



RADIANTLY

HEALTHY

New Female 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 _____



Pharmacy Information

Primary Pharmacy: Name: _____ Phone Number: _____
Address: _____ City: _____
State: _____ Zip: _____
Email: _____ Fax*: _____

* It is extremely important that you list the pharmacy's fax number.

Compounding Pharmacy: Name: _____ Phone Number: _____
Address: _____ City: _____
State: _____ Zip: _____
Email: _____ Fax*: _____

* It is extremely important that you list the pharmacy's fax number.

Lab Information

Name: _____ Phone Number: _____
Address: _____ City: _____
State: _____ Zip: _____
Email: _____ Fax*: _____

* It is extremely important that you list the lab's fax number.

Health Insurance Information

Insurance information is for the purpose of prescriptions, lab orders, and referrals

Health Insurance Plan: _____ Policy Holder Name: _____

Policy Holder D.O.B.: _____ Relationship To Patient: Self Spouse Other

Type: Insurance Medicare Medicare Advantage Medicaid Tri-Care

Policy Number: _____ Group Number: _____

Mailing Address: _____

Phone Number: _____

Please email a copy of the front and back of your insurance card to newpatient@rh-md.com



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? _____

Did Something trigger your change in health? _____

What makes you feel better? _____

What makes you feel worse? _____

How does your condition affect you? _____

What do you think is happening and why? _____

What do you feel needs to happen for you to get better? _____

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.

POINT SCALE 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/discolored 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
- Underweight
- 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:

- Fat 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 health foods
- Significant other or family members have special dietary needs
- Love to eat
- Eat because I have to
- Have negative relationship with 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



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

WOMEN'S HISTORY

Obstetric History (Check box if applicable)

Pregnancies _____ Miscarriages _____ Abortions _____ Living children _____

Vaginal deliveries _____ Cesarean _____ Term births _____ Premature birth _____

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, postpartum depression, issues with breast feeding, etc.? Yes No

If yes, please explain _____



Menstrual History

Age of 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, please describe: _____

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.)? _____

Other Gynecological Symptoms: (Check if applicable)

Endometriosis Infertility Fibrocystic breasts Vaginal infection Fibroids

Ovarian cysts Pelvic inflammatory disease Reproductive cancer

Sexually transmitted disease (describe) _____

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) _____



FAMILY HISTORY

<i>Check family members that apply</i>	Mother	Father	Brother(s)	Sisters(s)	Child	Child	Child	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	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"/>

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)		
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:	Yes	Past
Musculoskeletal		
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		
Arythmia (irregular heart rate)		
Murmur		
Mitral valve prolapse		
Other:		
Neurologic/Emotional		
Epilepsy/Seizures		
ADD/ADHD		
Heartaches		
Migraines		
Depression		
Anxiety		
Autism		
Multiple sclerosis		
Parkinson's disease		
Dementia		
Other:		
Cancer		
Lung		
Breast		
Colon		
Prostate		
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		
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:		
Hospitalization	Date	Reason



MEDICATION

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

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, or Aspirin? Yes No Tylenol (acetaminophen)? Yes No

Acid Blocking Drugs? (Tagamet, Zantac, Prilosec, etc.) Yes No



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?

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

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

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

Mental	Emotional	Spiritual



**THANK YOU FOR
COMPLETING THIS FORM.**

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