

## ADULT MEDICAL QUESTIONNAIRE

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will also assist us to formulate a treatment plan.

First Name: _____		Middle Name: _____		Last Name: _____	
Address: _____		City: _____		State: _____ ZIP: _____	
Home Phone: (_____) _____ - _____		Birth Date: ____/____/____		Age: _____	
		month    day    year			
Work Phone: (_____) _____ - _____		Place of Birth: _____			
Occupation: _____		City or town & country if not US			
Referred by: _____		Height: ____' ____" Weight: _____		Sex: _____	
Today's Date _____					

1. Please check appropriate box(es):

- |                                           |                                    |                                            |                                |
|-------------------------------------------|------------------------------------|--------------------------------------------|--------------------------------|
| <input type="checkbox"/> African American | <input type="checkbox"/> Hispanic  | <input type="checkbox"/> Mediterranean     | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Native American  | <input type="checkbox"/> Caucasian | <input type="checkbox"/> Northern European | <input type="checkbox"/> Other |

2. Please rank current and ongoing problems by priority and fill in the other boxes as completely as possible:

DESCRIBE PROBLEM	MILD/ MODERATE/ SEVERE	TREATMENT APPROACH	SUCCESS
<b>Example:</b> Post Nasal Drip	Moderate	Elimination Diet	Moderate
a.			
b.			
c.			
d.			
e.			
f.			
g.			

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3. With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)  
Example: Wendy, age 7, sister

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4. Do you have any pets or farm animals? Yes\_\_\_\_ No\_\_\_\_  
If yes, where do they live? 1. \_\_\_\_ indoors 2. \_\_\_\_ outdoors 3. \_\_\_\_ both indoors and outdoors

5. Have you lived or traveled outside of the United States? Yes\_\_\_\_ No\_\_\_\_  
If so, when and where? \_\_\_\_\_

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6. Have you or your family recently experienced any major life changes? Yes\_\_\_\_ No\_\_\_\_  
If yes, please comment: \_\_\_\_\_

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7. Have you experienced any major losses in life? Yes\_\_\_\_ No\_\_\_\_  
If so, please comment: \_\_\_\_\_

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8. How important is religion (or spirituality) for you and your family's life?  
a. \_\_\_\_ not at all important  
b. \_\_\_\_ somewhat important  
c. \_\_\_\_ extremely important

9. How much time have you lost from work or school in the past year?  
a. \_\_\_\_ 0-2 days  
b. \_\_\_\_ 3-14 days  
c. \_\_\_\_ > 15 days

10. Previous jobs:

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11. Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress, illness, and immune system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life, it is very important that you feel safe telling us about it, so that we can support you and optimize your treatment outcomes.

Please do your best to answer the following questions:

- a. Did you feel safe growing up?  
 Yes       No
- b. Have you been involved in abusive relationships in your life?  
 Yes       No
- c. Was alcoholism or substance abuse present in your childhood home, or is it present now in your relationships?  
 Yes       No
- d. Do you currently feel safe in your home?  
 Yes       No

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- e. Do you feel safe, respected and valued in your current relationship?  
 Yes       No
- f. Have you had any violent or otherwise traumatic life experiences, or have you witnessed any violence or abuse?  
 Yes       No
- g. Would you feel safer discussing any of these issues privately?  
 Yes       No

12. Past Medical and Surgical History:

ILLNESSES	WHEN	COMMENTS
a. Anemia		
b. Arthritis		
c. Asthma		
d. Bronchitis		
e. Cancer		
f. Chronic Fatigue Syndrome		
g. Crohn's Disease or Ulcerative Colitis		
h. Diabetes		
i. Emphysema		
j. Epilepsy, convulsions, or seizures		
k. Gallstones		
l. Gout		
ILLNESSES	WHEN	COMMENTS
m. Heart attack/Angina		
n. Heart failure		
o. Hepatitis		
p. High blood fats (cholesterol, triglycerides)		
q. High blood pressure (hypertension)		
r. Irritable bowel		
s. Kidney stones		
t. Mononucleosis		
u. Pneumonia		
v. Rheumatic fever		
w. Sinusitis		
x. Sleep apnea		
y. Stroke		
z. Thyroid disease		
aa. Other (describe)		
INJURIES	WHEN	COMMENTS
ab. Back injury		

