Integrative Kidney Institute
Intake Questionnaire

General Information

Name ________________ Gender identity___________________ Today's Date_________________________

Date of Birth ______________________________ Email ____

Address ____

Phone (Home) __________________ (Cell) ________________________ (Work) ___________________

Genetic Background: ☐ African ☐ American ☐ Hispanic ☐ Asian ☐ Mediterranean
☐ Native American ☐ Caucasian ☐ Northern European
☐ Other ____

When, where and from whom did you last receive medical or health care _____________________________

____

Emergency Contact: ____________________ Relationship___________ Phone __________________________

How did you hear about Integrative Kidney solutions

☐ Website ☐ Referral from doctor ☐ Referral from friend/family member
☐ Social media ☐ Other____

Current Health Concerns

Please rank current and ongoing health concerns in order of priority

Describe Problem Severity	Mild	Moderate	Severe	Prior Treatment/Approach Success	Excellent	Good	Fair
Sample: IgA nephropathy	X			*Elimination Diet*	x		
1.							
2.							
3.							
4.							
5.							
7.							
8.							
9.							
9.							
10.							

Allergies

Name of Medication/Supplement/Food:	Reaction:
1.	
2.	
3.	
4.	
5.	

Lifestyle Review

Sleep

How many hours of sleep do you get each night on average ______________________________

Do you have problems falling asleep ☐ Yes ☐ No Staying asleep ☐ Yes ☐ No

Do you have problems with insomnia ☐ Yes ☐ No Do you snore ☐ Yes ☐ No

Do you feel rested upon awakening ☐ Yes ☐ No

Do you use sleeping aids ☐ Yes ☐ No

If yes, explain: ____

Exercise

Current Exercise Program:

Activity	Type	# of Times Per Week	Time/Duration (Minutes)
Cardio/Aerobic			
Strength/Resistance			
Flexibility/Stretching			
Balance			
Sports/Leisure (e.g., golf)			
Other:			

Do you feel motivated to exercise ☐ Yes ☐ A little ☐ No

Are there any problems that limit exercise ☐ Yes ☐ No

If yes, explain: ____

Do you feel unusually fatigued or sore after exercise ☐ Yes ☐ No

If yes, explain: ____

Smoking

Do you smoke currently ☐ Yes ☐ No Packs per day: _____ Number of years _____

What type ☐ Cigarettes ☐ Smokeless ☐ Pipe ☐ Cigar ☐ E-Cig

Have you attempted to quit ☐ Yes ☐ No

If yes, using what methods: ____

If you smoked previously: Packs per day:_____ Number of years ________

Are you regularly exposed to second-hand smoke ☐ Yes ☐ No

Alcohol

How many alcoholic beverages do you drink in a week (1 drink=5 ounces wine, 12 ounces beer, 1.5 ounces spirits)

☐ 1–3 ☐ 4–6 ☐ 7–10 ☐ >10 ☐ None

Previous alcohol intake ☐ Yes (Mild ☐ Moderate ☐ High) ☐ None

Have you ever had a problem with alcohol ☐ Yes ☐ No

If yes, when ______________________________

Explain the problem: ______________________________

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

Other Substances

Are you currently using any recreational drugs ☐ Yes ☐ No

If yes, type: ______________________________

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

Stress

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

How much stress do each of the following cause on a daily basis (Rate on scale of 1 - 10, 10 being highest)

Work ______ Family ______ Social ______ Finances ______ Health ______ Other ______

Do you use relaxation techniques ☐ Yes ☐ No

If yes, how often ______________________________

Which techniques do you use (Check all that apply)

☐ Meditation ☐ Breathing ☐ Tai Chi ☐ Yoga ☐ Prayer ☐ Other: ____

Have you ever sought counseling ☐ Yes ☐ No

Are you currently in therapy ☐ Yes ☐ No

If yes, describe: ______________________________

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

What are your hobbies or leisure activities ______________________________

Relationships

Marital status:

