



**RADIANTLY**  
H E A L T H Y

## New Male Patient Packet

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**PLEASE COMPLETE THE FOLLOWING FORM.**



SAVE THIS FORM TO YOUR COMPUTER OR DEVICE AND [EMAIL TO NEWPATIENT@RH-MD.COM](mailto:NEWPATIENT@RH-MD.COM).  
YOU MAY ALSO PRINT THE FORM, FILL IT OUT AND BRING IT INTO OUR OFFICE.



## GENERAL INFORMATION

Name: \_\_\_\_\_  
*First Middle Last*

Date of Birth: \_\_\_\_\_ Gender:  Male  Female

Genetic Background:  African  European  Native American  Mediterranean  
 Asian  Ashkenazi  Middle Eastern  \_\_\_\_\_

Highest Education Level:  High School  Under-Graduate  Post-Graduate

Employer: \_\_\_\_\_

Job Title: \_\_\_\_\_

Primary Address: \_\_\_\_\_  
*House Number and Street Apt. No.*

\_\_\_\_\_

*City*

*State*

*Zip*

Alternate Address: \_\_\_\_\_  
*House Number and Street Apt. No.*

Preferred Contact Method

Home Phone: \_\_\_\_\_  Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_  Fax Number: \_\_\_\_\_

Email: \_\_\_\_\_

OK to Receive Text Messages About Appts etc?

Emergency Contact: Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Primary Care Physician Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

Referred by:  Website  Magazine Article  Friend/Family \_\_\_\_\_  
 Natural Awakenings  Space Coast Living  Other Doctor \_\_\_\_\_



## Health Goals

What would be your top 3 things you want to achieve with our partnership in your health and wellness journey?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

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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## MSQ - Medical Symptom/Toxicity Questionnaire

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If related to previous questionnaire, please record your symptoms for past 48 hours.

<b>POINT SCALE</b>	0 = Never or almost never have the symptom	1 = Occasionally have it, effect is not severe
	2 = Occasionally have it, effect is severe	3 = Frequently have it, effect is not severe
	4 = Frequently have it, effect is severe	

### DIGESTIVE TRACT

- Nausea or vomiting
- Diarrhea
- Constipation
- Bloating feeling
- Belching or passing gas
- Heartburn
- Intestinal/stomach pain

TOTAL \_\_\_\_\_

### EARS

- Itchy ears
- Earaches, ear infections
- Drainage from ear
- Ringing in ears, hearing loss

TOTAL \_\_\_\_\_

### EMOTIONS

- Mood Swings
- Anxiety, irritability, aggressiveness
- Depression

TOTAL \_\_\_\_\_

### ENERGY/ACTIVITY

- Fatigue, sluggishness
- Apathy, lethargy
- Hyperactivity
- Restlessness

TOTAL \_\_\_\_\_

### EYES

- Watery or itchy eyes
- Swollen, reddened, sticky eyelids
- Bags or dark circles under eyes
- Blurred or tunnel visions (does not include near or far-sightedness)

TOTAL \_\_\_\_\_

### HEAD

- Headaches
- Faintness
- Dizziness
- Insomnia

TOTAL \_\_\_\_\_

### HEART

- Irregular or skipped heartbeat
- Rapid or pounding heartbeat
- Chest pain

TOTAL \_\_\_\_\_

### JOINT/MUSCLES

- Pain or aches in joints
- Arthritis
- Stiffness, limitation of movement
- Pain or aches in muscles
- Feeling of weakness or tiredness

TOTAL \_\_\_\_\_

### LUNGS

- Chest congestion
- Asthma, bronchitis
- Shortness of breath
- Difficulty breathing

TOTAL \_\_\_\_\_

### MIND

- Poor memory
- Confusion, poor comprehension
- Poor concentration
- Poor physical coordination
- Difficulty in making decisions
- Stuttering or stammering
- Slurred speech
- Learning disabilities

TOTAL \_\_\_\_\_

### MOUTH/THROAT

- Chronic coughing
- Gagging: frequent need to clear throat
- Sore throat; hoarseness; loss of voice
- Swollen/dischored tongue, gum, lips

TOTAL \_\_\_\_\_

### NOSE

- Stuffy nose
- Sinus problems
- Hay fever
- Sneezing attacks
- Excessive mucus formation

TOTAL \_\_\_\_\_

### SKIN

- Acne
- Hives, rashes or dry skin
- Hair loss
- Flushing or hot flashes
- Excessive sweating

TOTAL \_\_\_\_\_

### WEIGHT

- Binge eating/drinking
- Craving certain foods
- Excessive weight
- Compulsive eating
- Water retention

TOTAL \_\_\_\_\_

### OTHER

- Frequent illness
- Frequent or urgent urination
- Genital itch or discharge

TOTAL \_\_\_\_\_

**GRAND TOTAL \_\_\_\_\_** Add individual scores and total each group. Add each group scores and give a grand total.  
**KEY - Optimal is less than 10 Mild Toxicity: 10-50 Moderate Toxicity: 50-100 Severe Toxicity: 100+**



