Irvine Functional Medicine & Nutrition

Express Your Inner Health

Intake Form

1219 County Line Road Suite B
Westerville, Ohio 43081

P. 614.839.2225 F. 614.891.8875

drirvine@sbcglobal.net

www.drsirvine.com

General Information

Date: Name:

Name _____
First *Middle* *Last*

Preferred Name _____

Date of Birth _____ Place of Birth _____

Age _____

Gender ○ Male ○ Female

Primary Address _____
Number, Street *Apt #*

_____
City *State/Province* *Zip Code/Postal Code*

Genetic Background
○ African ○ European ○ Native American ○ Mediterranean
○ Asian ○ Ashkenazi ○ Middle Eastern ○ Caucasian
○ Other: _____

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

Job Title _____ Hours per week _____

Nature of Business _____

Marital Status ○ Single ○ Married ○ Divorce ○ Widowed
○ Long Term Partnership

Home Phone _____

Work Phone _____

Cell Phone _____

Email _____

Emergency Contact _____
Name *Phone Number*

_____
Number, Street *Apt #*

_____
City *State/Province* *Zip Code/Postal Code*

Primary Care Physician _____
Name *Phone Number* *Fax Number*

How did you hear about our office? _____

Story Page

Name: Age: Sex: Date:

Please tell us your story about your health.

Medical Questionnaire

Allergies

Medication/Supplement/Food	Reaction

Complaints/Concerns

What do you hope to achieve by working with us? _____

_____

If you could permanently eliminate three problems, what would they be?

1. _____
2. _____
3. _____

When was the last time you felt well? _____

_____

Did something trigger change in health/symptoms? _____

_____

What makes you feel worse? _____

_____

What makes you feel better? _____

_____

Current Health Status/Concerns

Please provide us with current and ongoing problems

PROBLEM	DATE OF ONSET	SEVERITY/FREQUENCY	TREATMENT APPROACH	SUCCESS
EX. Headaches	*May 2006*	*2 times per week*	*Acupuncture/Aspirin*	*Mild Improvement*

What diagnosis or explanation(s), if any, have been given to you for these concerns?

What physician or other health care provider (including alternative or complimentary practitioners) have you seen for these conditions? _____

How much time have you lost from work or school in the past year due to these conditions? _____

Medical History

Diseases/Diagnosis/Conditions *Check appropriate box and provide date of onset (mm/yyyy).*

Past	Ongoing	GASTROINTESTINAL
☐	☐	Irritable Bowel Syndrome
☐	☐	Inflammatory Bowel Disease
☐	☐	Crohn's
☐	☐	Ulcerative Colitis
☐	☐	Gastritis or Peptic Ulcer Disease
☐	☐	GERD(reflux)
☐	☐	Celiac Disease
☐	☐	Gallstones
☐	☐	Other

Past	Ongoing	CARDIOVASCULAR
☐	☐	Heart Attack
☐	☐	Heart Disease
☐	☐	Stroke
☐	☐	Elevated Cholesterol
☐	☐	Arrhythmia (irregular heartbeat)
☐	☐	Hypertension (high blood pressure)
☐	☐	Rheumatic Fever
☐	☐	Mitral Valve Prolapse
☐	☐	Other

Past	Ongoing	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 Disorder
☐	☐	Eating Disorder (non-specific)
☐	☐	Other

Past	Ongoing	CANCER
☐	☐	Lung Cancer
☐	☐	Breast Cancer
☐	☐	Colon Cancer
☐	☐	Ovarian Cancer
☐	☐	Prostate Cancer
☐	☐	Skin Cancer
☐	☐	Other

Past	Ongoing	GENITAL & URINARY SYSTEMS
☐	☐	Kidney Stones
☐	☐	Gout
☐	☐	Interstitial Cystitis
☐	☐	Frequent Urinary Tract Infections
☐	☐	Frequent Yeast Infections
☐	☐	Erectile Dysfunction or Sexual Dysfunction
☐	☐	Other

Past	Ongoing	MUSCULOSKELETAL/PAIN
☐	☐	Osteoarthritis
☐	☐	Fibromyalgia
☐	☐	Chronic Pain
☐	☐	Other

Past	Ongoing	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
☐	☐	Hepatitis
☐	☐	Other

Medical History *(continued)*

Diseases/Diagnosis/Conditions *Check appropriate box and provide date of onset (mm/yyyy).*

Past	Ongoing	RESPIRATORY DISEASE
☐	☐	Asthma
☐	☐	Chronic Sinusitis
☐	☐	Bronchitis
☐	☐	Emphysema
☐	☐	Pneumonia
☐	☐	Tuberculosis
☐	☐	Sleep Apnea
☐	☐	Other

Past	Ongoing	SKIN DISEASE
☐	☐	Eczema
☐	☐	Psoriasis
☐	☐	Acne
☐	☐	Melanoma
☐	☐	Skin Cancer
☐	☐	Other

Past	Ongoing	MISCELLANEOUS
☐	☐	Anemia
☐	☐	Chicken Pox
☐	☐	German Measles
☐	☐	Measles
☐	☐	Mononucleosis
☐	☐	Mumps
☐	☐	Sleep Apnea
☐	☐	Whooping Cough

Past	Ongoing	NEUROLOGIC/MOOD
☐	☐	Depression
☐	☐	Anxiety
☐	☐	Bipolar Disorder
☐	☐	Schizophrenia
☐	☐	Headaches
☐	☐	Migraines
☐	☐	ADD/ADHD
☐	☐	Autism
☐	☐	Mild Cognitive Impairment
☐	☐	Memory Problems
☐	☐	Parkinson's Disease
☐	☐	Multiple Sclerosis
☐	☐	ALS
☐	☐	Seizures
☐	☐	Alzheimer's
☐	☐	Other

Medical History *(continued)*

Check appropriate box and provide date of test/injuries/surgeries (mm/yyyy).

PREVENTIVE TESTS

- ☐ Full Physical Exam
- ☐ Bone Density
- ☐ Colonoscopy
- ☐ Cardiac Stress Test
- ☐ EBT Heart Scan
- ☐ EKG
- ☐ Hemoccult Test- stool test for blood
- ☐ MRI
- ☐ CT Scan
- ☐ Upper Endoscopy
- ☐ Upper GI Series
- ☐ Ultrasound
- ☐ Mammogram
- ☐ X-Ray
- ☐ Other

SURGERIES

- ☐ Appendectomy
- ☐ Hysterectomy +/- Ovaries
- ☐ Gall Bladder
- ☐ Hernia
- ☐ Tonsillectomy
- ☐ Dental Surgery
- ☐ Joint Replacement (Knee/Hip)
- ☐ Heart Surgery - ByPass Valve
- ☐ Angioplasty or Stent
- ☐ Pacemaker
- ☐ Other *(List Below)*

INJURIES

- ☐ Back Injury
- ☐ Neck Injury
- ☐ Head Injury
- ☐ Broken Bones
- ☐ Other

BLOOD TYPE *(Please Check One)*

- ☐ A
- ☐ B
- ☐ AB
- ☐ O
- ☐ Rh+
- ☐ Unknown

Hospitalizations ☐ *NONE*

Date	Reason

COMMENTS

Gynecologic History

For Women Only

OBSTETRIC HISTORY *(Check Box If Yes And Provide Number Of)*

- ☐ Pregnancies
- ☐ Caesarean
- ☐ Vaginal Deliveries
- ☐ Miscarriage
- ☐ Abortion
- ☐ Living Children
- ☐ Post Partum Depression
- ☐ Toxemia
- ☐ Gestational Diabetes
- ☐ Baby Over 8 pounds
- ☐ Breast Feeding
  for how long?

MENSTRUAL HISTORY *(Check Box If Yes)*

Age at First Period?_____ Mensus Frequency?_____ Length?_____ Pain? ○ Yes ○ No

Clotting: ○ Yes ○ No Has your period ever skipped? ○ Yes ○ No For how long?

Last Menstrual Period?___

Use of hormonal contraception such as? ☐ Birth Control Pills ☐ Patch ☐ Nuva Ring

How Long?_____

Do you use contraception? ○ Yes ○ No ☐ Condom ☐ Diaphragm ☐ IUD ☐ Partner Vasectomy

WOMEN'S DISORDERS/ HORMONAL IMBALANCES

Do you experience breast tenderness, water retention, irritability or PMS symptoms in the second half of your cycle?

