Functional Medicine New Patient Application

General Information

Name:_____
First Middle Last

Preferred Name:_____

Date of Birth: _____Age: _____

Gender: ☐Male ☐Female

Genetic Background: ☐ African- American ☐ Northern European ☐ Native American ☐ Asian
☐ Mediterranean ☐ Middle Eastern ☐ Caucasian ☐ Other

Material Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Primary Address: _____
Number, Street Apt. No.

_____
City State Zip

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Employer:_____ **Length of Employment:**_____

Nature of Business: _____

If Child, Guardian: _____**Relationship**: _____

Emergency Contact: _____
Name Cell Phone Number

Primary Physician's Name: _____

Phone Number: _____ **Fax** : _____

Referred by:
☐ Google (which words): _____
☐ Media: _____
☐ Family Member: _____
☐ Friend: _____
☐ Other: _____

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COMPLAINTS/ CONCERNS

Please list current and ongoing problems in order of priority:

Describe Problems:	Mild	Moderate	Severe
Example type 2 Diabetes			X
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

Prior Treatment/ Approach	Excellent	Good	Fair	Poor
Example: Medication				X
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐

What makes you feel worse? _____

What makes you feel better? _____

What has your health problems caused you to miss out on in life:

Work: _____

Home: _____

Social/Daily Activities: _____

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

_____

If you were unable to find a solution to your health problem what do you think will happen? _____

_____

List your health goals? _____

_____

How to motivated are you to achieve your health goals? 0-10, 10 being most motivated: _____

ALLERGIES

Medication/ Supplement/ Food:

_____

_____

Reaction:

_____

_____

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MEDICAL HISTORY DISEASES/ DIAGNOSIS / CONDITIONS

Check appropriate box and provide date of onset

GASTROINTESTINAL

- ☐ Irritable Bowel Syndrome _____
- ☐ Inflammatory Bowel Disease _____
- ☐ Crohn's _____
- ☐ Ulcerative Colitis _____
- ☐ Gastritis or peptic Ulcer Disease_____
- ☐ GERD (reflux) _____
- ☐ Celiac Disease _____
- ☐ Other _____

CARDIOVASCULAR

- ☐ Heart Attack _____
- ☐ Other Heart Disease _____
- ☐ Stroke _____
- ☐ Elevated Cholesterol _____
- ☐ Arrhythmia (irregular heart rate)_____
- ☐ Hypertension (high blood pressure)_____
- ☐ Rheumatic Fever_____
- ☐ Mitral Valve Prolapse_____
- ☐ Other_____

METABOLIC/ENDOCRINE

- ☐ Type 1 Diabetes _____
- ☐ Type 2 Diabetes _____
- ☐ Hypoglycemia _____
- ☐ Metabolic Syndrome _____
- ☐ (Insulin Resistance or Pre-Diabetes)_____
- ☐ Hypothyroidism (low thyroid) _____
- ☐ Hyperthyroidism (overactive thyroid) _____
- ☐ Endocrine Problems _____
- ☐ Polycystic Ovarian Syndrome (PCOS) _____
- ☐ Infertility _____
- ☐ Weight Gain_____
- ☐ Weight Loss_____
- ☐ Frequent Weight Fluctuations_____
- ☐ Bulimia_____
- ☐ Anorexia_____
- ☐ Binge Eating Disorder_____
- ☐ Night Eating Syndrome_____
- ☐ Eating Disorder (non-specific_____
- ☐ Other_____

CANCER

- ☐ Lung Cancer _____
- ☐ Breast Cancer _____
- ☐ Colon Cancer_____
- ☐ Ovarian Cancer_____
- ☐ Prostate Cancer_____
- ☐ Skin Cancer_____

GENITAL AND URINARY SYSTEMS

- ☐ Kidney Stones _____
- ☐ Gout _____
- ☐ Interstitial Cystitis _____
- ☐ Frequent Urinary Tract Infections_____
- ☐ Frequent Yeast Infections_____
- ☐ Erectile Dysfunction or Sexual Dysfunction_____
- ☐ Other_____

MUSCULOSKELETAL/PAIN

- ☐ Osteoarthritis _____
- ☐ Fibromyalgia_____
- ☐ Chronic Pain_____
- ☐ Other _____