☐ Single ☐ Married ☐ Divorced ☐ Gay/Lesbian ☐ Long-Term Partner ☐ Widow/er

With whom do you live (Include children, parents, relatives, friends, pets) ______________________________

____

Current occupation: ______________________________

Previous occupations: ______________________________

Do you have resources for emotional support ☐ Yes ☐ No (Check all that apply)

☐ Spouse/Partner ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other: ___________

Do you have a religious or spiritual practice ☐ Yes ☐ No

If yes, what kind ______________________________

History

Patient's Birth/Childhood History:

You were born: Term Premature Don't know

Birth weight if known:__________________

Did mother need to use steroid prior to birth Yes No

Was mother malnourished prior to birth Yes No

Were there any pregnancy or birth complications Yes No

If yes, explain: ____

You were: ☐ Breast-fed/How long_____ ☐ Bottle-fed/Type of formula _____ ☐ Don't know

As a child, were there any foods that were avoided because they gave you symptoms ☐ Yes ☐ No

If yes, what foods and what symptoms (Example: milk—gas and diarrhea) ____________________

____

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

Dental History:

Check if you have any of the following, and provide number if applicable:

Silver mercury fillings ____ Gold fillings ____ Root canals ____ Implants ____

Caps/Crowns ____ Tooth pain ____ Bleeding gums ____ Gingivitis ____

Problems with chewing ____ Other dental concerns (explain): ____

Have you had any mercury fillings removed Yes No If yes, when: ____________

How many fillings did you have as a kid ______________

Do you brush regularly Yes No Do you floss regularly Yes No

Environmental/Detoxification History

Do any of these significantly affect you

Cigarette smoke Perfume/colognes Auto exhaust fumes Other: ________

In your work or home environment are you regularly exposed to: (Check all that apply)

Mold Water leaks Renovations Chemicals Electromagnetic radiation

Damp environments Carpets or rugs Old paint Stagnant or stuffy air

Smokers Pesticides Herbicides Harsh chemicals (solvents, glues, gas, acids, etc)

Cleaning chemicals Heavy metals (lead, mercury, etc.) Paints

Airplane travel Other _______________________

Have you had a significant exposure to any harmful chemicals Yes No

If yes: Chemical name, length of exposure, date: ______________________________________

Do you have any pets or farm animals Yes No

If yes, do they live: Inside Outside Both inside and outside

Do you use plastic containers regularly at home or work Yes No

Do you use a water filtration system in your house Yes No

If yes, what brand____

Women's History

Obstetric History: (Check box and provide number if applicable)

Pregnancies _______ Miscarriages Abortions _______ Living children _______

Vaginal deliveries _______ Cesarean Term births _____ Premature birt_____

Birth weight of largest baby _____________ Birth weight of smallest baby

Did you develop any problems in or after pregnancy, for example, toxemia (high blood pressure), diabetes, post-partum depression, issues with breast feeding, etc. Yes No

If yes, please explain ____

Menstrual History:

Age at first period ________ Date of last menstrual period ______________________________

Length of cycle ________ Time between cycles _____________________________________

Cramping Yes No Pain Yes No

Have you ever had premenstrual problems (bloating, breast tenderness, irritability, etc.) Yes No

If yes, please describe: ____

Do you have other problems with your periods (heavy, irregular, spotting, skipping, etc.) ☐ Yes ☐ No

If yes, please describe: ____

Use of hormonal birth control: Birth control pills Patch Nuva ring

Other __________________________ How Long ________________________________

Any problems with hormonal birth control Yes No

If yes, explain _____________

Use of other contraception Yes No Condoms Diaphragm IUD Partner vasectomy

Are you in menopause Yes No If yes, age at last period:________________

Was it surgical menopause Yes No

If yes, explain surgery: ____

____

Do you currently have symptomatic problems with menopause (Check all that apply)

Hot flashes Mood swings Concentration/memory problems Headaches Joint pain

Vaginal dryness Weight gain Decreased libido Loss of control of urine

Palpitations

Are you on hormone replacement therapy Yes No

If yes, for how long and for what reason (hot flashes, osteoporosis prevention, etc.) _______________