○ Yes ○ No

Please advise of any other symptoms that you feel are significant:_____

☐ 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?_____

Please check off if you are experiencing any of the following symptoms:

☐ Hot Flashes ☐ Mood Swings ☐ Concentration/ Memory Problems ☐ Joint Pains
☐ Vaginal Dryness ☐ Decreased Libido ☐ Heavy Bleeding ☐ Headaches
☐ Weight Gain ☐ Loss of Control of Urine ☐ Palpitations

☐ Use of hormone replacement therapy? *How Long?*_____

What Type? ☐ Estrogen ☐ Progesterone ☐ Ogen ☐ Estrace
☐ Premarin ☐ Provera ☐ Other: _____

Men's History

(For Men Only)

Have you ever had a PSA done? ○ Yes ○ No

PSA Level: ○ 0-2 ○ 2-4 ○ 4-10 ○ >10

☐ Prostate Enlargement ☐ Prostate Infection ☐ Change in Libido ☐ Impotence

☐ Difficulty Obtaining an Erection ☐ Difficulty Maintaining an Erection

Nocturia(urination at night) ○ Yes ○ No How many times a night?_____

☐ Urgency/Hesitancy/Change in Urinary System ☐ Lose of control of Urine

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 & Brand	Dose	Frequency	Start Date *(month/year)*	Reason For Use

Do your medications or supplements ever cause 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

Childhood History

Please answer to the best of your knowledge

	Yes	No	Don't Know	Comment
Were you a full term baby?				
A premature birth?				
Vaginal Delivery?				
C-Section?				
Breast fed?				
Bottle fed?				
WHEN PREGNANT WITH YOU, DID YOUR MOTHER:				
Smoke tobacco?				
Use recreational drugs?				
Drink alcohol?				
Use estrogen?				
Other prescriptions or non-prescription medications?				

Immunization History

Please indicate if you have been vaccinated against any of the following diseases:

	Yes	No	Don't Know	Comment
Smallpox				
Tetanus				
Diphtheria				
Pertussis				
Polio (oral)				
Polio (Injection)				
Mumps				
Measles				
Rubella (German Measles)				
Typhoid				
Cholera				

Childhood Diet

Was your childhood diet high in:

	Yes	No	Don't Know	Comment
Sugar? (Sweets, Candy, Cookies, etc)	◯	◯	◯	
Soda?	◯	◯	◯	
Fast food, pre-packaged foods, artificial sweeteners?	◯	◯	◯	
Milk, Cheeses, or other Dairy Products?	◯	◯	◯	
Meat, Vegetables, & Potato Diet	◯	◯	◯	
Vegetarian Diet?	◯	◯	◯	
Diet high in wheat (breads, cereals, pasta)?	◯	◯	◯	

As a child, were there foods that you had to avoid because they gave you symptoms? ◯ Yes ◯ No

If yes, please explain: (EX: milk – diarrhea)_____

Childhood Illnesses

Please indicate which of the following problems/conditions you experienced as a child (ages birth to 12 years) and the approximate age of onset.

	Yes	Age
ADD (Attention Deficient Disorder)	☐	
Asthma	☐	
Bronchitis	☐	
Chicken Pox	☐	
Colic	☐	
Congenital problems	☐	
Ear Infections	☐	
Fever Blisters	☐	
Frequent colds or Flu	☐	
Frequent Headaches	☐	
Hyperactivity	☐	
Jaundice	☐	

	Yes	Age
Mumps	☐	
Pneumonia	☐	
Seasonal Allergies	☐	
Skin Disorders	☐	
Strep Infections	☐	
Tonsillitis	☐	
Upset Stomach, Digestive Problems	☐	
Whooping Cough	☐	
Measles	☐	
Other (describe)	☐	
Other (describe)	☐	
Other (describe)	☐	

As a child did you have a high absence from school? ◯ Yes ◯ No

If yes, why?_____

Experience chronic exposure to second hand smoke in your home? ◯ Yes ◯ No

Experience Abuse? ◯ Yes ◯ No

Have alcoholic parents? ◯ Yes ◯ No

Family Health History

Please indicate current and past history to the best of your knowledge.

Please check family members that apply

	Father	Mother	Brother	Sister	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandfather	Paternal Grandmother
Age (if still living)									
Heart Attack									
Age at death (if deceased)									
Uterine Cancer									
Colon Cancer									
Breast Cancer									
Ovarian Cancer									
Prostate Cancer									
Skin Cancer									
ADD/ADHD									
ALS or other Motor Neuron Diseases									
Alzheimer's									
Anemia									
Anxiety									
Arthritis									
Asthma									
Autism									
Autoimmune Diseases (such as Lupus)									
Bipolar Disease									
Bladder disease									
Blood clotting problems									
Celiac disease									
Dementia									
Depression									
Diabetes									
Eczema									
Emphysema									
Environmental Sensitivities									

Family Health History *(continued)*

Please indicate current and past history to the best of your knowledge.
Please check family members that apply

	Father	Mother	Brother	Sister	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandfather	Paternal Grandmother
Epilepsy									
Flu									
Genetic Disorders									
Glaucoma									
Headache									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing spondylitis)									
Inflammatory Bowel Disease									
Insomnia									
Irritable Bowel Syndrome									
Kidney disease									
Multiple Sclerosis									
Nervous breakdown									
Obesity									
Osteoporosis									
Other									
Parkinson's									
Pneumonia/Bronchitis									
Psoriasis									
Psychiatric disorders									
Schizophrenia									
Sleep Apnea									
Smoking addiction									
Stroke									
Substance abuse (such as alcoholism)									
Ulcers									

Review Of Symptoms

Past	Ongoing	GENERAL
☐	☐	Fever
☐	☐	Chills/Cold all over
☐	☐	Aches/Pains
☐	☐	General Weakness
☐	☐	Difficulty sweating
☐	☐	Excessive Sweating
☐	☐	Swollen Glands
☐	☐	Cold hands & Feet
☐	☐	Fatigue
☐	☐	Difficulty falling asleep
☐	☐	Sleepwalker
☐	☐	Nightmares
☐	☐	No dream recall
☐	☐	Early waking
☐	☐	Daytime sleepiness
☐	☐	Distorted vision

		EARS
☐	☐	Aches
☐	☐	Discharge
☐	☐	Pains
☐	☐	Ringing
☐	☐	Deafness/Hearing loss
☐	☐	Itching
☐	☐	Pressure
☐	☐	Hearing Aid
☐	☐	Frequent Infections
☐	☐	Tubes in Ears
☐	☐	Sensitive to loud noises
☐	☐	Hearing Hallucinations

Past	Ongoing	HEAD
☐	☐	Poor Concentration
☐	☐	Confusion
☐	☐	Headaches:
☐	☐	After Meals
☐	☐	If meals skipped
☐	☐	Severe
☐	☐	Migraine
☐	☐	Frontal
☐	☐	Occipital
☐	☐	Afternoon
☐	☐	Daytime
		Relieved by:
☐	☐	Eating Sweets
☐	☐	Concussion/Whiplash
☐	☐	Mental sluggishness
☐	☐	Forgetfulness
☐	☐	Indecisive
☐	☐	Face twitch
☐	☐	Poor Memory
☐	☐	Hair Loss

		EYES
☐	☐	Feeling of sand in eyes
☐	☐	Double vision
☐	☐	Blurred vision
☐	☐	Poor night vision
☐	☐	See bright flashes
☐	☐	Halo around lights
☐	☐	Eye pains
☐	☐	Dark circles under eyes
☐	☐	Strong light irritates
☐	☐	Cataracts
☐	☐	Floaters in eyes
☐	☐	Visual hallucinations
☐	☐	Conjunctivitis

Past	Ongoing	SKIN
☐	☐	Cuts heal slowly
☐	☐	Bruise easily
☐	☐	Rashes
☐	☐	Pigmentation
☐	☐	Changing Moles
☐	☐	Calluses
☐	☐	Eczema
☐	☐	Psoriasis
☐	☐	Dryness/cracking skin
☐	☐	Oiliness
☐	☐	Itching
☐	☐	Acne
☐	☐	Boils
☐	☐	Hives
☐	☐	Fungus on Nails
☐	☐	Peeling Skin
☐	☐	Shingles
☐	☐	Nails Split
☐	☐	White Spots/Lines on Nails
☐	☐	Crawling Sensation
☐	☐	Burning on Bottom of Feet
☐	☐	Athletes Foot
☐	☐	Cellulite
☐	☐	Bugs love to bite you
		Is your skin sensitive to?:
☐	☐	Sun
☐	☐	Fabrics
☐	☐	Detergents
☐	☐	Lotions/Creams