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ac.	Broken (describe)		
ad.	Head injury		
ae.	Neck injury		
af.	Other (describe)		
<b>DIAGNOSTIC STUDIES</b>		<b>WHEN</b>	<b>COMMENTS</b>
ag.	Barium Enema		
ah.	Bone Scan		
ai.	CAT Scan of Abdomen		
aj.	CAT Scan of Brain		
ak.	CAT Scan of Spine		
al.	Chest X-ray		
am.	Colonoscopy		
an.	EKG		
ao.	Liver scan		
ap.	Neck X-ray		
aq.	NMR/MRI		
ar.	Sigmoidoscopy		
as.	Upper GI Series		
at.	Other (describe)		
<b>OPERATIONS</b>		<b>WHEN</b>	<b>COMMENTS</b>
au.	Appendectomy		
av.	Dental Surgery		
aw.	Gall Bladder		
ax.	Hernia		
ay.	Hysterectomy		
az.	Tonsillectomy		
ba.	Other (describe)		
bb.	Other (describe)		

13. Hospitalizations:

WHERE HOSPITALIZED	WHEN	FOR WHAT REASON
a.		
b.		
c.		
d.		
e.		

14. How often have you have taken antibiotics?

**< 5 times**                      **> 5 times**

Infancy/ Childhood		
Teen		
Adulthood		

15. How often have you have taken oral steroids (e.g., Cortisone, Prednisone, etc.)?

**< 5 times**                      **> 5 times**

Infancy/ Childhood		
Teen		
Adulthood		

16. What medications are you taking now? Include non-prescription drugs.

Medication Name	Date started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Are you allergic to any medications?

Yes\_\_\_\_ No\_\_\_\_

If yes, please list: \_\_\_\_\_  
 \_\_\_\_\_

17. List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible.

Vitamin/Mineral/Supplement Name	Date started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

18. Childhood:

Question	Yes	No	Don't Know	Comment
1. Were you a full term baby?				
a. A preemie?				
b. Breast fed?				
c. Bottle fed?				

2. As a child did you eat a lot of sugar and/or candy?				
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19. As a child, were there any foods that you had to avoid because they gave you symptoms?  
 Yes\_\_\_\_ No\_\_\_\_

If yes, please: name the food and symptom (Example: milk – gas and diarrhea)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

20. Place a check mark next to the food/drink that applies to your current diet. (List continues on next page.)

	Usual Breakfast	√		Usual Lunch	√		Usual Dinner	√
a.	None		a.	None		a.	None	
b.	Bacon/Sausage		b.	Butter		b.	Beans (legumes)	
c.	Bagel		c.	Coffee		c.	Brown rice	
d.	Butter		d.	Eat in a cafeteria		d.	Butter	
e.	Cereal		e.	Eat in restaurant		e.	Carrots	
f.	Coffee		f.	Fish sandwich		f.	Coffee	
g.	Donut		g.	Juice		g.	Fish	
h.	Eggs		h.	Leftovers		h.	Green vegetables	
i.	Fruit		i.	Lettuce		i.	Juice	
j.	Juice		j.	Margarine		j.	Margarine	
k.	Margarine		k.	Mayo		k.	Milk	
l.	Milk		l.	Meat sandwich		l.	Pasta	
m.	Oat bran		m.	Milk		m.	Potato	
n.	Sugar		n.	Salad		n.	Poultry	
	Usual Breakfast	√		Usual Lunch	√		Usual Dinner	√
o.	Sweet roll		o.	Salad dressing		o.	Red meat	
p.	Sweetener		p.	Soda		p.	Rice	
q.	Tea		q.	Soup		q.	Salad	
r.	Toast		r.	Sugar		r.	Salad dressing	
s.	Water		s.	Sweetener		s.	Soda	
t.	Wheat bran		t.	Tea		t.	Sugar	
u.	Yogurt		u.	Tomato		u.	Sweetener	
v.	Other: (List below)		v.	Water		v.	Tea	
			w.	Yogurt		w.	Water	
			x.	Other: (List below)		x.	Yellow vegetables	
						y.	Other: (List below)	