INFLAMMATORY/AUTOIMMUNE

- ☐ Chronic Fatigue Syndrome _____
- ☐ Autoimmune Disease _____
- ☐ Rheumatoid Arthritis _____
- ☐ Lupus SLE _____
- ☐ Immune Deficiency Disease _____
- ☐ Herpes-Genital _____
- ☐ Severe Infectious Disease_____
- ☐ Poor Immune Function_____
- ☐ (frequent infections)_____
- ☐ Food Allergies_____
- ☐ Environmental Allergies_____
- ☐ Multiple Chemical Sensitivities_____
- ☐ Latex Allergy_____
- ☐ Other_____

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MEDICAL HISTORY (CONTINUED)

DISEASES/DIAGNOSIS/CONDITIONS Check appropriate box and provide date of onset

RESPIRATORY DISEASES

- ☐ Asthma, _____
- ☐ Chronic Sinusitis _____
- ☐ Bronchitis _____
- ☐ Emphysema _____
- ☐ Pneumonia_____
- ☐ Tuberculosis_____
- ☐ Sleep Apnea_____
- ☐ Other_____

SKIN DISEASES

- ☐ Eczema _____
- ☐ Psoriasis _____
- ☐ Acne _____
- ☐ Melanoma_____
- ☐ Skin Cancer_____
- ☐ Other_____

NEUROLOGIC/MOOD

- ☐ Depression_____
- ☐ Anxiety_____
- ☐ Bipolar Disorder _____
- ☐ Schizophrenia _____
- ☐ Headaches _____
- ☐ Migraines _____
- ☐ ADD/ADHD _____
- ☐ Autism _____
- ☐ Mild Cognitive Impairment_____
- ☐ Memory Problems_____
- ☐ Parkinson's Disease_____
- ☐ Multiple Sclerosis_____
- ☐ ALS_____
- ☐ Seizures_____
- ☐ Other Neurological Problems_____

PREVENTIVE TESTS AND DATE OF LAST TEST

Check box if yes and provide date

- ☐ Full Physical Exam _____
- ☐ Bone Density _____
- ☐ Colonoscopy _____
- ☐ Cardiac Stress Test _____
- ☐ EBT Heart Scan _____
- ☐ EKG_____
- ☐ Hem occult Test-stool test for blood_____
- ☐ MRI_____
- ☐ CT Scan_____
- ☐ Upper Endoscopy_____
- ☐ Upper GI Series_____
- ☐ Ultrasound_____

INJURIES

Check box if yes: ☐ Back Injury ☐ Head Injury ☐ Neck Injury ☐ Broken Bones

SURGERIES

Check box if yes and provide date of surgery

- ☐ Appendectomy _____
- ☐ Hysterectomy+/-Ovaries _____
- ☐ Gall Bladder _____
- ☐ Hernia _____
- ☐ Tonsillectomy _____
- ☐ Dental Surgery _____
- ☐ Joint Replacement -Knee/Hip _____
- ☐ Heart Surgery-Bypass Valve _____
- ☐ Angioplasty or Stent _____
- ☐ Pacemaker _____
- ☐ Other _____
- ☐ None _____

BLOOD TYPE: ☐ A ☐ B ☐ AB ☐ O ☐ Rh+ ☐ Unknown

HOSPITALIZATIONS

☐ None

Date:	**Reason:**

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GI HISTORY

Foreign Travel? ☐ Yes ☐ No Where? _____
Wilderness Camping? ☐ Yes ☐ No Where? _____
Have you ever had severe: ☐ Gastroenteritis ☐ Diarrhea
Do you feel like you digest your food well? ☐ Yes ☐ No
Do you feel bloated after meals? ☐ Yes ☐ No

PATIENT BIRTH HISTORY

☐ Term ☐ Premature
Pregnancy Complications: _____
Birth Complications: _____
☐ Breast Fed. How long? _____ ☐ Bottle-fed
Age at introduction of: Solid Foods: _____ Dairy: _____Wheat: _____
Did you eat a lot of candy or sugar as a child? ☐ Yes ☐ No

