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# Male Intake Questionnaire

## General Information

Name \_\_\_\_\_ Age \_\_\_\_\_ Today's Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Email \_\_\_\_\_

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

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

Genetic Background:  African American  Hispanic  Mediterranean  Asian  
 Native American  Caucasian  Northern European  
 Other \_\_\_\_\_

When, where and from whom did you last receive medical or health care? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship \_\_\_\_\_

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

## How did you hear about our practice?

Clinic website  IFM 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
Example: Post Nasal Drip	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: \_\_\_\_\_

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## 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:

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

## Diet

Please record what you eat in a typical day:

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks \_\_\_\_\_

Fluids \_\_\_\_\_

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) \_\_\_\_\_ Red meat \_\_\_\_\_ Fish \_\_\_\_\_

Dairy/Alternatives \_\_\_\_\_ Nuts & Seeds \_\_\_\_\_ 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

Do you have adverse reactions to caffeine?  Yes  No

If yes, explain: \_\_\_\_\_

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

## 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? \_\_\_\_\_

**How well have things been going for you?** *(Mark on scale of 1-10, or N/A if not applicable)*

	<b>N/A</b>	<b>Poorly</b>				<b>Fine</b>				<b>Very Well</b>	
Overall	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
At school	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
In your job	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
In your social life	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With close friends	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With sex	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your attitude	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your boyfriend/girlfriend	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your children	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your parents	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your spouse	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10

## History

### Patient's Birth/Childhood History:

You were born:  Term  Premature  Don't know

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

Age of introduction of: Solid food: \_\_\_\_\_ Wheat \_\_\_\_\_ Dairy \_\_\_\_\_

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

### 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) \_\_\_\_\_

## Men's History (cont.)

### 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
<i>Age (if still alive)</i>													
<i>Age at death (if deceased)</i>													
Cancer	<input type="checkbox"/>												
Heart disease	<input type="checkbox"/>												
Hypertension	<input type="checkbox"/>												
Obesity	<input type="checkbox"/>												
Diabetes	<input type="checkbox"/>												
Stroke	<input type="checkbox"/>												
Autoimmune disease	<input type="checkbox"/>												
Arthritis	<input type="checkbox"/>												
Kidney disease	<input type="checkbox"/>												
Thyroid problems	<input type="checkbox"/>												
Seizures/epilepsy	<input type="checkbox"/>												
Psychiatric disorders	<input type="checkbox"/>												
Anxiety	<input type="checkbox"/>												
Depression	<input type="checkbox"/>												
Asthma	<input type="checkbox"/>												
Allergies	<input type="checkbox"/>												
Eczema	<input type="checkbox"/>												
ADHD	<input type="checkbox"/>												
Autism	<input type="checkbox"/>												
Irritable Bowel Syndrome	<input type="checkbox"/>												
Dementia	<input type="checkbox"/>												
Substance abuse	<input type="checkbox"/>												
Genetic disorders	<input type="checkbox"/>												
Other: _____	<input type="checkbox"/>												

## Medical History: Illnesses/Conditions

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

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

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

## 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		
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	Musculoskeletal (cont.)	Mild	Moderate	Severe
Cold hands and feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck muscle spasm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tendonitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daytime sleepiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tension headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty falling asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TMJ problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Early waking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Mood/Nerves</b>			
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Agoraphobia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flushing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Auditory hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heat intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blackouts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night waking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nightmares	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can't remember dreams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low body temperature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	With balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Head, Eyes, and Ears</b>				With thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conjunctivitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	With judgment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted sense of smell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	With speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted taste	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	With memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear fullness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness (spinning)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear ringing/buzzing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye crusting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fearfulness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyelid margin redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Light-headedness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other phobias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paranoia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to loud noises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Musculoskeletal</b>				Tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back muscle spasm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tremor/trembling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Calf cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Visual hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest tightness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Cardiovascular</b>			
Foot cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Angina/chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint deformity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breathlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irregular pulse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle spasms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle twitches:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Around eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen ankles/feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arms or legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

## Symptom Review (cont.)

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

Urinary	Mild	Moderate	Severe	Digestion (cont.)	Mild	Moderate	Severe
Bed wetting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lower abdominal pain			
Hesitancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mucus in stools			
Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Periodontal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore tongue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leaking/incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Strong stool odor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain/burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Undigested food in stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate enlargement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Upper abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urgency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Eating</b>			
<b>Digestion</b>				Binge eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anal spasms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bad teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Can't gain weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Can't lose weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloating of:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Carbohydrate craving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Carbohydrate intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whole abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloating after meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Salt cravings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood in stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent dieting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sweet cravings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Canker sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Caffeine dependency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Respiratory</b>			
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cracking at corner of lips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bad odor in nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dentures w/poor chewing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cough - dry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cough - productive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hayfever:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Farting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Summer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fissures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foods "repeat" (reflux)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Change of season	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nasal stuffiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intolerance to:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lactose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All dairy products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus fullness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gluten (wheat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Corn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Snoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eggs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatty foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yeast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Liver disease/jaundice (yellow eyes or skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

## Symptom Review (cont.)

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

Nails	Mild	Moderate	Severe	Skin Problems (cont.)	Mild	Moderate	Severe
Bitten	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brittle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Curve up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Herpes - genital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frayed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fungus - fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jock itch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fungus - toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lackluster skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Moles w color/size change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ragged cuticles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oily skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ridges	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pale skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patchy dullness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thickening of:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Finger nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toenails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Red face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
White spots/lines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to bites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Lymph Nodes</b>				Sensitive to poison ivy/oak	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged/neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tender/neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other enlarged/tender	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin darkening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
lymph nodes				Strong body odor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Skin, Dryness of</b>				Thick calluses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vitiligo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Itching Skin</b>			
Any cracking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any peeling?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear canals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
And unmanageable?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any cracking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any peeling?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mouth/throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nipples	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scalp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any dandruff?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin in general	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Roof of mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Skin Problems</b>				Scalp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne on back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin in general	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne on chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne on face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Male Reproductive</b>			
Acne on shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Discharge from penis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Athlete's foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ejaculation problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bumps on back of upper arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genital pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cellulite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Impotence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dark circles under eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ears get red	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lumps in testicles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Poor libido (low sex drive)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Medications/Supplements

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

## **Nutritional supplements (vitamins/minerals/herbs etc.)**

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?

	<b>&lt; 5</b>	<b>&gt; 5</b>	<b>Reason for Use</b>
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.)?

	<b>&lt; 5</b>	<b>&gt; 5</b>	<b>Reason for Use</b>
Infancy/Childhood			
Teen			
Adulthood			

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## Readiness Assessment and Health Goals

### 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 \_\_\_\_\_

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## Health Goals

What do you hope to achieve in your visit with us? \_\_\_\_\_

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When was the last time you felt well? \_\_\_\_\_

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Did something trigger your change in health? \_\_\_\_\_

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What makes you feel better? \_\_\_\_\_

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What makes you feel worse? \_\_\_\_\_

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How does your condition affect you? \_\_\_\_\_

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What do you think is happening and why? \_\_\_\_\_

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What do you feel needs to happen for you to get better? \_\_\_\_\_

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