21. How much of the following do you consume each week?

a.	Candy	
b.	Cheese	
c.	Chocolate	
d.	Cups of coffee containing caffeine	
e.	Cups of decaffeinated coffee or tea	

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f. Cups of hot chocolate	
g. Cups of tea containing caffeine	
h. Diet sodas	
i. Ice cream	
j. Salty foods	
k. Slices of white bread (rolls/bagels)	
l. Sodas with caffeine	
m. Sodas without caffeine	

22. Are you on a special diet? Yes\_\_\_ No\_\_\_  
 \_\_\_ ovo-lacto \_\_\_ vegetarian \_\_\_ other (describe):  
 \_\_\_ diabetic \_\_\_ vegan \_\_\_\_\_  
 \_\_\_ dairy restricted \_\_\_ blood type diet \_\_\_\_\_

23. Is there anything special about your diet that we should know? Yes\_\_\_ No\_\_\_  
 If yes, please explain: \_\_\_\_\_

24. a. Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc.?  
 Yes\_\_\_ No\_\_\_  
 b. If yes, are these symptoms associated with any particular food or supplement(s)?  
 Yes\_\_\_ No\_\_\_  
 c. Please name the food or supplement and symptom(s). Example: Milk – gas and diarrhea.  
 \_\_\_\_\_  
 \_\_\_\_\_

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

26. Do you feel much **worse** when you eat a lot of :  
 \_\_\_ high fat foods \_\_\_ refined sugar (junk food)  
 \_\_\_ high protein foods \_\_\_ fried foods  
 \_\_\_ high carbohydrate foods \_\_\_ 1 or 2 alcoholic drinks  
 (breads, pastas, potatoes) \_\_\_ other \_\_\_\_\_

27. Do you feel much **better** when you eat a lot of :  
 \_\_\_ high fat foods \_\_\_ refined sugar (junk food)  
 \_\_\_ high protein foods \_\_\_ fried foods  
 \_\_\_ high carbohydrate foods \_\_\_ 1 or 2 alcoholic drinks  
 (breads, pastas, potatoes) \_\_\_ other \_\_\_\_\_

28. Does skipping a meal greatly affect your symptoms? Yes\_\_\_ No\_\_\_

29. Have you ever had a food that you craved or really "binged" on over a period of time?  
 Food craving may be an indicator that you may be allergic to that food. Yes\_\_\_ No\_\_\_  
 If yes, what food(s)? \_\_\_\_\_  
 \_\_\_\_\_

30. Do you have an aversion to certain foods? Yes\_\_\_ No\_\_\_  
 If yes, what foods? \_\_\_\_\_

31. Please fill in the chart below with information about your bowel movements:

a. Frequency	√	b. Color	√
More than 3x/day		Medium brown consistently	
1-3x/day		Very dark or black	
4-6x/week		Greenish color	
2-3x/week		Blood is visible.	
1 or fewer x/week		Varies a lot.	
		Dark brown consistently	
b. Consistency		Yellow, light brown	
Soft and well formed		Greasy, shiny appearance	
Often float			
Difficult to pass			
Diarrhea			
Thin, long or narrow			
Small and hard			
Loose but not watery			
Alternating between hard and loose/watery			

32. Intestinal gas: \_\_\_\_\_ Daily \_\_\_\_\_ Present with pain  
 \_\_\_\_\_ Occasionally \_\_\_\_\_ Foul smelling  
 \_\_\_\_\_ Excessive \_\_\_\_\_ Little odor

33. a. Have you ever used alcohol? Yes\_\_\_\_\_ No\_\_\_\_\_

b. If yes, how often do you now drink alcohol? \_\_\_\_\_ No longer drinking alcohol  
 \_\_\_\_\_ Average 1-3 drinks per week  
 \_\_\_\_\_ Average 4-6 drinks per week  
 \_\_\_\_\_ Average 7-10 drinks per week  
 \_\_\_\_\_ Average >10 drinks per week

c. Have you ever had a problem with alcohol? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, please indicate time period (month/year): from \_\_\_\_\_ to \_\_\_\_\_.