DENTAL HISTORY

☐ Silver Mercury Fillings How many? _____
☐ Gold Fillings
☐ Root Canals How many? _____
☐ Implants
☐ Tooth Pain
☐ Bleeding Gums
☐ Gingivitis
☐ Problems with Chewing

Do you floss regularly? ☐ Yes ☐ No

MEN'S HISTORY (FOR MEN ONLY)

Have you had a PSA done? ☐ Yes ☐ No
PSA Level: ☐0-2 ☐2-4 ☐4-10 ☐>1O
☐ Prostate Enlargement ☐ Prostate infection ☐Change in Libido ☐ Impotence
☐ Difficulty Obtaining an Erection ☐ Difficulty Maintaining an Erection
☐ Nocturia (urination at night) How many times at night? _____
☐ Urgency/Hesitancy/Change in Urinary Stream ☐Loss of Control of Urine

GYNECOLOGIC HISTORY (FOR WOMEN ONLY)
OBSTETRI C HISTORY (Check box if yes and provide number)

☐ Pregnancies _____ ☐Caesarean. _____ ☐Vaginal deliveries _____
☐ Miscarriage_____ ☐Abortion. _____ ☐Living Children. _____
☐ Post-partum Depression ☐Toxemia ☐Gestational Diabetes Baby over 8 Pounds
☐ Breast Feeding for how long? _____

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MENSTRUAL HISTORY

Age at First Period: _____ Menses Frequency: _____ Length: _____ Pain: ☐Yes ☐No
Clotting: ☐Yes ☐No
Has your period ever skipped? _____ For how long? _____
Last Menstrual Period: _____
Use of hormonal contraception such as: ☐Birth Control Pills ☐Patch ☐Other _____
How long? _____
Do you use contraception? ☐Yes ☐No
☐Condom ☐Diaphragm ☐IUD ☐Partner Vasectomy

WOMEN'S DISORDERS/HORMONAL IMBALANCES

☐ Fibrocystic Breasts ☐Endometriosis ☐Fibroids ☐Infertility
☐ Painful Periods ☐Heavy periods ☐PMS
Last Mammogram: _____Breast Biopsy/Date: _____
Last Pap test: _____ ☐ Normal ☐ Abnormal
Last Bone Density: _____ Results: ☐High ☐Low ☐within Normal Range
Are you in menopause? ☐Yes ☐No
Age at Menopause _____
☐Hot Flashes ☐Mood Swings ☐Concentration/Memory Problems ☐Vaginal Dryness
☐Decreased Libido ☐Heavy Bleeding ☐ Joint Pains ☐ Headaches
☐Weight Gain ☐Loss of Control of Urine ☐ Palpitations
☐Use of hormone replacement therapy? how long? _____

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MEDICATIONS
CURRENT MEDICATIONS

MEDICATION	DOSE	FREQUENCY	START DATE (MONTH/YEAR)	REASON FOR USE

Previous Medications: *Last 10 Years*

MEDICATION	DOSE	FREQUENCY	START DATE (MONTH/YEAR)	REASON FOR USE

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

SUPPLEMENT AND BRAND	DOSE	FREQUENCY	START DATE (MONTH/YEAR)	REASON FOR USE

Have your medications or supplements ever caused you unusual side effects or problems? ☐Yes ☐No
Describe: _____
Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ☐Yes ☐No
Have you had prolonged or regular use of Tylenol? ☐Yes ☐No
Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.) ☐Yes ☐No
Frequent antibiotics> 3 times/year ☐Yes ☐No
Long term antibiotics ☐Yes ☐No
Use of steroids (prednisone, nasal allergy inhalers) in the past ☐Yes ☐No
Use of oral contraceptives ☐Yes ☐No