		THROAT
☐	☐	Mucus
☐	☐	Difficulty swallowing
☐	☐	Frequent hoarseness
☐	☐	Tonsillitis
☐	☐	Enlarged glands
☐	☐	Constant clearing of throat
☐	☐	Throat closes up

Review Of Symptoms *(continued)*

Past	Ongoing	NOSE/SINUSES
☐	☐	Stuffy
☐	☐	Bleeding
☐	☐	Running/Discharge
☐	☐	Watery nose
☐	☐	Congested
☐	☐	Infection
☐	☐	Polyps
☐	☐	Acute smell
☐	☐	Drainage
☐	☐	Sneezing spells
☐	☐	Post nasal drip
☐	☐	No sense of smell
		Do the change of seasons tend to make your symptoms worse? ◯ Yes ◯ No
		If yes, is it worse in the:
☐	☐	Spring
☐	☐	Summer
☐	☐	Fall
☐	☐	Winter

Past	Ongoing	CIRCULATION/ RESPIRATION
☐	☐	Swollen Ankles
☐	☐	Sensitive to hot
☐	☐	Sensitive to cold
☐	☐	Extremities cold or clammy
☐	☐	Hands/Feet go to sleep/ numbness/tingling
☐	☐	High Blood Pressure
☐	☐	Chest Pain
☐	☐	Pain between shoulders
☐	☐	Dizziness upon standing
☐	☐	Fainting Spells
☐	☐	High cholesterol
☐	☐	High triglycerides
☐	☐	Wheezing
☐	☐	Irregular heartbeat
☐	☐	Palpitations
☐	☐	Low exercise tolerance
☐	☐	Frequent coughs
☐	☐	Breathing heavily
☐	☐	Frequently sighing
☐	☐	Shortness of breath
☐	☐	Night sweats
☐	☐	Varicose veins/spider veins
☐	☐	Mitral valve prolapse
☐	☐	Murmurs
☐	☐	Skipped heartbeat
☐	☐	Heart enlargement
☐	☐	Angina pain
☐	☐	Bronchitis/Pneumonia
☐	☐	Emphysema
☐	☐	Croup
☐	☐	Frequent colds
☐	☐	Heavy/tight chest
☐	☐	Prior heart attack ?
		When___/___/_____
☐	☐	Phlebitis

Past	Ongoing	NECK
☐	☐	Stiffness
☐	☐	Swelling
☐	☐	Lumps
☐	☐	Neck glands swell

		MOUTH
☐	☐	Coated tongue
☐	☐	Sore tongue
☐	☐	Dental problems
☐	☐	Bleeding gums
☐	☐	Canker sores
☐	☐	TMJ
☐	☐	Cracked lips/ corners
☐	☐	Chapped lips
☐	☐	Fever blisters
☐	☐	Wear dentures
☐	☐	Grind teeth when sleeping
☐	☐	Bad breath
☐	☐	Dry mouth

Review Of Symptoms *(continued)*

Past	Ongoing	GASTROINTESTINAL
☐	☐	Peptic/Duodenal Ulcer
☐	☐	Poor appetite
☐	☐	Excessive appetite
☐	☐	Gallstones
☐	☐	Gallbladder pain
☐	☐	Nervous stomach
☐	☐	Full feeling after small meal
☐	☐	Indigestion
☐	☐	Heartburn
☐	☐	Acid Reflux
☐	☐	Hiatal Hernia
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Vomiting blood
☐	☐	Abdominal Pains/Cramps
☐	☐	Gas
☐	☐	Diarrhea
☐	☐	Constipation
☐	☐	Changes in bowels
☐	☐	Rectal bleeding
☐	☐	Tarry stools
☐	☐	Rectal itching
☐	☐	Use laxatives
☐	☐	Bloating
☐	☐	Belch frequently
☐	☐	Anal itching
☐	☐	Anal fissures
☐	☐	Bloody stools
☐	☐	Undigested food in stools

Past	Ongoing	MEN'S HISTORY *For Men Only*
☐	☐	Prostate enlargement
☐	☐	Prostate infection
☐	☐	Change in libido
☐	☐	Impotence
☐	☐	Diminished/poor libido Infertility
☐	☐	Lumps in testicles
☐	☐	Sore on penis
☐	☐	Genital pain
☐	☐	Hernia
☐	☐	Prostate cancer
☐	☐	Low sperm count
☐	☐	Difficulty obtaining erection
☐	☐	Difficulty maintaining an erection
☐	☐	Nocturia (urination at night) How many times at night?
☐	☐	Urgency/Hesitancy/Change in Urinary Stream
☐	☐	Loss of bladder control

		KIDNEY/URINARY TRACT
☐	☐	Burning
☐	☐	Frequent urination
☐	☐	Blood in urine
☐	☐	Night time urination
☐	☐	Problem passing urine
☐	☐	Kidney pain
☐	☐	Kidney stones
☐	☐	Painful urination
☐	☐	Bladder infections
☐	☐	Kidney infections
☐	☐	Syphilis
☐	☐	Bedwetting
☐	☐	Trichomonas

Past	Ongoing	WOMEN'S HISTORY *For Women Only*
☐	☐	Fibrocystic breasts
☐	☐	Lumps in breast
☐	☐	Fibroid Tumors/Breast
☐	☐	Spotting
☐	☐	Heavy periods
☐	☐	Fibroid Tumors/Uterus
☐	☐	Painful periods
☐	☐	Change in period
☐	☐	Breast soreness before period
☐	☐	Endometriosis
☐	☐	Non-period bleeding
☐	☐	Breast soreness during period
☐	☐	Vaginal dryness
☐	☐	Vaginal discharge
☐	☐	Partial/total hysterectomy
☐	☐	Hot flashes
☐	☐	Mood swings
☐	☐	Concentration/Memory Problems
☐	☐	Breast cancer
☐	☐	Ovarian cysts
☐	☐	Pregnant
☐	☐	Infertility
☐	☐	Decreased libido
☐	☐	Heavy bleeding
☐	☐	Joint pains
☐	☐	Headaches
☐	☐	Weight gain
☐	☐	Loss of bladder control
☐	☐	Palpitations

Review Of Symptoms *(continued)*

Past	Ongoing	EMOTIONAL
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Fainting Spells
☐	☐	Blackouts/Amnesia
☐	☐	Had prior shock therapy
☐	☐	Frequently keyed up and jittery
☐	☐	Startled by sudden noises
☐	☐	Anxiety/Feeling of panic
☐	☐	Go to pieces easily
☐	☐	Forgetful
☐	☐	Listless/groggy
☐	☐	Withdrawn feeling/Feeling 'lost'
☐	☐	Had nervous breakdown
☐	☐	Unable to concentrate/short attention span
☐	☐	Unable to reason
☐	☐	Tends to worry needlessly
☐	☐	Considered a nervous person by others
☐	☐	Unusual tension
☐	☐	Frustration
☐	☐	Emotional numbness
☐	☐	Often break out in cold sweats
☐	☐	Profuse sweating
☐	☐	Depressed
☐	☐	Often awakened by frightening dreams
☐	☐	Previously admitted for psychiatric care
☐	☐	Family member had nervous breakdown
☐	☐	Use tranquilizers
☐	☐	Misunderstood by others
☐	☐	Irritable
☐	☐	Feeling of hostility/volatile or aggressive
☐	☐	Fatigue
☐	☐	Hyperactive
☐	☐	Restless leg syndrome
☐	☐	Considered clumsy
☐	☐	Vision changes

Past	Ongoing	EMOTIONAL *(continued)*
☐	☐	Unable to coordinate muscles
☐	☐	Have difficulty falling asleep
☐	☐	Have difficulty staying asleep
☐	☐	Daytime sleepiness
☐	☐	Workaholic
☐	☐	Have had hallucinations

		JOINT/MUSCLES/TENDONS
☐	☐	Pain wakes you
☐	☐	Weakness in legs and arms
☐	☐	Balance problems
☐	☐	Muscle cramping
☐	☐	Head injury
☐	☐	Muscle stiffness in morning
☐	☐	Damp weather bothers you

Pain Assessment

Are you currently in pain? ◯ Yes ◯ No

Is the source of your pain due to an injury? ◯ Yes ◯ No

If yes, please describe your injury and the date in which it occurred_____

_____

If no, please describe how long you have experienced this pain and what you believe it is attributed to