____

Gynecological Screening/Procedures: (If applicable, provide date)

Last Pap test _________________ Normal Abnormal

Last mammogram: _____________ Normal Abnormal

Last bone density: ______________ Results: High Low Within Normal Range

Other tests/procedures (list type and dates) ____

____

Men's History

(Check box if applicable)

Testicular mass Testicular pain Prostate enlargement Prostate infection

Change in sex drive Impotence Premature ejaculation Difficulty obtaining an erection Difficulty maintaining an erection Loss of control of urine

Urinary urgency/hesitancy/change in stream Vasectomy

Nocturia (urination at night) # of times per night ______________________

Sexually transmitted diseases (describe) ____

Screening/Procedures: (If applicable, provide date)

Last PSA test: ____________ PSA Level: 0–2 2–4 4–10 >10

Other tests/procedures (list type and dates) ____

____

Family History:

Check family members that have/had any of the following

	Mother	Father	Brother (s)	Sister (s)	Child	Child	Child	Child	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other
Age (if still alive)													
Age at death (if deceased)													
Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Autoimmune disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Seizures/epilepsy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
ADHD	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Autism	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Irritable Bowel Syndrome	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Substance abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Genetic disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other: _____________	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney disease													
Diabetic kidney disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertensive kidney disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Polycystic kidney disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
IgA nephropathy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
FSGS	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other: _____________	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Medical History: Illnesses/Conditions

Check YES = a condition you currently have, **Check PAST** = a condition you've had in the past.

Gastrointestinal	Yes	Past
Irritable bowel syndrome	☐	☐
GERD (reflux)	☐	☐
Crohn's disease/ulcerative colitis	☐	☐
Peptic ulcer disease	☐	☐
Celiac disease	☐	☐
Gallstones	☐	☐
Other:	☐	☐
Respiratory		
Bronchitis	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Pneumonia	☐	☐
Sinusitis	☐	☐
Sleep apnea	☐	☐
Other:	☐	☐
Urinary/Genital		
Kidney stones	☐	☐
Gout	☐	☐
Interstitial cystitis	☐	☐
Frequent yeast infections	☐	☐
Frequent urinary tract infections	☐	☐
Sexual dysfunction	☐	☐
Sexually transmitted diseases	☐	☐
Other:	☐	☐
Endocrine/Metabolic		
Diabetes	☐	☐
Hypothyroidism (low thyroid)	☐	☐
Hyperthyroidism (overactive thyroid)	☐	☐
Polycystic Ovarian Syndrome	☐	☐
Infertility	☐	☐
Metabolic syndrome/insulin resistance	☐	☐
Eating disorder	☐	☐
Hypoglycemia	☐	☐
Other:	☐	☐
Inflammatory/Immune		
Rheumatoid arthritis	☐	☐
Chronic fatigue syndrome	☐	☐
Food allergies	☐	☐
Environmental allergies	☐	☐
Multiple chemical sensitivities	☐	☐
Autoimmune disease	☐	☐
Immune deficiency	☐	☐
Mononucleosis	☐	☐
Hepatitis	☐	☐
Other:	☐	☐

Musculoskeletal	Yes	Past
Fibromyalgia	☐	☐
Osteoarthritis	☐	☐
Chronic pain	☐	☐
Other:	☐	☐
Skin		
Eczema	☐	☐
Psoriasis	☐	☐
Acne	☐	☐
Skin cancer	☐	☐
Other:	☐	☐
Cardiovascular		
Angina	☐	☐
Heart attack	☐	☐
Heart failure	☐	☐
Hypertension (high blood pressure)	☐	☐
Stroke	☐	☐
High blood fats (cholesterol, triglycerides)	☐	☐
Rheumatic fever	☐	☐
Arrythmia (irregular heart rate)	☐	☐
Murmur	☐	☐
Mitral valve prolapse	☐	☐
Other:	☐	☐
Neurologic/Emotional		
Epilepsy/Seizures	☐	☐
ADD/ADHD	☐	☐
Headaches	☐	☐
Migraines	☐	☐
Depression	☐	☐
Anxiety	☐	☐
Autism	☐	☐
Multiple sclerosis	☐	☐
Parkinson's disease	☐	☐
Dementia	☐	☐
Other:	☐	☐
Cancer		
Lung	☐	☐
Breast	☐	☐
Colon	☐	☐
Ovarian	☐	☐
Skin	☐	☐
Other:	☐	☐