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FAMILY HISTORY

Check family members that apply.	MOTHER	FATHER	BROTHER(S)	SISTER(S)	MATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	PATERNAL GRANDFATHER
Age (if still alive)								
Age at death (if deceased)								
Cancers	☐	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Breast or Ovarian Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Sondylitis)	☐	☐	☐	☐	☐	☐	☐	☐
Inflammatory Bowel Disease	☐	☐	☐	☐	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Problems	☐	☐	☐	☐	☐	☐	☐	☐
Irritable Bowel Syndrome	☐	☐	☐	☐	☐	☐	☐	☐
Celiac Disease	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Eczema / Psoriasis	☐	☐	☐	☐	☐	☐	☐	☐
Food Allergies, Sensitivities or Intolerances	☐	☐	☐	☐	☐	☐	☐	☐
Environmental Sensitivities	☐	☐	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐	☐	☐
Parkinson's	☐	☐	☐	☐	☐	☐	☐	☐
ALS or other Motor Neuron Diseases	☐	☐	☐	☐	☐	☐	☐	☐
Genetic Disorders	☐	☐	☐	☐	☐	☐	☐	☐
Substance Abuse (such as alcoholism)	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric Disorders	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐
Schizophrenia	☐	☐	☐	☐	☐	☐	☐	☐
ADHD	☐	☐	☐	☐	☐	☐	☐	☐
Autism	☐	☐	☐	☐	☐	☐	☐	☐
Bipolar Disease	☐	☐	☐	☐	☐	☐	☐	☐
Lupus	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐

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SOCIAL HISTORY

NUTRITION HISTORY

Have you ever had a nutrition consultation? ☐Yes ☐No
Have you made any changes in your eating habits because of your health? ☐Yes ☐No
Describe: _____
Do you currently follow a special diet or nutritional program? ☐Yes ☐No

Check all that apply:

☐Low Fat ☐Low Carbohydrate ☐High Protein ☐Low Sodium ☐Diabetic ☐No Dairy
☐No Wheat ☐Gluten Restricted ☐Vegetarian ☐Vegan
☐Specific Program for Weight Loss/Maintenance Type: _____
☐Other: _____

Height (feet/inches) _____ Current Weight _____
Usual Weight Range +/- 5 lbs _____ Desired Weight Range +/- 5 lbs _____
Highest adult weight _____ Lowest adult weight _____
Weight Fluctuations (> 10 lbs.) ☐Yes ☐No Body Fat%_____

How often do you weigh yourself? ☐Daily ☐Weekly ☐Monthly ☐Rarely ☐Never
Have you ever had your metabolism (resting metabolic rate) checked? ☐Yes ☐No
If yes, what was it? _____
Do you avoid any particular foods? ☐Yes ☐No
If yes, types and reason _____
_____
If you could only eat a few foods a week, what would they be?
_____
Do you grocery shop? ☐Yes ☐No
If no, who does the shopping? _____
Do you read food labels? ☐Yes ☐No
Do you cook? □ Yes □ No If no, who does the cooking? _____
How many meals do you eat out per week? ☐0-1 ☐1-3 ☐3-5 ☐>5 meals per week

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

☐Fast eater
☐Erratic eating pattern
☐Eat too much
☐Late night eating
☐Dislike healthy food
☐Time constraints
☐Eat more than 50% meals away from home
☐Travel frequently
☐Non-availability of healthy foods
☐Do not plan meals or menus
☐Reliance on convenience items
☐Poor snack choices
☐Significant other or family members don't like healthy foods
☐Significant other or family members have special dietary needs or food preferences
☐Love to eat
☐Eat because I have to
☐Have a negative relationship to food
☐Struggle with eating issues
☐Emotional eater (eat when sad, lonely depressed, bored)
☐Eat too much under stress
☐Eat too little under stress
☐Don't care to cook
☐Eating in the middle of the night
☐Confused about nutrition advice

The most important thing I should change about my diet to improve my health is:

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SMOKING

Currently Smoking? ☐Yes ☐No
How many years? _____ Packs per day: _____ Attempts to quit: _____
Previous Smoking: How many years? _____ Packs per day? _____
Second Hand Smoke Exposure? _____

ALCOHAL INTAKE

How many drinks currently per week? 1 drink= 5 ounces wine, 12 ounces beer, 1.5 ounces spirits
☐None ☐1-3 ☐4-6 ☐7-10 ☐> 10 If "None," skip to Other Substances
Previous alcohol intake? ☐Yes (☐Mild ☐Moderate ☐High) ☐None