34. Have you ever used recreational drugs? Yes\_\_\_\_\_ No\_\_\_\_\_

35. Have you ever used tobacco? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, number of years as a nicotine user \_\_\_\_\_. Amount per day \_\_\_\_\_. Year quit \_\_\_\_\_.  
 If yes, what type of nicotine have you used? \_\_\_\_\_Cigarette \_\_\_\_\_ Smokeless  
 \_\_\_\_\_Cigar \_\_\_\_\_Pipe \_\_\_\_\_Patch/Gum

36. Are you exposed to second hand smoke regularly? Yes\_\_\_\_\_ No\_\_\_\_\_

37. Do you have mercury amalgam fillings? Yes\_\_\_\_\_ No\_\_\_\_\_

38. Do you have any artificial joints or implants? Yes\_\_\_\_\_ No\_\_\_\_\_

39. Do you feel worse at certain times of the year? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, when? \_\_\_\_\_spring \_\_\_\_\_fall  
 \_\_\_\_\_summer \_\_\_\_\_winter



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40. Have you, to your knowledge, been exposed to toxic metals in your job or at home? Yes\_\_\_\_ No\_\_\_\_  
 If yes, which one(s)? \_\_\_\_\_lead \_\_\_\_\_cadmium  
 \_\_\_\_\_arsenic \_\_\_\_\_mercury  
 \_\_\_\_\_aluminum

41. Do odors affect you? Yes\_\_\_\_ No\_\_\_\_

42. How well have things been going for you?

	Very Well	Fair	Poorly	Very Poorly	Does not apply
a. At school					
b. In your job					
c. In your social life					
d. With close friends					
e. With sex					
f. With your attitude					
g. With your boyfriend/girlfriend					
h. With your children					
i. With your parents					
j. With your spouse					

43. Have you ever had psychotherapy or counseling? Yes\_\_\_\_ No\_\_\_\_  
 Currently? \_\_\_\_\_ Previously? \_\_\_\_\_ If previously, from \_\_\_\_\_ to \_\_\_\_\_.  
 What kind? \_\_\_\_\_  
 Comments: \_\_\_\_\_

44. Are you currently, or have you ever been, married? Yes\_\_\_\_ No\_\_\_\_  
 If so, when were you married? \_\_\_\_\_ Spouse's occupation \_\_\_\_\_  
 When were you separated? \_\_\_\_\_ Never \_\_\_\_\_  
 When were you divorced? \_\_\_\_\_ Never \_\_\_\_\_  
 When were you remarried? \_\_\_\_\_ Never \_\_\_\_\_ Spouse's occupation \_\_\_\_\_  
 Comments: \_\_\_\_\_

45. Hobbies and leisure activities: \_\_\_\_\_  
 \_\_\_\_\_

46. Do you exercise regularly? Yes\_\_\_\_ No\_\_\_\_  
 If so, how many times a week? \_\_\_\_\_ When you exercise, how long is each session?  
 1. \_\_\_\_\_1x 1. \_\_\_\_\_ ≤15 min  
 2. \_\_\_\_\_2x 2. \_\_\_\_\_ 16-30 min  
 3. \_\_\_\_\_3x 3. \_\_\_\_\_ 31-45 min  
 4. \_\_\_\_\_4x or more 4. \_\_\_\_\_ > 45 min  
 What type of exercise is it?  
 \_\_\_\_\_jogging/walking \_\_\_\_\_tennis  
 \_\_\_\_\_basketball \_\_\_\_\_water sports  
 \_\_\_\_\_home aerobics \_\_\_\_\_other \_\_\_\_\_

47. Any other family history we should know about? Yes\_\_\_\_ No\_\_\_\_  
 If so, please comment: \_\_\_\_\_

**47. FAMILY HISTORY:** For each member of your family, follow the grey or white line

across the page and check the boxes for:

1. Their present state of health, and
2. Any illnesses they have had.

(Note: Except for spouse, Family refers to blood or natural relatives.)