## Allergies

Name of Medication/Supplement/Food

Reaction

_____	_____
_____	_____
_____	_____
_____	_____

## 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

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

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



## 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, list food and symptoms: \_\_\_\_\_

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 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"/> Fat 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 with 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 health foods | <input type="checkbox"/> Confused about nutrition advice                                |



**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 quite?  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 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 sought counseling?  Yes  No

Are you currently in therapy?  Yes  No

If yes, describe: \_\_\_\_\_

Have you ever been abused, a victim of crime, or experiences 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 occupation: \_\_\_\_\_

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 a scale of 1-10, or N/A if not applicable)*

	N/A	POORLY			FINE			VERY WELL			
	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
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

### PATIENTS 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: \_\_\_\_\_

If you 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: \_\_\_\_\_

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) \_\_\_\_\_

### 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 apply*

	Mother	Father	Brother(s)	Sisters(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age (if still alive)												
Age at death (if deceased)												
Cancers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Auto Immune Diseases (such as lupus)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genetic disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



**Medications/Supplements**

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

Medication	Dosage	Start Date (mc/yr)	Reason for Use

Nutritional supplements (vitamins/minerals/herbs etc.)

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

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

## 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	<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"/>
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"/>

Musculoskeletal	Yes	Past
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"/>
Arythmia (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"/>
Heartaches	<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.)**

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



## 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 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 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 life lead you to question your capacity to follow through?**

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*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 on-going support (e.g. telephone consults, email correspondence) from our professional staff would be helpful to you as you implement a personal health program?**  5  4  3  2  1

**Comments:** \_\_\_\_\_  
\_\_\_\_\_



# Diet, Nutrition, and Lifestyle Journal - 3 Day

Patient Name: \_\_\_\_\_ Date \_\_\_\_\_

Food Plan Type: \_\_\_\_\_

## DAY 1

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-AM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Lunch Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Dinner Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Bed Time		

P: Proteins F: Fats C: Carbohydrates R: Red; O: Orange; Y: Yellow; G: Green; B/P/BL: Blue/Purple/Black W/T/BR: White/Tan/Brown

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
<b>SLEEP</b> Quantity: _____ (hours) Quality: <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good  <b>RELAXATION</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Type/amount:	<b>Type, Duration, &amp; Intensity</b> <input type="checkbox"/> Aerobic:  <input type="checkbox"/> Strength:  <input type="checkbox"/> Flexibility:	<b>Stress Reduction Practices:</b>   <b>Stressors:</b>	<b>Supporting:</b>   <b>Non-supporting:</b>

Mental	Emotional	Spiritual



# Diet, Nutrition, and Lifestyle Journal - 3 Day

Patient Name: \_\_\_\_\_ Date \_\_\_\_\_

Food Plan Type: \_\_\_\_\_

## DAY 2

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-AM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Lunch Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Dinner Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Bed Time		

P: Proteins F: Fats C: Carbohydrates R: Red; O: Orange; Y: Yellow; G: Green; B/P/BL: Blue/Purple/Black W/T/BR: White/Tan/Brown

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
<b>SLEEP</b> Quantity: _____ (hours) Quality: <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good  <b>RELAXATION</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Type/amount:	<b>Type, Duration, &amp; Intensity</b> <input type="checkbox"/> Aerobic:  <input type="checkbox"/> Strength:  <input type="checkbox"/> Flexibility:	<b>Stress Reduction Practices:</b>   <b>Stressors:</b>	<b>Supporting:</b>   <b>Non-supporting:</b>

Mental	Emotional	Spiritual





# Diet, Nutrition, and Lifestyle Journal - 3 Day

Patient Name: \_\_\_\_\_ Date \_\_\_\_\_

Food Plan Type: \_\_\_\_\_

## DAY 3

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-AM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Lunch Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Dinner Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Bed Time		

P: Proteins F: Fats C: Carbohydrates R: Red; O: Orange; Y: Yellow; G: Green; B/P/BL: Blue/Purple/Black W/T/BR: White/Tan/Brown

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
<b>SLEEP</b> Quantity: _____ (hours) Quality: <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good  <b>RELAXATION</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Type/amount:	<b>Type, Duration, &amp; Intensity</b> <input type="checkbox"/> Aerobic:  <input type="checkbox"/> Strength:  <input type="checkbox"/> Flexibility:	<b>Stress Reduction Practices:</b>   <b>Stressors:</b>	<b>Supporting:</b>   <b>Non-supporting:</b>

Mental	Emotional	Spiritual



## **THANK YOU FOR COMPLETING THIS FORM.**

**PLEASE SAVE THIS FORM TO YOUR COMPUTER OR DEVICE  
AND [EMAIL TO NEWPATIENT@RH-MD.COM.](mailto:NEWPATIENT@RH-MD.COM)**

**YOU MAY ALSO PRINT THE FORM, FILL IT OUT AND  
BRING IT INTO OUR OFFICE.**