OTHER SUBSTANCES

Caffeine Intake: ☐Yes ☐No
Coffee cups/day: ☐1 ☐2-4 ☐> 4 I Tea cups/day: ☐1 ☐2-4 ☐> 4
Caffeinated Sodas or Diet Sodas Intake: ☐Yes ☐No
12-ounce can/bottle ☐1 ☐2-4 ☐> 4 per day
List favorite type (Ex. Diet Coke, Pepsi, etc.): _____
Are you currently using any recreational drugs? ☐Yes ☐No
Type _____
Have you ever used IV or inhaled recreational drugs? ☐Yes ☐No

EXERCISE

Current Exercise Program: (List type of activity, number of sessions/week, and duration)

Activity	Type	Frequency per Week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength			
Other (yoga, Pilates, etc.)			
Sports or Leisure Activities (golf, tennis, jogging, etc.)			

Rate your level of motivation for including exercise in your life? ☐Low ☐Medium ☐High
List problems that limit activity: _____
_____

Do you feel unusually fatigued after exercise? ☐Yes ☐No
If yes, please describe: _____
Do you usually sweat when exercising? ☐Yes ☐No

SLEEP/REST

Average number of hours you sleep per night: ☐>10 ☐8-10 ☐6-8 ☐< 6
Do you have trouble falling asleep? ☐Yes ☐No
Do you feel rested upon awakening? ☐Yes ☐No
Do you have problems with insomnia? ☐Yes ☐No
Do you experience "night sweats"? ☐Yes ☐No
Do you snore? ☐Yes ☐No
Do you use sleeping aids? ☐Yes ☐No
Explain: _____

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ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

Do you have known adverse food reactions or sensitivities? ☐Yes ☐No
If yes, describe symptoms: _____

Do you have any food allergies? ☐Yes ☐No
If yes, list all: _____
_____

Do you have an adverse reaction to caffeine? ☐Yes ☐No
When you drink caffeine do you feel: ☐Irritable or wired ☐Aches & Pains

Do you adversely react to (Check all that apply)?
☐Monosodium glutamate (MSG) ☐Aspartame ☐Caffeine ☐Bananas
☐Garlic ☐Onion ☐Cheese ☐Citrus Foods ☐Chocolate ☐Alcohol ☐Red Wine
☐Sulfite Containing Foods (wine, dried fruit, salad bars) ☐Preservatives (ex. sodium benzoate)
☐Other: _____

Which of these significantly affect you? Check all that apply:
☐Cigarette Smoke ☐Perfumes/Colognes ☐Auto Exhaust Fumes ☐Other: _____

In your work or home environment, are you exposed to:
☐Chemicals ☐Electromagnetic Radiation ☐Mold ☐Water Damage (past/present)

Do you or have you lived or worked in a damp or moldy environment or had other mold exposures? ☐Yes ☐No

Do you have a known history of significant exposure to any harmful chemicals such as the following:
☐Herbicides ☐insecticides (frequent visits of exterminator) ☐Pesticides ☐Organic Solvents
☐Heavy Metals ☐Other _____
Chemical Name, Date, Length of Exposure: _____

Have you ever turned yellow (jaundiced)? ☐Yes ☐No
Have you ever been told you have Gilbert's syndrome or a liver disorder? ☐Yes ☐No
Explain: _____

Do you dry clean your clothes frequently? ☐Yes ☐No

Do you have any pets or farm animals? ☐Yes ☐No

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SYMPTOMS REVIEW

Please check all current symptoms or those present in during the past the 6 months.

GENERAL
- ☐ Cold Hands & Feet
- ☐ Cold Intolerance
- ☐ Low Body Temperature
- ☐ Low Blood Pressure
- ☐ Daytime Sleepiness
- ☐ Difficulty Falling Asleep
- ☐ Early Waking
- ☐ Fatigue
- ☐ Fever
- ☐ Flushing
- ☐ Heat Intolerance
- ☐ Night Waking
- ☐ Nightmares
- ☐ No Dream Recall