_____

Please use the area(s) and illustrations below to describe the severity of your pain. (0=no pain, 10=severe pain)

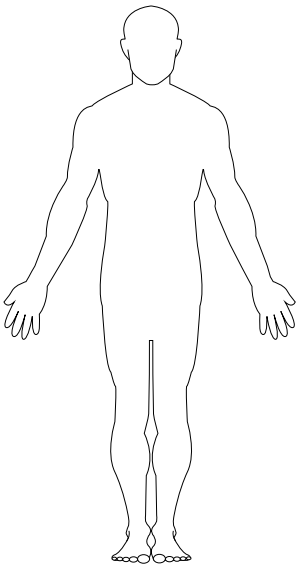
*Example:*_____*Neck*_____5_____

Area 1._____0_____ Area 2._____0_____

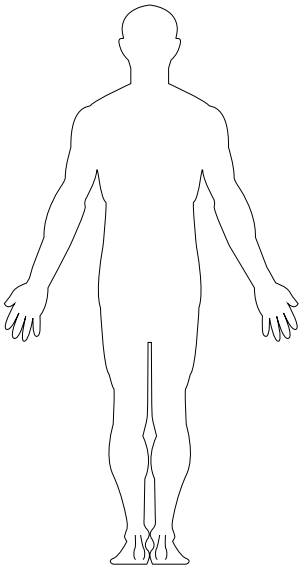
Area 3._____0_____ Area 4._____0_____

Use the letters provided to mark your area(s) of pain on the illustration.

A= ache B= burning N= numbness S= stiffness T=tingling Z= sharp/shooting



Front



Back

Left

Right

Dental History

	Yes	No
Problem with sore gums (gingivitis)?	◯	◯
Ringing in the ears (tinnitus)?	◯	◯
Have TMJ (temporal mandibular joint) problems?	◯	◯
Metallic taste in mouth?	◯	◯
Problems with bad breath (halitosis) or white tongue (thrush)?	◯	◯
Previously or currently wear braces?	◯	◯
Problems chewing?	◯	◯
Floss regularly?	◯	◯
Do you have amalgam dental fillings? How many?	◯	◯
Did you receive these fillings as a child?	◯	◯
Do you have Gold Fillings?	◯	◯
Do you have Root Canals?	◯	◯
Implants?	◯	◯
Tooth Pain?	◯	◯
Bleeding Gums?	◯	◯
Gingivitis?	◯	◯

List your approximate age and the type of dental work done from childhood until present:

Age	Type of dental work:	Health Problems following dental work? (describe)

Social History

Height (feet/inches)	Current Weight
Usual Weight +/- 5lbs.	Desired Weight Range (+/- 5lbs.)
Highest Adult Weight	Lowest Adult Weight
Weight Fluctuations (>10 lbs.)	Body Fat %

How often do you weigh yourself? ◯ Daily ◯ Weekly ◯ Monthly ◯ Rarely ◯ Never

Do you grocery shop? ◯ Yes ◯ No

If no, who does the shopping? _____

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 cook? ◯ Yes ◯ No

If no, who does the cooking? _____

Do you read food labels? ◯ Yes ◯ No

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

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

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

_____

Nutritional History

Have you made any changes in your eating habits because of your health? ◯ Yes ◯ No

Food Diary

Place a check mark next to the food/drink that applies to your current diet.

USUAL BREAKFAST	USUAL LUNCH	USUAL DINNER
☐ None	☐ None	☐ None
☐ Bacon/Sausage	☐ Butter	☐ Beans (legumes)
☐ Bagel	☐ Coffee	☐ Brown rice
☐ Butter	☐ Eat in a cafeteria	☐ Butter
☐ Cereal	☐ Eat in restaurant	☐ Carrots
☐ Coffee	☐ Fish sandwich	☐ Coffee
☐ Donut	☐ Fried foods	☐ Fish
☐ Eggs	☐ Hamburger	☐ Green vegetables
☐ Fruit	☐ Hot dogs	☐ Juice
☐ Juice	☐ Juice	☐ Margarine
☐ Margarine	☐ Leftovers	☐ Milk
☐ Milk	☐ Lettuce	☐ Pasta
☐ Oat bran	☐ Margarine	☐ Potato
☐ Sugar	☐ Mayo	☐ Poultry
☐ Sweet roll	☐ Meat sandwich	☐ Red meat
☐ Sweetener	☐ Milk	☐ Rice
☐ Tea	☐ Pizza	☐ Salad
☐ Toast	☐ Potato chips	☐ Salad dressing
☐ Water	☐ Salad	☐ Soda
☐ Wheat bran	☐ Salad dressing	☐ Sugar
☐ Yogurt	☐ Soda	☐ Sweetener
☐ Oatmeal	☐ Soup	☐ Tea
☐ Milk protein shake	☐ Sugar	☐ Vinegar
☐ Slim fast	☐ Sweetener	☐ Water
☐ Carnation shake	☐ Tea	☐ White rice
☐ Soy protein	☐ Tomato	☐ Yellow vegetables
☐ Whey protein	☐ Vegetables	☐ Other: (List below)
☐ Rice protein	☐ Water	
☐ Other: (List below)	☐ Yogurt	
	☐ Slim fast	
	☐ Carnation shake	
	☐ Protein shake	
	☐ Other: (List below)	

Nutritional History *(continued)*

How much of the following do you consume each week?

Candy	
Cheese	
Chocolate	
Cups of coffee containing caffeine	
Cups of decaffeinated coffee or tea	
Cups of Hot chocolate	
Diet Soda	
Ice Cream	
Salty foods	
Slices of white bread (rolls,bagels,etc)	
Soda with caffeine	
Soda without caffeine	
Cups of tea containing caffeine	

Do you currently follow a special diet or nutritional program? ◯ Yes ◯ No

☐ Gluten-Free ☐ Diabetic ☐ Dairy Restricted ☐ Vegetarian ☐ Vegan ☐ Blood type diet

Other:_____

Please tell us if there is anything special about your diet that we should know._____

_____

Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc? ◯ Yes ◯ No

If yes, are these symptoms associated with any particular food or supplement? ◯ Yes ◯ No

If yes, please name the food or supplement and symptom(s)._____

Do you feel that you have delayed symptoms after eating certain foods, such as fatigue, muscle aches, sinus congestion, etc? (symptoms may not be evident for 24 hours or more) ◯ Yes ◯ No

DO YOU FEEL WORSE WHEN YOU EAT A LOT OF:		DO YOU FEEL BETTER WHEN YOU EAT A LOT OF:	
High fat foods	☐	High fat foods	☐
High protein foods	☐	High protein foods	☐
High carbohydrate foods (breads, pasta, potatoes)	☐	High carbohydrate foods (breads, pasta, potatoes)	☐
Refined sugar (junk food)	☐	Refined sugar (junk food)	☐
Fried foods	☐	Fried foods	☐
1 or 2 alcoholic drinks	☐	1 or 2 alcoholic drinks	☐
Other:		Other:	

Nutritional History *(continued)*

Does skipping meals greatly affect your symptoms? ◯ Yes ◯ No

Has there ever been a food that you have craved or 'binged' on over a period of time? ◯ Yes ◯ No

If yes, what food(s) _____

_____

How many times do you chew your food? _____

How much fluid do you drink with your meals? _____

How many servings of fruits & vegetables do you eat per week? _____

What foods do you dislike? _____

What foods do you not tolerate well or do you react to? _____

What type of cuisine do you like? _____

What is your typical breakfast? _____

How much time do you have in the morning to prepare breakfast? _____

What is your typical lunch? _____

What is your typical dinner? _____

What meats do you eat? _____

Do you eat eggs? _____

Do you ever do vegetarian? If so how often? _____

What foods do you crave? _____

Do you have snacks during the day? If so what do you snack on? _____

Do you eat fish or other seafood? If so what types? _____

Do you eat dessert? If so what do you eat? _____

Do you skip any meals? _____

What time do you eat your breakfast, lunch, dinner? _____

What time do you usually eat snacks? _____

What types of beverages do you consume? _____

How many ounces/mls of water do you consume daily? _____

What oils do you cook with? _____

Caffeine Intake: ◯ Yes ◯ No

Coffee Cups/day: ◯ 1 ◯ 2-4 ◯ > per day

Tea Cups/day: ◯ 1 ◯ 2-4 ◯ > per day

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.): _____

Digestive 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

Please complete the following chart as it relates to your bowel movements:

FREQUENCY	
More than 3x a day	◯
1-3x a day	◯
4-6x a week	◯
2-3x a week	◯
1 or fewer x a week	◯

CONSISTENCY	
Soft and well formed	◯
Often floats	◯
Difficult to pass	◯
Diarrhea	◯
Thin, long or narrow	◯
Small and hard	◯
Loose but not watery	◯
Alternating between hard and loose/watery	◯

COLOR	
Medium brown consistently	☐
Very dark or black	☐
Greenish color	☐
Blood is visible	☐
Varies a lot	☐
Dark brown consistently	☐
Yellow, light brown	☐
Greasy, shiny appearance	☐

INTESTINAL GAS:	
	☐ Daily
	☐ Occasionally
	☐ Excessive
	☐ Present with Pain
	☐ Foul Smelling
	☐ Little Odor

Lifestyle History

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?_____

Alcohol 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

Have you been told you should cut down your alcohol intake?	◯ Yes	◯ No
Do you get annoyed when people ask you about your drinking?	◯ Yes	◯ No
Do you feel guilty about your alcohol consumption?	◯ Yes	◯ No
Do you ever take an eye opener?	◯ Yes	◯ No
Do you notice a tolerance to alcohol (can you hold more than others)?	◯ Yes	◯ No
Have you ever been unable to remember what you did during a drinking episode?	◯ Yes	◯ No
Do you get into arguments or physical fights when you have been drinking alcohol?	◯ Yes	◯ No
Have you ever been arrested or hospitalized because of drinking?	◯ Yes	◯ No
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 Type:_____
Have you ever used IV or inhaled recreational drugs? ◯ Yes ◯ No Type:_____

Exercise

Do you exercise regularly? ◯ Yes ◯ No

Current exercise program; (List type of activity, number of sessions/week, and duration)

Activity	Type	Frequency per week	Duration in Minutes
Stretching/Jogging/Walking			
Cardio/Aerobics			
Strength Training			
Other(Yoga, Pilates, Gyrotonics,etc.)			
Sports or Leisure Activities (golf, tennis, rollerblading,etc.)			
Other			

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

Psychosocial

Do you feel significantly less vital than you did a year ago? ◯ Yes ◯ No

Are you happy? ◯ Yes ◯ No

Do you feel your life has meaning and purpose? ◯ Yes ◯ No

Do you still believe stress is presently reducing the quality of your life? ◯ Yes ◯ No

Do you like the work you do? ◯ Yes ◯ No

Have you ever experienced major losses in your life? ◯ Yes ◯ No

Do you spend the majority of your time and money to fulfill responsibilities and obligations ◯ Yes ◯ No

Would you describe your experience as a child in your family as happy and secure? ◯ Yes ◯ No

Stress/Coping

Have you ever sought counseling? ◯ Yes ◯ No

Are you currently in therapy? ◯ Yes ◯ No

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

Daily Stressors: Rate on scale 1-10. (1 - minimal stress. 10 - very high stress)

Work_____ Family_____ Social_____ Finances_____ Health_____ Other_____

Do you practice meditation or relaxation technique? ◯ Yes ◯ No

Check all that apply

☐ Yoga ☐ Meditation ☐ Imagery ☐ Breathing ☐ Tai Chi ☐ Prayer ☐ Other _____

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

Hobbies & Leisure activities: _____

Sleep and 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 snore? ◯ Yes ◯ No

Do you use sleeping aids? ◯ Yes ◯ No

What time do you go to bed? _____

What time do you wake up? _____

Roles/Relationships

List Children

CHILD'S NAME	AGE	GENDER

Who is living in your household? Number:_____ Names:_____

Their Employment/Occupations:_____

Resources for emotional support? _____

Check all thay apply:

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

Are you satisfied with your sex life? ◯ Yes ◯ No

HOW WELL HAVE THINGS BEEN GOING FOR YOU?	*Very Well*	*Fine*	*Poorly*	*Does Not Apply*
Overall	◯	◯	◯	◯
At school	◯	◯	◯	◯
In your job	◯	◯	◯	◯
In your social life	◯	◯	◯	◯
With close friends	◯	◯	◯	◯
With sex	◯	◯	◯	◯
With your attitude	◯	◯	◯	◯
With your boyfriend/girlfriend	◯	◯	◯	◯
With your children	◯	◯	◯	◯
With your parents	◯	◯	◯	◯
With your spouse	◯	◯	◯	◯

Environmental & Detoxification Assessment

Do you have known adverse food reactions or sensitivities? ◯ Yes ◯ No

If yes, describe symptoms:_____

_____

Do you have any food allergies or sensitivities? ◯ Yes ◯ No

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 (Nutrasweet)	☐ Caffeine	☐ Bananas
☐ Garlic	☐ Onion	☐ Cheese	☐ Citrus Foods
☐ Chocolate	☐ Alcohol	☐ Red Wine	☐ Sulfite containing food (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

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 have a known history of significant exposure to any harmful chemicals such as the following:

☐ Herbicides	☐ Insecticides (frequent visits of exterminator)	☐ Pesticides	☐ Organic Solvents
☐ Lead	☐ Arsenic	☐ Aluminum	☐ Cadmium
☐ Mercury	☐ Other:		

Chemical Name, Date, Length of Exposure: _____

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

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

Do you have any pets or animals? ◯ Yes ◯ No

What type/brands of personal care products do you use? (Deodorant, Lotion,Soaps) _____

_____

Irvine Functional Medicine & Nutrition

Express Your Inner Health

Functional Symptom Assessment

Metabolic Assessment Form (MAF)

Name:_____Age:_____Sex:_____Date:_____

PART I

Please list your 5 major health concerns in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

PART II

Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

CATEGORY I

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Feeling that bowels do not empty completely	◯	◯	◯	◯	Hard, dry, or small stool	◯	◯	◯	◯
Lower abdominal pain relieved by passing stool or gas	◯	◯	◯	◯	Coated tongue or "fuzzy" debris on tongue	◯	◯	◯	◯
Alternating constipation and diarrhea	◯	◯	◯	◯	Pass large amount of foul-smelling gas	◯	◯	◯	◯
Diarrhea	◯	◯	◯	◯	More than 3 bowel movements daily	◯	◯	◯	◯
Constipation	◯	◯	◯	◯	Use laxatives frequently	◯	◯	◯	◯

CATEGORY II

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Excessive belching, burping, or bloating	◯	◯	◯	◯	Difficult bowel movements	◯	◯	◯	◯
Gas immediately following a meal	◯	◯	◯	◯	Sense of fullness during and after meals	◯	◯	◯	◯
Offensive breath	◯	◯	◯	◯	Difficulty digesting fruits and vegetables; undigested foods found in stools	◯	◯	◯	◯

CATEGORY III

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Stomach pain, burning, or aching 1-4 hours after eating	◯	◯	◯	◯	Temporary relief by using antacids, food, milk, or carbonated beverages	◯	◯	◯	◯
Use antacids	◯	◯	◯	◯	Digestive problems subside with rest and relaxation	◯	◯	◯	◯
Feel hungry an hour or two after eating	◯	◯	◯	◯	Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	◯	◯	◯	◯
Heartburn when lying down or bending forward	◯	◯	◯	◯					

CATEGORY IV

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Roughage and fiber cause constipation	◯	◯	◯	◯	Stool undigested, foul smelling, mucous like, greasy, or poorly formed	◯	◯	◯	◯
Indigestion and fullness last 2-4 hours after eating	◯	◯	◯	◯	Frequent urination	◯	◯	◯	◯
Pain, tenderness, soreness on left side under rib cage	◯	◯	◯	◯	Increased thirst and appetite	◯	◯	◯	◯
Excessive passage of gas	◯	◯	◯	◯	Difficulty losing weight	◯	◯	◯	◯
Nausea and/or vomiting	◯	◯	◯	◯					

CATEGORY V

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Greasy or high-fat foods cause distress	◯	◯	◯	◯	Stool color alternates from clay colored to normal brown	◯	◯	◯	◯
Lower bowel gas and/or bloating several hours after eating	◯	◯	◯	◯	Reddened skin, especially palms	◯	◯	◯	◯
Bitter metallic taste in mouth, especially in the morning	◯	◯	◯	◯	Dry or flaky skin and/or hair	◯	◯	◯	◯
Unexplained itchy skin	◯	◯	◯	◯	History of gallbladder attacks or stones	◯	◯	◯	◯
Yellowish cast to eyes	◯	◯	◯	◯	Have you had your gallbladder removed?	◯	Yes	◯	No