PRINT NAMES BELOW	Good Health	Poor Health	Deceased	Write in age and cause of death. Include accidents and suicides.	Alcoholism	Allergies or Asthma	Alzheimer's or Dementia	Anemia	Blood Clotting Problems	Diabetes	Cancer or Tumor	Epilepsy	Genetic Disease	Heart Trouble	High Blood Pressure	Kidney or Bladder Dis.	Nervous Breakdown	Rheumatism or Arthritis	Stomach or Duodenal Ulcer		
Father																					
Mother:																					
Brothers/Sisters:																					
Spouse:																					
Child:																					
Child:																					
Child:																					
Child:																					
Paternal relatives (in each box, write in how many affected with condition):																					
Maternal relatives (in each box, write in how many affected with condition):																					

48. What is the attitude of those close to you about your illness?

\_\_\_\_\_ Supportive  
\_\_\_\_\_ Non-supportive

**FOR WOMEN ONLY (questions 49-57):**

49. Have you ever been pregnant? (If no, skip to question 50.) Yes\_\_\_\_ No\_\_\_\_

Number of miscarriages \_\_\_\_\_ Number of abortions \_\_\_\_\_ Number of preemies \_\_\_\_\_

Number of term births \_\_\_\_\_ Birth weight of largest baby \_\_\_\_\_ Smallest baby \_\_\_\_\_

Did you develop toxemia (high blood pressure)? Yes\_\_\_\_ No\_\_\_\_

Have you had other problems with pregnancy? Yes\_\_\_\_ No\_\_\_\_

If so, please comment:

\_\_\_\_\_

50. Age at first period \_\_\_\_\_ Date of last Pap Smear \_\_\_\_\_ Date of last Mammogram \_\_\_\_\_

Pap Smear: \_\_\_ Normal \_\_\_ Abnormal

Mammogram: \_\_\_ Normal \_\_\_ Abnormal

51. Have you ever used birth control pills? Yes\_\_\_\_ No\_\_\_\_ If yes, when \_\_\_\_\_

52. Are you taking the pill now? Yes\_\_\_\_ No\_\_\_\_

53. Did taking the pill agree with you? Yes\_\_\_\_ No\_\_\_\_ Not applicable \_\_\_\_\_

54. Do you currently use contraception? Yes\_\_\_\_ No\_\_\_\_

If yes, what type of contraception do you use? \_\_\_\_\_

55. Are you in menopause? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, age at last period \_\_\_\_\_

Do you take: Estrogen?\_\_\_ Ogen?\_\_\_ Estrace?\_\_\_ Premarin?\_\_\_ Other (specify) \_\_\_\_\_

Progesterone?\_\_\_ Provera? \_\_\_ Other (specify) \_\_\_\_\_

56. How long have you been on hormone replacement therapy (if applicable)? \_\_\_\_\_

57. In the second half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)? Yes\_\_\_\_ No\_\_\_\_ Not applicable \_\_\_\_\_

59. Please check if these symptoms occur presently **or** have occurred in the past 6 months.

<b>GENERAL:</b>	<b>Mild</b>	<b>Mod- erate</b>	<b>Severe</b>
Cold hands & feet			
Cold intolerance			
Daytime sleepiness			
Difficulty falling asleep			
Early waking			
Fatigue			
Fever			
Flushing			
Heat intolerance			
Night waking			
Nightmares			
No dream recall			
<b>HEAD, EYES &amp; EARS:</b>			
Conjunctivitis			
Distorted sense of smell			
Distorted taste			
Ear fullness			
Ear noises			
Ear pain			
Ear ringing/buzzing			
Eye crusting			
Eye pain			
Headache			
Hearing loss			
Hearing problems			
Lid margin redness			
Migraine			
Sensitivity to loud noises			
Vision problems			

<b>MUSCULOSKELETAL:</b>	<b>Mild</b>	<b>Mod- erate</b>	<b>Severe</b>
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			
Tendonitis			
Tension headache			
TMJ problems			
<b>MOOD/NERVES:</b>			
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			