HEAD, EYES & EARS
- ☐ Conjunctivitis
- ☐ Distorted Sense of Smell
- ☐ Distorted Taste
- ☐ Ear Fullness
- ☐ Ear Pain
- ☐ Ear Ringing/Buzzing
- ☐ Lid Margin Redness
- ☐ Eye Crusting
- ☐ Eye Pain
- ☐ Hearing Loss
- ☐ Hearing Problems
- ☐ Headache
- ☐ Migraine
- ☐ Sensitivity to Loud Noises
- ☐ Vision problems (other than glasses)
- ☐ Macular Degeneration
- ☐ Vitreous Detachment
- ☐ Retinal Detachment

MUSCULOSKELETAL
- ☐ Back Muscle Spasm
- ☐ Calf Cramps
- ☐ Chest Tightness
- ☐ Foot Cramps
- ☐ Joint Deformity
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Stiffness
- ☐ Muscle Pain
- ☐ Muscle Spasms
- ☐ Muscle Stiffness

Muscle Twitches:
- ☐ Around Eyes
- ☐ Arms or Legs
- ☐ Muscle Weakness
- ☐ Neck Muscle Spasm D Tendonitis
- ☐ Tension Headache
- ☐ TMJ Problems

MOOD/NERVES
- ☐ Agoraphobia
- ☐ Anxiety
- ☐ Auditory Hallucinations
- ☐ Black-out
- ☐ Depression

Difficulty:
- ☐ Concentrating
- ☐ With Balance
- ☐ With Thinking
- ☐ With Judgment
- ☐ With Speech
- ☐ With Memory
- ☐ Dizziness (Spinning)
- ☐ Fainting
- ☐ Fearfulness
- ☐ Irritability
- ☐ Light-headedness
- ☐ Numbness
- ☐ Other Phobias
- ☐ Panic Attacks
- ☐ Paranoia
- ☐ Seizures
- ☐ Suicidal Thoughts
- ☐ Tingling
- ☐ Tremor /Trembling
- ☐ Visual Hallucinations

EATING
- ☐ Binge Eating
- ☐ Bulimia
- ☐ Can't Gain Weight
- ☐ Can't Lose Weight
- ☐ Can't Maintain Healthy Weight
- ☐ Frequent Dieting
- ☐ Poor Appetite
- ☐ Salt Cravings
- ☐ Carbohydrate Craving (breads, pastas)
- ☐ Sweet Cravings (candy, cookies, cakes)
- ☐ Chocolate Cravings
- ☐ Caffeine Dependency

DIGESTION
- ☐ Anal Spasms
- ☐ Bad Teeth
- ☐ Bleeding Gums

Bloating of:
- ☐ Lower Abdomen
- ☐ Whole Abdomen
- ☐ Bloating After Meals
- ☐ Blood in Stools
- ☐ Burping
- ☐ Canker Sores
- ☐ Cold Sores
- ☐ Constipation
- ☐ Cracking at Corner of Lips
- ☐ Cramps
- ☐ Dentures w /Poor Chewing
- ☐ Diarrhea
- ☐ Alternating Diarrhea and Constipation
- ☐ Difficulty Swallowing
- ☐ Dry Mouth
- ☐ Excess Flatulence/Gas
- ☐ Fissures
- ☐ Foods "Repeat" (Reflux)
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Upper Abdominal Pain
- ☐ Vomiting

Intolerance to:
- ☐ Lactose
- ☐ All Dairy Products Wheat
- ☐ Gluten (Wheat, Rye, Barley)
- ☐ Corn
- ☐ Eggs
- ☐ Fatty Foods
- ☐ Yeast
- ☐ Liver Disease/Jaundice (Yellow Eyes or Skin)
- ☐ Abnormal Liver Function Tests D Lower
- ☐ Abdominal Pain
- ☐ Mucus in Stools
- ☐ Periodontal Disease
- ☐ Sore Tongue
- ☐ Strong Stool Odor
- ☐ Undigested Food in Stomach