Medical History (cont.)

Diagnostic Studies	Date	Comments
Bone density		
CT scan		
Colonoscopy		
Cardiac stress test		
EKG		
MRI		
Upper endoscopy		
Upper GI series		
Chest X-ray		
Other X-rays		
Barium enema		
Other:		
Injuries		
Broken bone(s)		
Back injury		
Neck injury		
Head injury		
Other:		
Surgeries		
Appendectomy		
Dental		
Gallbladder		
Hernia		
Hysterectomy		
Tonsillectomy		
Joint replacement		
Heart surgery		
Other:		
Hospitalizations	**Date**	**Reason**

Symptom Review

Please check if these symptoms occur presently or have occurred in the last 6 months

General	Mild	Moderate	Severe
Cold hands and feet	☐	☐	☐
Cold intolerance	☐	☐	☐
Daytime sleepiness	☐	☐	☐
Diffculty dalling asleep	☐	☐	☐
Early waking	☐	☐	☐
Fatigue	☐	☐	☐
Fever	☐	☐	☐
Flushing	☐	☐	☐
Heat intolerance	☐	☐	☐
Night waking	☐	☐	☐
Nightmares	☐	☐	☐
Can't remember dreams	☐	☐	☐
Low body temperature	☐	☐	☐
Head, Eyes, and Ears			
Conjunctivitis	☐	☐	☐
Dry eyes	☐	☐	☐
Distorted taste	☐	☐	☐
Dry mouth and throat	☐	☐	☐
Eye pain	☐	☐	☐
Eyelid margin redness	☐	☐	☐
Headache	☐	☐	☐
Hearing loss	☐	☐	☐
Hearing problems	☐	☐	☐
Migraine	☐	☐	☐
Vision problems	☐	☐	☐
Musculoskeletal			
Back muscle spasm	☐	☐	☐
Calf cramps	☐	☐	☐
Chest tightness	☐	☐	☐
Foot cramps	☐	☐	☐
Joint pain	☐	☐	☐
Joint redness	☐	☐	☐
Joint stiffness	☐	☐	☐
Muscle pain	☐	☐	☐
Muscle spasms	☐	☐	☐
Muscle stiffness	☐	☐	☐
Muscle twitches:	☐	☐	☐
Around eyes	☐	☐	☐
Arms or legs	☐	☐	☐
Muscle weakness	☐	☐	☐

Musculoskeletal (cont.)	Mild	Moderate	Severe
Neck muscle spasm	☐	☐	☐
Tendonitis	☐	☐	☐
Tension headache	☐	☐	☐
TMJ problems	☐	☐	☐
Mood/Nerves			
Anxiety	☐	☐	☐
Blackouts	☐	☐	☐
Depression	☐	☐	☐
Diffculty:	☐	☐	☐
Concentrating	☐	☐	☐
With balance	☐	☐	☐
With thinking	☐	☐	☐
With judgment	☐	☐	☐
With speech	☐	☐	☐
With memory	☐	☐	☐
Dizziness (spinning)	☐	☐	☐
Fainting	☐	☐	☐
Irritability	☐	☐	☐
Light-headedness	☐	☐	☐
Numbness	☐	☐	☐
Panic attacks	☐	☐	☐
Seizures	☐	☐	☐
Suicidal thoughts	☐	☐	☐
Tingling	☐	☐	☐
Tremor/trembling	☐	☐	☐
Cardiovascular			
Angina/chest pain	☐	☐	☐
Breathlessness	☐	☐	☐
Heart murmur	☐	☐	☐
High blood pressure	☐	☐	☐
Irregular pulse	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Palpitations	☐	☐	☐
Phlebitis	☐	☐	☐
Swollen ankles/feet	☐	☐	☐
Varicose veins	☐	☐	☐