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<b>MOOD/NERVES, Cont'd:</b>	<b>Mild</b>	<b>Mod- erate</b>	<b>Severe</b>
Numbness			
Other Phobias			
Panic attacks			
Paranoia			
Seizures			
Suicidal thoughts			
Tingling			
Tremor/trembling			
Visual hallucinations			
<b>EATING:</b>			
Binge eating			
Bulimia			
Can't gain weight			
Can't lose weight			
Carbohydrate craving			
Carbohydrate intolerance			
Poor appetite			
Salt craving			
<b>DIGESTION:</b>			
Anal spasms			
Bad teeth			
Bleeding gums			
Bloating of: Lower abdomen			
Whole abdomen			
Blood in stools			
Burping			
Canker sores			
Cold sores			
Constipation			
Cracking at corner of lips			
Dentures w/poor chewing			
Diarrhea			
Difficulty swallowing			
Dry mouth			
Farting			

<b>DIGESTION, Cont'd:</b>	<b>Mild</b>	<b>Mod- erate</b>	<b>Severe</b>
Fissures			
Foods "repeat" (reflux)			
Heartburn			
Hemorrhoids			
Intolerance to: Lactose			
All milk products			
Intolerance to: Gluten (wheat)			
Corn			
Eggs			
Fatty foods			
Yeast			
Liver disease/jaundice (yellow eyes or skin)			
Lower abdominal pain			
Mucus in stools			
Nausea			
Periodontal disease			
Sore tongue			
Strong stool odor			
Undigested food in stools			
Upper abdominal pain			
Vomiting			
<b>SKIN PROBLEMS:</b>			
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			

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<b>SKIN PROBLEMS, Cont'd:</b>	<b>Mild</b>	<b>Mod- erate</b>	<b>Severe</b>
Eczema			
Herpes - genital			
Hives			
Jock itch			
Lackluster skin			
Moles w color/size change			
Oily skin			
Pale skin			
Patchy dullness			
Psoriasis			
Rash			
Red face			
Sensitive to bites			
Sensitive to poison ivy/oak			
Shingles			
Skin cancer			
Skin darkening			
Strong body odor			
Thick calluses			
Vitiligo			
<b>SKIN, ITCHING:</b>			
Anus			
Arms			
Ear canals			
Eyes			
Feet			
Hands			
Legs			
Nipples			
Nose			
Penis			
Roof of mouth			
Scalp			
Skin in general			
Throat			

<b>SKIN, DRYNESS OF:</b>	<b>Mild</b>	<b>Mod- erate</b>	<b>Severe</b>
Eyes			
Feet			
Any cracking?			
Any peeling?			
Hair			
And unmanageable?			
Hands			
Any cracking?			
Any peeling?			
Mouth/throat			
Scalp			
Any dandruff?			
Skin in general			
<b>LYMPH NODES:</b>			
Enlarged/neck			
Tender/neck			
Other enlarged/tender lymph nodes			
<b>NAILS:</b>			
Bitten			
Brittle			
Curve up			
Frayed			
Fungus - fingers			
Fungus - toes			
Pitting			
Ragged cuticles			
Ridges			
Soft			
Thickening of: Finger nails			
Toenails			
White spots/lines			

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<b>RESPIRATORY:</b>	<b>Mild</b>	<b>Mod- erate</b>	<b>Severe</b>
Bad breath			
Bad odor in nose			
Cough - dry			
Cough - productive			
Hay fever : Spring			
Summer			
Fall			
Change of season			
Hoarseness			
Nasal stuffiness			
Nose bleeds			
Post nasal drip			
Sinus fullness			
Sinus infection			
Snoring			
Sore throat			
Wheezing			
Winter stuffiness			
<b>CARDIOVASCULAR:</b>			
Angina/chest pain			
Breathlessness			
Heart attack			
Heart murmur			
High blood pressure			
Irregular pulse			
Mitral valve prolapse			
Palpitations			
Phlebitis			
Swollen ankles/feet			
Varicose veins			