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SKIN PROBLEMS

- ☐ Acne on Back
- ☐ Acne on Chest
- ☐ Acne on Face
- ☐ Acne on Shoulders
- ☐ Athlete's Foot
- ☐ Bumps on Back of Upper Arms
- ☐ Cellulite
- ☐ Dark Circles Under Eyes
- ☐ Ears Get Red
- ☐ Easy Bruising
- ☐ Lack Of Sweating
- ☐ Eczema
- ☐ Hives
- ☐ Jock Itch
- ☐ Lackluster Skin
- ☐ Moles w/Color/Size Change
- ☐ Oily Skin
- ☐ Pale Skin
- ☐ Patchy Dullness
- ☐ Rash
- ☐ Red Face
- ☐ Sensitivity to Bites
- ☐ Sensitivity to Poison Ivy/Oak D Shingles
- ☐ Skin Darkening
- ☐ Strong Body Odor
- ☐ Hair Loss
- ☐ Vitiligo

ITCHING SKIN

- ☐ **S**kin in General
- ☐ Anus
- ☐ Arms
- ☐ Ear Canals
- ☐ Eyes
- ☐ Feet
- ☐ Hands
- ☐ Legs
- ☐ Nipples
- ☐ Nose
- ☐ Penis
- ☐ Roof of Mouth
- ☐ Scalp
- ☐ Throat

CARDIOVASCULAR

- ☐ Angina/ chest pain
- ☐ Breathlessness
- ☐ Heart Murmur
- ☐ Irregular Pulse
- ☐ Palpitations
- ☐ Phlebitis
- ☐ Swollen Ankles/Feet
- ☐ Varicose Veins

SKIN, DRYNESS OF

- ☐ Eyes
- ☐ Feet
  - ☐ Cracking?
  - ☐ Peeling?
- ☐ Hair ☐ Unmanageable?
- ☐ Hands
  - ☐ Cracking? ☐ Peeling?
- ☐ Mouth/Throat
- ☐ Scalp
- ☐ Dandruff?
- ☐ Skin In General

LYMPH NODES

- ☐ Enlarged/neck
- ☐ Tender/neck
- ☐ Other Enlarged/Tender
- ☐ Lymph Nodes

NAILS

- ☐ Bitten
- ☐ Brittle
- ☐ Curve Up
- ☐ Frayed
- ☐ Fungus-Fingers
- ☐ Fungus-Toes
- ☐ Pitting
- ☐ Ragged Cuticles
- ☐ Ridges
- ☐ Soft

Thickening of:

- ☐ Fingernails
- ☐ Toenails
- ☐ White Spots/Lines

RESPIRATORY

- ☐ Bad Breath
- ☐ Bad Odor in Nose
- ☐ Cough-Dry
- ☐ Cough-Productive
- ☐ Hoarseness
- ☐ Sore Throat

Hay Fever:

- ☐ Spring
- ☐ Summer
- ☐ Fall
- ☐ Change Of Season
- ☐ Nasal Stuffiness
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Fullness
- ☐ Sinus Infection
- ☐ Snoring
- ☐ Wheezing
- ☐ Winter Stuffiness

URINARY

- ☐ Bed Wetting
- ☐ Hesitancy (trouble getting started)
- ☐ Infection
- ☐ Kidney Disease
- ☐ Leaking/Incontinence
- ☐ Pain/Burning
- ☐ Prostate Infection
- ☐ Urgency

MALE REPRODUCTIVE

- ☐ Discharge From Penis
- ☐ Ejaculation Problem
- ☐ Genital Pain
- ☐ Impotence
- ☐ Prostate or Urinary Infection
- ☐ Lumps In Testicles
- ☐ Poor Libido (Sex Drive)

FEMALE REPRODUCTIVE

- ☐ Breast Cysts
- ☐ Breast Lumps
- ☐ Breast Tenderness
- ☐ Ovarian Cyst
- ☐ Poor Libido (Sex Drive)
- ☐ Vaginal Discharge
- ☐ Vaginal Odor
- ☐ Vaginal Itch
- ☐ Vaginal Pain with Sex

Premenstrual:

- ☐ Bloating Breast Tenderness
- ☐ Carbohydrate Cravings
- ☐ Chocolate Cravings
- ☐ Constipation
- ☐ Decreased Sleep
- ☐ Diarrhea
- ☐ Fatigue
- ☐ Increased Sleep
- ☐ Irritability

Menstrual:

- ☐ Cramps
- ☐ Heavy Periods
- ☐ Irregular Periods
- ☐ No Periods
- ☐ Scanty Periods

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