Urinary	Mild	Moderate	Severe
Hesitancy	☐	☐	☐
Infection	☐	☐	☐
Kidney disease	☐	☐	☐
Kidney stone	☐	☐	☐
Leaking/ incontinence	☐	☐	☐
Pain/burning	☐	☐	☐
Urgency	☐	☐	☐
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	☐	☐	☐
Dentures w/poor chewing	☐	☐	☐
Diarrhea	☐	☐	☐
Difficulty swallowing	☐	☐	☐
Dry mouth	☐	☐	☐
Farting	☐	☐	☐
Fissures	☐	☐	☐
Foods "repeat" (reflux)	☐	☐	☐
Heartburn	☐	☐	☐
Hemorrhoids	☐	☐	☐
Intolerance to:	☐	☐	☐
Lactose	☐	☐	☐
All dairy products	☐	☐	☐
Gluten (wheat)	☐	☐	☐
Corn	☐	☐	☐
Eggs	☐	☐	☐
Fatty foods	☐	☐	☐
Yeast	☐	☐	☐
Liver disease/jaundice	☐	☐	☐
(yellow eyes or skin)			
Lower abdominal pain	☐	☐	☐
Mucus in stools	☐	☐	☐

Digestion (cont.)	Mild	Moderate	Severe
Nausea	☐	☐	☐
Periodontal disease	☐	☐	☐
Sore tongue	☐	☐	☐
Strong stool odor	☐	☐	☐
Undigested food in stools	☐	☐	☐
Upper abdominal pain	☐	☐	☐
Vomiting	☐	☐	☐
Eating			
Binge eating	☐	☐	☐
Bulimia	☐	☐	☐
Can't gain weight	☐	☐	☐
Can't lose weight	☐	☐	☐
Carbohydrate craving	☐	☐	☐
Carbohydrate intolerance	☐	☐	☐
Poor appetite	☐	☐	☐
Salt cravings	☐	☐	☐
Frequent dieting	☐	☐	☐
Sweet cravings	☐	☐	☐
Caffeine dependency	☐	☐	☐
Respiratory			
Bad breath	☐	☐	☐
Cough – dry	☐	☐	☐
Cough – productive	☐	☐	☐
Hay fever:	☐	☐	☐
Spring	☐	☐	☐
Summer	☐	☐	☐
Fall	☐	☐	☐
Change of season	☐	☐	☐
Hoarseness	☐	☐	☐
Nasal stuffiness	☐	☐	☐
Nose bleeds	☐	☐	☐
Postnasal drip	☐	☐	☐
Sinus fullness	☐	☐	☐
Sinus infection	☐	☐	☐
Snoring	☐	☐	☐
Sore throat	☐	☐	☐
Wheezing	☐	☐	☐
Winter stuffiness	☐	☐	☐

Nails	Mild	Moderate	Severe
Bitten			
Brittle			
Curve up			
Frayed			
Fungus – fingers			
Fungus – toes			
Pitting			
Ragged cuticles			
Ridges			
Soft			
Thickening of:		☐	
Finger nails			
Toenails			
White spots/lines			
Lymph Nodes			
Enlarged/neck		☐	☐
Tender/neck		☐	☐
Other enlarged/ tender	☐	☐	☐
lymph nodes			
Skin, Dryness of			
Feet			
Any cracking			
Any peeling			
Hair	☐		☐
And unmanageable	☐		
Hands	☐	☐	
Any cracking			
Any peeling	☐		☐
Scalp	☐		☐
Any dandruff	☐	☐	☐
Skin in general			☐
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			