<b>URINARY:</b>	<b>Mild</b>	<b>Mod- erate</b>	<b>Severe</b>
Bed wetting			
Hesitancy			
Infection			
Kidney disease			
Kidney stone			
Leaking/incontinence			
Pain/burning			
Prostate enlargement			
Prostate infection			
Urgency			
<b>MALE REPRODUCTIVE:</b>			
Discharge from penis			
Ejaculation problem			
Genital pain			
Impotence			
Infection			
Lumps in testicles			
Poor libido (sex drive)			
<b>FEMALE REPRODUCTIVE:</b>			
Breast cysts			
Breast lumps			
Breast tenderness			
Ovarian cyst			
Poor libido (sex drive)			
Endometriosis			
Fibroids			
Infertility			
Vaginal discharge			
Vaginal odor			
Vaginal itch			
Vaginal pain			

Adult Medical Questionnaire

<b>FEMALE REPRODUCTIVE, Cont'd:</b>	<b>Mild</b>	<b>Mod- erate</b>	<b>Severe</b>
<u>Premenstrual:</u>			
Bloating			
Breast tenderness			
Carbohydrate craving			
Chocolate craving			
Constipation			
Decreased sleep			
Diarrhea			
Fatigue			
Increased sleep			
Irritability			
<u>Menstrual:</u>			
Cramps			
Heavy periods			
Irregular periods			
No periods			
Scanty periods			
Spotting between			





# 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 <b>Time</b>		_____ <b>P</b> _____ <b>F</b> _____ <b>C</b> <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>O</b> <input type="checkbox"/> <b>Y</b> <input type="checkbox"/> <b>G</b> <input type="checkbox"/> <b>B/P/BL</b> <input type="checkbox"/> <b>W/T/BR</b>
Mid-AM Snack <b>Time</b>		_____ <b>P</b> _____ <b>F</b> _____ <b>C</b> <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>O</b> <input type="checkbox"/> <b>Y</b> <input type="checkbox"/> <b>G</b> <input type="checkbox"/> <b>B/P/BL</b> <input type="checkbox"/> <b>W/T/BR</b>
Lunch <b>Time</b>		_____ <b>P</b> _____ <b>F</b> _____ <b>C</b> <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>O</b> <input type="checkbox"/> <b>Y</b> <input type="checkbox"/> <b>G</b> <input type="checkbox"/> <b>B/P/BL</b> <input type="checkbox"/> <b>W/T/BR</b>
Mid-PM Snack <b>Time</b>		_____ <b>P</b> _____ <b>F</b> _____ <b>C</b> <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>O</b> <input type="checkbox"/> <b>Y</b> <input type="checkbox"/> <b>G</b> <input type="checkbox"/> <b>B/P/BL</b> <input type="checkbox"/> <b>W/T/BR</b>
Dinner <b>Time</b>		_____ <b>P</b> _____ <b>F</b> _____ <b>C</b> <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>O</b> <input type="checkbox"/> <b>Y</b> <input type="checkbox"/> <b>G</b> <input type="checkbox"/> <b>B/P/BL</b> <input type="checkbox"/> <b>W/T/BR</b>
PM Snack <b>Time</b>		_____ <b>P</b> _____ <b>F</b> _____ <b>C</b> <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>O</b> <input type="checkbox"/> <b>Y</b> <input type="checkbox"/> <b>G</b> <input type="checkbox"/> <b>B/P/BL</b> <input type="checkbox"/> <b>W/T/BR</b>
Bed Time		