CATEGORY VI

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Crave sweets during the day	◯	◯	◯	◯	Feel shaky, jittery, or have tremors	◯	◯	◯	◯
Irritable if meals are missed	◯	◯	◯	◯	Agitated, easily upset, nervous	◯	◯	◯	◯
Depend on coffee to keep going/get started	◯	◯	◯	◯	Poor memory/forgetful	◯	◯	◯	◯
Get light-headed if meals are missed	◯	◯	◯	◯	Blurred vision	◯	◯	◯	◯
Eating relieves fatigue	◯	◯	◯	◯					

CATEGORY VII

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Fatigue after meals	◯	◯	◯	◯	Waist girth is equal to or larger than hip girth	◯	◯	◯	◯
Crave sweets during the day	◯	◯	◯	◯	Frequent urination	◯	◯	◯	◯
Eating sweets does not relieve cravings for sugar	◯	◯	◯	◯	Increased thirst and appetite	◯	◯	◯	◯
Must have sweets after meals	◯	◯	◯	◯	Difficulty losing weight	◯	◯	◯	◯

CATEGORY VIII

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Cannot stay asleep	◯	◯	◯	◯	Dizziness when standing up quickly	◯	◯	◯	◯
Crave salt	◯	◯	◯	◯	Afternoon headaches	◯	◯	◯	◯
Slow starter in the morning	◯	◯	◯	◯	Headaches with exertion or stress	◯	◯	◯	◯
Afternoon fatigue	◯	◯	◯	◯	Weak nails	◯	◯	◯	◯

CATEGORY IX

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Cannot fall asleep	◯	◯	◯	◯	Weight gain when under stress	◯	◯	◯	◯
Perspire easily	◯	◯	◯	◯	Wake up tired even after 6 or more hours of sleep	◯	◯	◯	◯
Under high amount of stress	◯	◯	◯	◯	Excessive perspiration or perspiration with little or no activity	◯	◯	◯	◯

CATEGORY X

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Tired/sluggish	◯	◯	◯	◯	Depression/lack of motivation	◯	◯	◯	◯
Feel cold–hands, feet, all over	◯	◯	◯	◯	Morning headaches that wear off as the day progresses	◯	◯	◯	◯
Require excessive amounts of sleep to function properly	◯	◯	◯	◯	Outer third of eyebrow thins	◯	◯	◯	◯
Increase in weight even with low-calorie diet	◯	◯	◯	◯	Thinning of hair on scalp, face, or genitals; excessive hair loss	◯	◯	◯	◯
Gain weight easily	◯	◯	◯	◯	Dryness of skin and/or scalp	◯	◯	◯	◯
Difficult, infrequent bowel movements	◯	◯	◯	◯	Mental sluggishness	◯	◯	◯	◯

CATEGORY XI

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Heart palpitations	◯	◯	◯	◯	Insomnia	◯	◯	◯	◯
Inward trembling	◯	◯	◯	◯	Night sweats	◯	◯	◯	◯
Increased pulse even at rest	◯	◯	◯	◯	Difficulty gaining weight	◯	◯	◯	◯
Nervous and emotional	◯	◯	◯	◯					

CATEGORY XII

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Diminished sex drive	◯	◯	◯	◯	Increased ability to eat sugars without symptoms	◯	◯	◯	◯
Menstrual disorders or lack of menstruation	◯	◯	◯	◯					

CATEGORY XIII

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Increased sex drive	◯	◯	◯	◯	"Splitting"-type headaches	◯	◯	◯	◯
Tolerance to sugars reduced	◯	◯	◯	◯					

CATEGORY XIV (MALES ONLY)

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Urination difficulty or dribbling	◯	◯	◯	◯	Feeling of incomplete bowel emptying	◯	◯	◯	◯
Frequent urination	◯	◯	◯	◯	Leg twitching at night	◯	◯	◯	◯
Pain inside of legs or heels	◯	◯	◯	◯					

CATEGORY XV (MALES ONLY)

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Decreased libido	◯	◯	◯	◯	Muscle soreness	◯	◯	◯	◯
Decreased number of spontaneous morning erections	◯	◯	◯	◯	Decreased physical stamina	◯	◯	◯	◯
Decreased fullness of erections	◯	◯	◯	◯	Unexplained weight gain	◯	◯	◯	◯
Difficulty maintaining morning erections	◯	◯	◯	◯	Increase in fat distribution around chest and hips	◯	◯	◯	◯
Spells of mental fatigue	◯	◯	◯	◯	Sweating attacks	◯	◯	◯	◯
Inability to concentrate	◯	◯	◯	◯	More emotional than in the past	◯	◯	◯	◯
Episodes of depression	◯	◯	◯	◯					

CATEGORY XVI (MENOSTRUATING FEMALES ONLY)

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Perimenopausal	◯	Yes	◯	No	Breast pain and swelling during menses	◯	◯	◯	◯
Alternating menstrual cycle lengths	◯	Yes	◯	No	Pelvic pain during menses	◯	◯	◯	◯
Extended menstrual cycle (greater than every 32 days)	◯	Yes	◯	No	Irritable and depressed during menses	◯	◯	◯	◯
Shortened menstrual cycle (less than every 24 days)	◯	Yes	◯	No	Acne	◯	◯	◯	◯
Pain and cramping during periods	◯	◯	◯	◯	Facial hair growth	◯	◯	◯	◯
Scanty blood flow	◯	◯	◯	◯	Hair loss/thinning	◯	◯	◯	◯
Heavy blood flow	◯	◯	◯	◯					

CATEGORY XVII (MENOPAUSAL FEMALES ONLY)

Please Select One	0	1	2	3	Please Select One	0	1	2	3
How many years have you been menopausal?	_____				Depression	◯	◯	◯	◯
Since menopause, do you ever have uterine bleeding?	◯	Yes	◯	No	Painful intercourse	◯	◯	◯	◯
Hot flashes	◯	◯	◯	◯	Shrinking breasts	◯	◯	◯	◯
Mental fogginess	◯	◯	◯	◯	Facial hair growth	◯	◯	◯	◯
Disinterest in sex	◯	◯	◯	◯	Acne	◯	◯	◯	◯
Mood swings	◯	◯	◯	◯	Increased vaginal pain, dryness, or itching	◯	◯	◯	◯

Brain Function Assessment Form (BFAF)

Name:_____Age:_____Sex:_____Date:_____

PART ONE

Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

CATEGORY ONE

Please Select One	0	1	2	3	Please Select One	0	1	2	3
A decrease in attention span	◯	◯	◯	◯	Experiencing fatigue when reading sooner than in the past	◯	◯	◯	◯
Mental fatigue	◯	◯	◯	◯	Experiencing fatigue when driving sooner than in the past	◯	◯	◯	◯
Difficulty learning new things	◯	◯	◯	◯	Need for caffeine to stay mentally alert	◯	◯	◯	◯
Difficulty staying focused and concentrating for extended periods of time	◯	◯	◯	◯	Overall brain function impairs your daily life	◯	◯	◯	◯

CATEGORY TWO

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Twitching or tremor in your hands and legs when resting	◯	◯	◯	◯	Constipation	◯	◯	◯	◯
Handwriting has gotten smaller and more crowded together	◯	◯	◯	◯	Voice has become softer	◯	◯	◯	◯
A loss of smells to foods	◯	◯	◯	◯	Facial expression that is serious or angry	◯	◯	◯	◯
Difficulty sleeping or fitful sleep	◯	◯	◯	◯	Episodes of dizziness or light-headedness upon standing	◯	◯	◯	◯
Stiffness in shoulders and hips that goes away when you start to move	◯	◯	◯	◯	A hunched over posture when getting up and walking	◯	◯	◯	◯

CATEGORY THREE

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Memory loss that impacts daily activities	◯	◯	◯	◯	Difficulty finding words when speaking	◯	◯	◯	◯
Difficulty planning, problem solving, or working with numbers	◯	◯	◯	◯	Misplacement of things and inability to retrace steps	◯	◯	◯	◯
Difficulty completing daily tasks	◯	◯	◯	◯	Poor judgment and bad decisions	◯	◯	◯	◯
Confusion about dates, the passage of time, or place	◯	◯	◯	◯	Disinterest in hobbies, social activities, or work	◯	◯	◯	◯
Difficulty understanding visual images and spatial relationships (addresses and locations)	◯	◯	◯	◯	Personality or mood changes	◯	◯	◯	◯