Skin Problems (cont.)	Mild	Moderate	Severe
Ears get red	☐	☐	☐
Easy bruising	☐	☐	☐
Eczema	☐	☐	☐
Herpes – genital	☐	☐	☐
Hives	☐	☐	☐
Jock itch	☐	☐	☐
Lackluster skin	☐	☐	☐
Moles w color/size change	☐	☐	☐
Oily skin	☐	☐	☐
Pale skin	☐	☐	☐
Patchy dullness	☐	☐	☐
Psoriasis	☐	☐	☐
Rash			
Red face			
Sensitive to bites			
Sensitive to poison ivy/oak			
Shingles	☐	☐	☐
Skin cancer	☐	☐	☐
Skin darkening	☐	☐	☐
Strong body odor	☐	☐	☐
Thick calluses	☐	☐	☐
Vitiligo	☐	☐	☐
Itching Skin			
Anus	☐	☐	☐
Arms	☐	☐	☐
Ear canals	☐	☐	☐
Eyes	☐	☐	☐
Feet	☐	☐	☐
Hands	☐	☐	☐
Legs	☐	☐	☐
Nipples	☐	☐	☐
Nose	☐	☐	☐
Genitals	☐	☐	☐
Roof of mouth	☐	☐	☐
Scalp	☐	☐	☐
Skin in general	☐	☐	☐
Throat	☐	☐	☐

Male Reproductive			
Discharge from penis	☐	☐	☐
Ejaculation problem	☐	☐	☐
Genital pain	☐	☐	☐
Impotence	☐	☐	☐
Infection	☐	☐	☐
Lumps in testicles	☐	☐	☐
Poor libido (low sex drive)	☐	☐	☐

Female Reproductive	Mild	Moderate	Severe
Breast cysts	☐	☐	
Breast lumps			☐
Breast tenderness		☐	
Ovarian cyst			
Poor libido (sex drive)	☐	☐	☐
Endometriosis	☐	☐	
Fibroids	☐	☐	☐
Infertility	☐	☐	
Vaginal discharge	☐	☐	☐
Vaginal odor	☐	☐	☐
Vaginal itch			
Vaginal pain			
Premenstrual:			
Bloating			
Breast tenderness			
Carbohydrate craving			
Chocolate craving			
Constipation			
Decreased sleep	☐		☐
Diarrhea	☐	☐	☐
Fatigue			
Increased sleep			
Irritability			
Menstrual:			
Cramps			
Heavy periods			
Irregular periods			
No periods			
Scanty periods			
Spotting between			

Medications/Supplements

Current medications (include prescription and over-the-counter)

Medication	**Dosage**	**Start Date** (mo/yr)	**Reason for Use**

Nutritional supplements (vitamins/minerals/herbs etc.)

Name and Brand	**Dosage**	**Start Date** (mo/yr)	**Reason for Use**

Medications/Supplements

Have medications or supplements ever caused unusual side effects or problems ☐ Yes ☐ No If yes, describe: ____

Have you used any of these regularly or for a long time:

NSAIDs (Advil, Aleve, etc.), Motrin, Aspirin ☐ Yes ☐ No Tylenol (acetaminophen) ☐ Yes ☐ No

Acid-blocking drugs (Zantac, Prilosec, Nexium, etc.) ☐ Yes ☐ No

How many times have you taken antibiotics

	< 5	> 5	Reason for Use
Infancy/Childhood			
Teen			
Adulthood			

Have you ever taken long term antibiotics ☐ Yes ☐ No

If yes, explain: ____

How often have you taken oral steroids (e.g., cortisone, prednisone, etc.)