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

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
<b>Sleep</b> Quantity: _____ (hours) Quality: <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <b>Relaxation</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Type/Amount:	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 <b>Time</b>		_____ <b>P</b> _____ <b>F</b> _____ <b>C</b> <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>O</b> <input type="checkbox"/> <b>Y</b> <input type="checkbox"/> <b>G</b> <input type="checkbox"/> <b>B/P/BL</b> <input type="checkbox"/> <b>W/T/BR</b>
Mid-AM Snack <b>Time</b>		_____ <b>P</b> _____ <b>F</b> _____ <b>C</b> <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>O</b> <input type="checkbox"/> <b>Y</b> <input type="checkbox"/> <b>G</b> <input type="checkbox"/> <b>B/P/BL</b> <input type="checkbox"/> <b>W/T/BR</b>
Lunch <b>Time</b>		_____ <b>P</b> _____ <b>F</b> _____ <b>C</b> <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>O</b> <input type="checkbox"/> <b>Y</b> <input type="checkbox"/> <b>G</b> <input type="checkbox"/> <b>B/P/BL</b> <input type="checkbox"/> <b>W/T/BR</b>
Mid-PM Snack <b>Time</b>		_____ <b>P</b> _____ <b>F</b> _____ <b>C</b> <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>O</b> <input type="checkbox"/> <b>Y</b> <input type="checkbox"/> <b>G</b> <input type="checkbox"/> <b>B/P/BL</b> <input type="checkbox"/> <b>W/T/BR</b>
Dinner <b>Time</b>		_____ <b>P</b> _____ <b>F</b> _____ <b>C</b> <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>O</b> <input type="checkbox"/> <b>Y</b> <input type="checkbox"/> <b>G</b> <input type="checkbox"/> <b>B/P/BL</b> <input type="checkbox"/> <b>W/T/BR</b>
PM Snack <b>Time</b>		_____ <b>P</b> _____ <b>F</b> _____ <b>C</b> <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>O</b> <input type="checkbox"/> <b>Y</b> <input type="checkbox"/> <b>G</b> <input type="checkbox"/> <b>B/P/BL</b> <input type="checkbox"/> <b>W/T/BR</b>
Bed Time		

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

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
<b>Sleep</b> Quantity: _____ (hours) Quality: <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <b>Relaxation</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Type/Amount:	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 <b>Time</b>		_____ <b>P</b> _____ <b>F</b> _____ <b>C</b> <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>O</b> <input type="checkbox"/> <b>Y</b> <input type="checkbox"/> <b>G</b> <input type="checkbox"/> <b>B/P/BL</b> <input type="checkbox"/> <b>W/T/BR</b>
Mid-AM Snack <b>Time</b>		_____ <b>P</b> _____ <b>F</b> _____ <b>C</b> <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>O</b> <input type="checkbox"/> <b>Y</b> <input type="checkbox"/> <b>G</b> <input type="checkbox"/> <b>B/P/BL</b> <input type="checkbox"/> <b>W/T/BR</b>
Lunch <b>Time</b>		_____ <b>P</b> _____ <b>F</b> _____ <b>C</b> <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>O</b> <input type="checkbox"/> <b>Y</b> <input type="checkbox"/> <b>G</b> <input type="checkbox"/> <b>B/P/BL</b> <input type="checkbox"/> <b>W/T/BR</b>
Mid-PM Snack <b>Time</b>		_____ <b>P</b> _____ <b>F</b> _____ <b>C</b> <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>O</b> <input type="checkbox"/> <b>Y</b> <input type="checkbox"/> <b>G</b> <input type="checkbox"/> <b>B/P/BL</b> <input type="checkbox"/> <b>W/T/BR</b>
Dinner <b>Time</b>		_____ <b>P</b> _____ <b>F</b> _____ <b>C</b> <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>O</b> <input type="checkbox"/> <b>Y</b> <input type="checkbox"/> <b>G</b> <input type="checkbox"/> <b>B/P/BL</b> <input type="checkbox"/> <b>W/T/BR</b>
PM Snack <b>Time</b>		_____ <b>P</b> _____ <b>F</b> _____ <b>C</b> <input type="checkbox"/> <b>R</b> <input type="checkbox"/> <b>O</b> <input type="checkbox"/> <b>Y</b> <input type="checkbox"/> <b>G</b> <input type="checkbox"/> <b>B/P/BL</b> <input type="checkbox"/> <b>W/T/BR</b>
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
<p><b>Sleep</b> Quantity: _____ (hours) Quality: <input type="checkbox"/> Poor   <input type="checkbox"/> Fair   <input type="checkbox"/> Good</p> <p><b>Relaxation</b> <input type="checkbox"/> Yes   <input type="checkbox"/> No Type/Amount:</p>	<p>Type, Duration, &amp; Intensity</p> <p><input type="checkbox"/> Aerobic:</p> <p><input type="checkbox"/> Strength:</p> <p><input type="checkbox"/> Flexibility:</p>	<p>Stress Reduction Practices:</p> <p>Stressors:</p>	<p>Supporting:</p> <p>Non-supporting:</p>

Mental	Emotional	Spiritual