_Emotional eater

 What % of your meals are eaten at home? \_\_\_\_\_\_\_\_\_\_\_\_% What % are eaten out? \_\_\_\_\_\_\_\_\_\_\_%

 What % of the food you eat is cooked? \_\_\_\_\_\_\_\_\_\_\_\_\_% What % is raw? \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_%

 YES\_\_ NO \_\_ Do you eat/consume any: Soy/tofu products? If yes, how often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 YES\_\_ NO \_\_ Do you use any soy nutritional supplements?

 What is your craving weakness? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**There is a saying, “Nothing tastes as good as Healthy FEELS!”**

YES\_\_ NO \_\_ Is getting your health back worth letting go of this food?

 **Spiritual**:

 Optional: My spiritual preference, if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Exercise Habits**

 YES\_\_ NO \_\_ Are you doing any type of exercise?

 What type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 How often: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any of the following tests?

X-Rays Area(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Result:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MRI Area(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Result:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CAT Scan Area(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Result:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ultrasound Area(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Result:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bone scan Area(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Result:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bone density Area(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Result:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMG/NCV Area(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Result:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thermography Area(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Result:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mammogram Area(s) Breast Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Result:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PET Scan Area(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Result:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Colonoscopy Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Result:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zyto Scan Last date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was the date of your last blood work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What are you to do to get your health back?**

On a scale of 1 to 10 with 10 being the most willing mark the number that best describes your motivation to:

Significantly NO-excuses modify your diet? Least 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ Most

Take supplements/essential oils each day? Least 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ Most

Keep a record of everything that you eat/drink? Least 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ Most

Modify your lifestyle (sleep and relax)? Least 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ Most

Participate in exercise program? Least 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ Most

Have periodic lab tests to assess progress? Least 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ Most

Take time to participate in one on one coaching? Least 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ Most

At the present time, how supportive do you think people in your household will be to your implementing the above changes? Least 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ Most

Where do you think you will be health-wise in year if you do not get help now?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Where do you want to be health-wise in 1 year as a result of getting help? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**How motivated are you to getting your health back?**

This is the section to tell your story. We really do care and want to know what is important to you.

On a scale of 1-10, from your heart – seriously! How motivated are you?

1 2 3 4 5 6 7 8 9 10

**Because of condition:**

I can no longer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I hate it because: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I really don’t want to get to the point that: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I am frustrated because I have tried these things \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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With these results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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If I don’t get help with your program, I will \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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The things that are my WHY! - Why I am worth the cost of money, time, effort. Getting healthy is rarely CHEAP/FREE, it is not EASY and it certainly takes effort. Not just for a set period of time, but a lifetime. If it was easy, no one would be sick. So, what are your WHYs?

Could be a desire to travel, start a new business, play with grandkids, see your children graduate, etc.

Whatever is important to you!

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything else that you wanted to add that is not already discussed on this form or you simply want to elaborate?

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Thank you for taking the time to complete this health history medical questionnaire. The information derived from all of these forms will provide invaluable data in identifying the underlying problems of your health concerns and enable our doctors to design a custom program that fits your needs!

We look forward to helping you achieve lifelong health and well-being.

Sincerely,

Dr. Deborah McFarland and Dr. Brent Zerkle

Chiropractic Physicians