	< 5	> 5	Reason for Use
Infancy/Childhood			
Teen			
Adulthood			

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 day	**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**

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 follow through ______________________________

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**

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

How much ongoing support (e.g., telephone consults, email correspondence) from our professional staff would be helpful to you as you implement your personal health program

☐ **5** ☐ **4** ☐ **3** ☐ **2** ☐ **1**

Comments ____

Global Health

Please respond to each item by marking on box per row					
	Excellent	Very good	Good	Fair	Poor
In general, would you say your health is:					
In general, would you say your quality of life is:					
In general, how would you rate your physical health					
In general, how would you rate your mental health, including your mood and your ability to think	□	□		□	□
In general, how would you rate your satisfaction with your social activities and relationships					
In general, please rate how well you carry out your usual social activities and roles (This includes activities at home, at work, and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)					
	Completely	Mostly	Moderately	A little	Not at all
To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair					
In the past 7 days...					
How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable	Never	Rarely	Sometimes	Often	Always
How would you rate your fatigue on average	None	Mild	Moderate	Severe	Very severe

How would you rate your pain on average	0 No pain	1	2	3	4	5	6	7	8	9	10 Worst pain

Medical Symptoms Questionnaire

Rate each of the following symptoms based upon your typical health profile for the past 14 days.

Point Scale
0 – Never or almost never have the symptom
1 – Occasionally have it, effect is not serve
2 – Occasionally have it, effect is serve
3 – Frequently have it, effect is not serve
4 – Frequently have it, effect is serve

Category	Symptom	Score	Total
HEAD	Headaches	______	
	Faintness	______	
	Dizziness	______	
	Insomnia	______	Total ________
EYES	Watery or itchy eyes	______	
	Swollen, reddened or sticky stickyeyelids	______	
	Bags or dark circles under eyes	______	
	Blurred or tunnel vision (Does not include near or far-sightedness)	______	Total ________
EARS	Itchy ears	______	
	Earaches, ear infections	______	
	Drainage from ear	______	
	Ringing in ears, hearing lossa	______	Total ________
NOSE	Stuffy Nose	______	
	Sinus problems	______	
	Hayfever	______	
	Sneezing attacks	______	
	Excessive mucus formation	______	Total ________
MOUTH/ THROAT	Chronic coughing	______	
	Gagging, frequent need to clear throat	______	
	Sore throat, hoarseness, loss of voice	______	
	Swollen or discolored tongue, gums, lips	______	
	Canker sores	______	Total ________
SKIN	Acne	______	
	Hives, rashes, dry skin	______	
	Hair loss	______	
	Flushing, hot flashes	______	
	Excessive sweating	______	Total ________
HEART	Irregular or skipped heartbeat	______	
	Rapid or pounding heartbeat	______	
	Chest pain	______	Total ________

Section	Symptom	Score	Total
LUNGS	Chest congestion	______	
	Asthma, bronchitis	______	
	Shortness of breath	______	
	Difficulty breathing	______	Total ______
DIGESTIVE TRACT	Nausea, vomiting	______	
	Diarrhea	______	
	Constipation Bloated	______	
	feeling Belching,	______	
	passing gas	______	
	Heartburn	______	
	Intestinal/Stomach pain	______	Total ______
JOINTS/ MUSCLE	Joints pain or aches	______	
	Arthritis	______	
	Stiffness or limitation of movement	______	
	Muscle pain or aches	______	
	Weakness or tiredness	______	Total ______
WEIGHT	Binge eating/drinking	______	
	Craving certain foods	______	
	Excessive weight	______	
	Compulsive eating	______	
	Water retention	______	
	Underweight	______	Total ______
ENERGY/ ACTIVITY	Fatigue, sluggishness	______	
	Apathy, lethargy	______	
	Hyperactivity	______	
	Restlessness	______	Total ______
MIND	Poor memory	______	
	Confusion, poor comprehension	______	
	Poor concentration	______	
	Poor physical coordination	______	
	Difficulty in making decisions	______	
	Stuttering or stammering	______	
	Slurred speech	______	
	Learning disabilities	______	Total ______
EMOTIONS	Mood swings	______	
	Anxiety, fear, nervousness	______	
	Anger, irritability, aggressiveness	______	
	Depression	______	Total ______
OTHER	Frequent illness	______	
	Frequent or urgent urination	______	
	Genital itch or discharge	______	Total ______