CATEGORY FOUR

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Reduced function in overall hearing	◯	◯	◯	◯	Inability to comprehend familiar words when read	◯	◯	◯	◯
Difficulty understanding language with background or scatter noise	◯	◯	◯	◯	Difficulty spelling familiar words	◯	◯	◯	◯
Ringing or buzzing in the ear	◯	◯	◯	◯	Monotone, unemotional speech	◯	◯	◯	◯
Difficulty comprehending language without perfect pronunciation	◯	◯	◯	◯	Difficulty understanding the emotions of others when they speak (nonverbal cues)	◯	◯	◯	◯
Difficulty recognizing familiar faces	◯	◯	◯	◯	Disinterest in music and a lack of appreciation for melodies	◯	◯	◯	◯
Changes in comprehending the meaning of sentences written or spoken	◯	◯	◯	◯	Difficulty with long-term memory	◯	◯	◯	◯
Difficulty with verbal memory and finding words	◯	◯	◯	◯	Memory impairment when doing the basic activities of daily living	◯	◯	◯	◯
Difficulty remembering events	◯	◯	◯	◯	Difficulty with directions and visual memory	◯	◯	◯	◯
Difficulty recalling previously learned facts and names	◯	◯	◯	◯	Noticeable differences in energy levels throughout the day	◯	◯	◯	◯

CATEGORY FIVE

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Difficulty coordinating visual inputs and hand movements, resulting in an inability to efficiently reach for objects	◯	◯	◯	◯	Dullness of colors in your visual field during different times of the day	◯	◯	◯	◯
Difficulty comprehending written text	◯	◯	◯	◯	Difficulty discriminating similar shades of color	◯	◯	◯	◯
Floaters or halos in your visual field	◯	◯	◯	◯					

CATEGORY SIX

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Difficulty with detailed hand coordination	◯	◯	◯	◯	Decisions made based on desires, regardless of the consequences	◯	◯	◯	◯
Difficulty with making decisions	◯	◯	◯	◯	Difficulty planning and organizing daily events	◯	◯	◯	◯
Difficulty with suppressing socially inappropriate thoughts	◯	◯	◯	◯	Difficulty motivating yourself to start and finish tasks	◯	◯	◯	◯
Socially inappropriate behavior	◯	◯	◯	◯	A loss of attention and concentration	◯	◯	◯	◯

CATEGORY SEVEN

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Hypersensitivities to touch or pain	◯	◯	◯	◯	Handwriting has become sloppier	◯	◯	◯	◯
Difficulty with spatial awareness when moving, laying back in a chair, or leaning against a wall	◯	◯	◯	◯	Difficulty with basic math calculations	◯	◯	◯	◯
Frequently bumping into the wall or objects	◯	◯	◯	◯	Difficulty finding words for written or verbal communication	◯	◯	◯	◯
Difficulty with right-left discrimination	◯	◯	◯	◯	Difficulty recognizing symbols, words, or letters	◯	◯	◯	◯

CATEGORY EIGHT

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Difficulty swallowing supplements or large bites of food	◯	◯	◯	◯	A racing heart	◯	◯	◯	◯
Bowel motility and movements slow	◯	◯	◯	◯	A flutter in the chest or an abnormal heart rhythm	◯	◯	◯	◯
Bloating after meals	◯	◯	◯	◯	Bowel or bladder incontinence, resulting in staining your underwear	◯	◯	◯	◯
Dry eyes or dry mouth	◯	◯	◯	◯					

CATEGORY NINE

Please Select One	0	1	2	3	Please Select One	0	1	2	3
A decrease in movement speed	◯	◯	◯	◯	A stooped posture when walking	◯	◯	◯	◯
Difficulty initiating movement	◯	◯	◯	◯	Cramping of your hand when writing	◯	◯	◯	◯
Stiffness in your muscles (not joints)	◯	◯	◯	◯					

CATEGORY TEN

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Abnormal body movements (such as twitching legs)	◯	◯	◯	◯	Compulsive behaviors	◯	◯	◯	◯
Desires to flinch, clear your throat, or perform some type of movement	◯	◯	◯	◯	Increased tightness and tone in specific muscles	◯	◯	◯	◯
Constant nervousness and a restless mind	◯	◯	◯	◯					

CATEGORY ELEVEN

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Difficulty with balance, or balance that is noticeably worse on one side	◯	◯	◯	◯	A quick impact after consuming alcohol	◯	◯	◯	◯
A need to hold the handrail or watch each step carefully when going down stairs	◯	◯	◯	◯	A slight hand shake when reaching for something	◯	◯	◯	◯
Episodes of dizziness	◯	◯	◯	◯	Back muscles that tire quickly when standing or walking	◯	◯	◯	◯
Nausea, car sickness, or seasickness	◯	◯	◯	◯	Chronic neck or back muscle tightness	◯	◯	◯	◯

Brain Health and Nutrition Assessment Form (BHNAF)

Name:_____Age:_____Sex:_____Date:_____

PART ONE

Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

CATEGORY ONE

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Low brain endurance for focus and concentration	◯	◯	◯	◯	Fungal growth on toenails	◯	◯	◯	◯
Cold hands and feet	◯	◯	◯	◯	Must wear socks at night	◯	◯	◯	◯
Must exercise or drink coffee to improve brain function	◯	◯	◯	◯	Nail beds are white instead of pink	◯	◯	◯	◯
Poor nail health	◯	◯	◯	◯	The tip of the nose is cold	◯	◯	◯	◯

CATEGORY TWO

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Irritable, nervous, shaky, or light-headed between meals	◯	◯	◯	◯	Crave sugar and sweets in the afternoon	◯	◯	◯	◯
Fell energized after meals	◯	◯	◯	◯	Wake up in the middle of the night	◯	◯	◯	◯
Difficulty eating large meals in the morning	◯	◯	◯	◯	Difficulty concentrating before eating	◯	◯	◯	◯
Energy level drops in the afternoon	◯	◯	◯	◯	Depend on coffee to keep going	◯	◯	◯	◯

CATEGORY THREE

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Fatigue after meals	◯	◯	◯	◯	Difficulty losing weight	◯	◯	◯	◯
Sugar and sweet cravings after meals	◯	◯	◯	◯	Increased frequency of urination	◯	◯	◯	◯
Need for a stimulant, such as coffee, after meals	◯	◯	◯	◯	Difficulty falling asleep	◯	◯	◯	◯
Increase appetite	◯	◯	◯	◯					

CATEGORY FOUR

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Always have projects and things that need to be done	◯	◯	◯	◯	Difficulty getting regular exercise	◯	◯	◯	◯
Never have time for yourself	◯	◯	◯	◯	Feel that you are not accomplishing your life's purpose	◯	◯	◯	◯
Not getting enough sleep or rest	◯	◯	◯	◯					

CATEGORY FIVE

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Dry and unhealthy skin	◯	◯	◯	◯	Difficulty consuming raw nuts or seeds	◯	◯	◯	◯
Dandruff or a flaky scap	◯	◯	◯	◯	Difficulty consuming fish (not fried)	◯	◯	◯	◯
Consumption of processed foods that are bagged or boxed	◯	◯	◯	◯	Difficulty consuming olive oil, avocados, flax seed oil, or natural fats	◯	◯	◯	◯
Consumption of fried foods	◯	◯	◯	◯					

CATEGORY SIX

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Difficulty digesting food	◯	◯	◯	◯	Difficulty digesting starch-rich foods	◯	◯	◯	◯
Constipation or inconsistent bowel movements	◯	◯	◯	◯	Difficulty digesting fatty or greasy foods	◯	◯	◯	◯
Increased bloating or gas	◯	◯	◯	◯	Difficulty swallowing supplements or large bites of food	◯	◯	◯	◯
Abdominal distention after meals	◯	◯	◯	◯	Abnormal gag reflex	◯	Yes	◯	No
Difficulty digesting protein-rich foods	◯	◯	◯	◯					

CATEGORY SEVEN

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Brain fog (unclear thought or concentration)	◯	Yes	◯	No	Brain fatigue after meals	◯	◯	◯	◯
Pain and inflammation	◯	Yes	◯	No	Brain fatigue after exposure to chemicals, scents, or pollutants	◯	◯	◯	◯
Noticeable variations in mental speed	◯	Yes	◯	No	Brain fatigue when the body is inflamed	◯	◯	◯	◯

CATEGORY EIGHT

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Grain consumption leads to tiredness	◯	◯	◯	◯	Grain consumptions causes the development of any symptoms	◯	◯	◯	◯
Grain consumption makes it difficult to focus and concentrate	◯	◯	◯	◯	A 100% gluten free diet	◯	Yes	◯	No
Feel better when bread and grains are avoided	◯	◯	◯	◯					

CATEGORY NINE

Please Select One	0	1	2	3	Please Select One	0	1	2	3
A diagnosis of celiac disease, gluten sensitivity, hypothyroidism, or an autoimmune disease	◯	Yes	◯	No	Family members who have been diagnosed with celiac disease or gluten sensitivity	◯	Yes	◯	No
Family members who have been diagnosed with an autoimmune disease	◯	Yes	◯	No	Changes in brain function with stress, poor sleep, or immune activation	◯	◯	◯	◯

CATEGORY TEN

Please Select One	0	1	2	3	Please Select One	0	1	2	3
A loss of pleasure in hobbies and interests	◯	◯	◯	◯	A lack of artistic appreciation	◯	Yes	◯	No
Feel overwhelmed with ideas to manage	◯	◯	◯	◯	Feelings of sadness in overcast weather	◯	◯	◯	◯
Feelings of inner rage or unprovoked anger	◯	◯	◯	◯	A loss of enthusiasm for favorite activities	◯	◯	◯	◯
Feelings of paranoia	◯	◯	◯	◯	A loss of enjoyment in favorite foods	◯	◯	◯	◯
Feelings of sadness for no reason	◯	◯	◯	◯	A loss of enjoyment in friendships and relationships	◯	◯	◯	◯
A loss of enjoyment in life	◯	◯	◯	◯	Inability to fall into deep, restful sleep	◯	◯	◯	◯
Feelings of dependency on others	◯	◯	◯	◯	Feelings of susceptibility to pain	◯	◯	◯	◯

CATEGORY ELEVEN

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Feelings of worthlessness	◯	◯	◯	◯	Feelings of tiredness, even after many hours of sleep	◯	◯	◯	◯
Feelings of hopelessness	◯	◯	◯	◯	A desire to isolate yourself from others	◯	◯	◯	◯
Self-destructive thoughts	◯	◯	◯	◯	An unexplained lack of concern for family and friends	◯	◯	◯	◯
Inability to handle stress	◯	◯	◯	◯	An inability to finish tasks	◯	◯	◯	◯
Anger and aggression while under stress	◯	◯	◯	◯	Feeling of anger for minor reasons	◯	◯	◯	◯

CATEGORY TWELVE

Please Select One	0	1	2	3	Please Select One	0	1	2	3
A decrease in visual memory (shapes and images)	◯	Yes	◯	No	Difficulty calculating numbers	◯	◯	◯	◯
A decrease in verbal memory	◯	◯	◯	◯	Difficulty recognizing objects and faces	◯	◯	◯	◯
Occurrence of memory lapses	◯	◯	◯	◯	A change in opinion about yourself	◯	◯	◯	◯
A decrease in creativity	◯	◯	◯	◯	Slow mental recall	◯	◯	◯	◯
A decrease in comprehension	◯	◯	◯	◯					

CATEGORY THIRTEEN

Please Select One	0	1	2	3	Please Select One	0	1	2	3
A decrease in mental alertness	◯	◯	◯	◯	Impaired mental performance	◯	◯	◯	◯
A decrease in mental speed	◯	◯	◯	◯	An increase in the ability to be distracted	◯	◯	◯	◯
A decrease in concentration quality	◯	◯	◯	◯	Need coffee or caffeine sources to improve mental function	◯	◯	◯	◯
Slow cognitive processing	◯	◯	◯	◯					

CATEGORY FOURTEEN

Please Select One	0	1	2	3	Please Select One	0	1	2	3
Feelings of nervousness or panic for no reason	◯	◯	◯	◯	A restless mind	◯	◯	◯	◯
Feelings of dread	◯	◯	◯	◯	An inability to turn off the mind when relaxing	◯	◯	◯	◯
Feelings of a “know” in your stomach	◯	◯	◯	◯	Disorganized attention	◯	◯	◯	◯
Feelings of being overwhelmed for no reason	◯	◯	◯	◯	Worry over things never thought about before	◯	◯	◯	◯
Feelings of guilt about everyday decisions	◯	◯	◯	◯	Feelings of inner tension and inner excitability	◯	◯	◯	◯

Personal Stress Inventory *(Include past and present events)*

Life Event	Points	Yes
Death of spouse	100	☐
Divorce	73	☐
Marital Separation	65	☐
Detention in jail or other institution	63	☐
Death of a close family member	63	☐
Major personal injury or illness	53	☐
Marriage	50	☐
Being tired from work	47	☐
Marital reconciliation	45	☐
Retirement from work	45	☐
Major change in health or behavior of a family member	44	☐
Pregnancy	40	☐
Sexual Difficulties	39	☐
Gaining a new family member (birth, adoption, older adult moving in, etc.)	39	☐
Major Business readjustment	39	☐
Major change in financial state (a lot worse or better off than usual)	38	☐
Death of a close friend	37	☐
Changing to a different line of work	36	☐
Major change in number of arguments with spouse on core issues	35	☐
Taking on a mortgage (for home, business, etc.)	31	☐
Foreclosure on a mortgage or loan	30	☐
Major change in responsibilities at work (promotion,demotion, etc.)	29	☐
Son or daughter leaving home (marriage, college, etc.)	29	☐
Conflict or tension with parents/in laws	29	☐
Outstanding personal achievement	28	☐
Spouse beginning or ceasing work outside the home	26	☐
Beginning or completing formal schooling	26	☐
Major change in living condition (new home, remodeling, deterioration of home)	25	☐
Change of personal habits (dress, manners, association, quitting, smoking)	24	☐
Conflict at work with employer or manager	23	☐
Major changes in working hours or conditions	20	☐
Changes in residence	20	☐
Changing to a new school	20	☐
Major change in usual type/ or amount of recreation	19	☐
Major change in church activity (a lot more or less than usual)	19	☐
Major change in social activities (clubs, movies, visiting, etc)	18	☐
Taking on a loan (car, TV, appliances, etc..)	17	☐
Major change in sleeping habits (a lot more or less than usual)	16	☐
Major change in number of family get-togethers	15	☐
Major change in eating habits (food amount, meal hours or surrounding)	15	☐
Vacation	13	☐
Major holidays	12	☐
Minor violations of the law (traffic, tickets, etc...)	11	☐
Your Total		

Disc Scoring Sheet

In order to determine your Communication Style, please complete the following:

For each of the 10 word groups below, select the word that is MOST like you, LEAST like you, and IN BETWEEN. You are to assign 4 points to the word that is most like you, 3 points to the word that is like you, 2 points to the word that is somewhat like you, and 1 point to the word that is least like you. (There should be a 4, a 3, a 2, and a 1 on each line. See the example). Once you have completed this, follow the next set of instructions.

Example:

1.	3	Determined	4	Convincing	1	Predictable	2	Cautious

1.		Determined		Convincing		Predictable		Cautious
2.		Strong Willed		Persuausive		Easy-going		Orderly
3.		Direct		Expressive		Kind		Analytical
4.		Bold		Socialable		Cooperative		Precise
5.		Outspoken		Animated		Patient		Logical
6.		Decisive		Talkative		Loyal		Controlled
7.		Daring		Outgoing		Agreeable		Careful
8.		Restless		Enthusiastic		Considerate		Thorough
9.		Competitive		Inspiring		Consistent		Detailed
10.		Aggressive		Playful		Satisfied		Accurate

Once you have assigned numbers to all 10 word groups, total the points for each column and write the total in the spaces provided below.

Totals:				
Styles:	D	I	S	C

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:	5	4	3	2	1
Significantly modify your diet	◯	◯	◯	◯	◯
Take nutritional supplements each day	◯	◯	◯	◯	◯
Keep a record of everything you eat each day	◯	◯	◯	◯	◯
Modify your lifestyle (e.g. work demands, sleep habits)	◯	◯	◯	◯	◯
Practice relaxation techniques	◯	◯	◯	◯	◯
Engage in regular exercise	◯	◯	◯	◯	◯
Have periodic lab tests to assess progress	◯	◯	◯	◯	◯

Comments:

Thank you for taking the time to complete this health history questionnaire. The information derived from all of these forms will provide invaluable data in identifying the underlying problems of your health concerns rather than simply treating the symptoms alone. We look forward to helping you achieve lifelong health and well being.

Sincerely,

Irvine Functional Medicine & Nutrition