Grand total ______

Diet & Lifestyle History

Nutrition

Do you currently follow any of the following special diets or nutritional programs(Check all that apply)

Vegetarian Vegan Allergy Elimination Low Fat Low Carb

High Protein Blood Type Low sodium No Dairy No Wheat Gluten Free

Other: ____

Do you have sensitivities to certain foods Yes No

If yes, list food and symptoms: ______________________________________

Do you have an aversion to certain foods Yes No

If yes, explain: ____

Do you adversely react to: (Check all that apply)

Monosodium glutamate (MSG) Artificial sweeteners Garlic/onion Cheese

Citrus foods Chocolate Alcohol Red wine Sulfite–containing foods (wine, dried fruit, salad bars)

Preservatives Food colorings Other food substances: ________________

Are there any foods that you crave or binge on Yes No

If yes, what foods ____

Do you eat 3 meals a day Yes No If no, how many ______________

Does skipping a meal greatly affect you Yes No

How many meals do you eat out per week 0–1 1–3 3–5 >5 meals per week

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

- Fast eater
- Eat too much
- Late-night eating
- Dislike healthy foods
- Time constraints
- Travel frequently
- Eat more than 50% of meals away from home
- Healthy foods not readily available
- Poor snack choices
- Significant other or family members don't like healthy foods
- Significant other or family members have special dietary needs
- Love to eat
- Eat because I have to
- Have negative relationship to food
- Struggle with eating issues
- Emotional eater (eat when sad, lonely, bored, etc.)
- Eat too much under stress
- Eat too little under stress
- Don't care to cook
- Confused about nutrition advice

Diet

How many servings do you eat in a typical week of these foods:

Fruits (not juice) ____________ Vegetables (not including white potatoes)

Legumes (beans, peas, etc) ____________ Dairy/Alternatives ____________

Red meat ____________ Nuts & Seeds ____________ Fish ____________

Fats & Oils ____________

Cans of soda (regular or diet) _________ Sweets (candy, cookies, cake, ice cream, etc.) ____________

Do you drink caffeinated beverages Yes No If yes, check amounts:

Coffee (cups per day) 1 2-4 >4 Tea (cups per day) 1 2-4 >4

Caffeinated sodas—regular or diet (cans per day) 1 2-4 >4

When you drink caffeine do you feel: Irritable or wired Aches or pains

Other (explain) ____________

3-Day Diet and Lifestyle Journal

Day 1 Date:

Day Event	Food & Drink Intake (include type, amount, brand)
Rising Time	
Breakfast Time	
Mid-AM Snack Time	
Lunch Time	
Mid-PM Snack Time	
Dinner Time	
PM Snack Time	
Bedtime	

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
Sleep Quantity: __________ (hours) Quality: Poor Fair Good Relaxation Yes No Type/Amount:	Type, Duration, & Intensity Aerobic: Strength: Flexibility:	Stress Reduction Practices: Stressors:	Supporting: Non-supporting:

Day 2 Date:

Day Event	Food & Drink Intake (include type, amount, brand)
Rising Time	
Breakfast Time	
Mid-AM Snack Time	
Lunch Time	
Mid-PM Snack Time	
Dinner Time	
PM Snack Time	
Bedtime	

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
Sleep Quantity: __________ (hours) Quality: Poor Fair Good Relaxation Yes No Type/Amount:	Type, Duration, & Intensity Aerobic: Strength: Flexibility:	Stress Reduction Practices: Stressors:	Supporting: Non-supporting:

Day 3 Date:

Day Event	Food & Drink Intake (include type, amount, brand)
Rising Time	
Breakfast Time	
Mid-AM Snack Time	
Lunch Time	
Mid-PM Snack Time	
Dinner Time	
PM Snack Time	
Bedtime	

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
Sleep Quantity: ___________ (hours) Quality: Poor Fair Good Relaxation Yes No Type/Amount:	Type, Duration, & Intensity Aerobic: Strength: Flexibility:	Stress Reduction Practices: Stressors:	Supporting: Non-supporting: