CHAPEL MCMURTRIE BARTLETT CHIROPRACTIC

FUNCTIONAL HEALTH ASSESSMENT

Thank you for choosing our office to assist you with your health care. Please complete the below assessment to the best of your ability. Health issues may be influenced by many factors: therefore, it is important that you carefully consider the questions asked in this form as well as those posed by your doctor during your consultation. Our ability to draw effective conclusions about your state of health and how to best optimize its improvement largely depends on the accuracy of the information you provide, including symptoms that you may consider minor. This will assist our goal to provide you with an optimal plan of health care, enhance our efficiency, and will provide effective use of your scheduled time.

Date:_____

First Name:_____ Middle:_____Last:_____

Address _____ City _____ State _____ Zip Code_____

Phone Number (____) ____-_____

Email _____

Age _____ Date of Birth ____/____/_____ Gender: Female__Male___ Height: _____ Weight:_____

Referred by:_____

Name, address, & phone number of primary care physician:_____

_____

Marital Status:

Single____ Married____ Divorced____ Widowed____ Long Term Partnership____

Emergency Contact: _____
Relationship Name Phone

_____
Address

Occupation _____ Hours per week _____

Genetic Background: Please check appropriate box(es):

- ❑ African American ❑ Hispanic ❑ Mediterranean ❑ Asian
- ❑ Native American ❑ Caucasian ❑ Northern European ❑ Other

TELL US YOUR STORY

In the box below, please describe the health concerns that bring you in today.

CURRENT HEALTH STATUS/CONCERNS

Please provide us with current and ongoing problems

Problem	Date of Onset	Severity/Frequency	Treatment Approach	Success
Example: 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?

_____

_____

_____

When was the last time that you felt well?_____

What seems to worsen your symptoms?_____

What seems to make you feel better?_____

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?_____

PAST MEDICAL AND SURGICAL HISTORY

If you have experienced reoccurrence of an illness, please indicate when or how often under comments.

ILLNESSES	WHEN /ONSET	COMMENTS
Anemia		
Arthritis		
Asthma		
Bronchitis		
Cancer		
Chicken Pox		
Chronic Fatigue Syndrome		
Crohn's Disease or Ulcerative Colitis		
Diabetes		
Emphysema		
Epilepsy, convulsions, or seizures		
Gallstones		

Gout		
Heart Attack, Angina		
Heart Failure		
Hepatitis		
Herpes Lesions/Shingles		
High blood fats (cholesterol, triglycerides)		
High blood pressure (hypertension)		
Irritable bowel (or chronic diarrhea)		
Kidney stones		
Measles		
Mononucleosis		
Mumps		
Pneumonia		
Rheumatic Fever		
Sinusitis		
Sleep Apnea		
Stroke		
Thyroid disease		
Whooping Cough		
Other (describe)		
Other (describe)		
INJURIES	**WHEN**	**COMMENTS**
Broken bones or fractures (describe)		
Back Injury		
Head injury		
Neck injury		
Other (describe)		
Other (describe)		

DIAGNOSTIC STUDIES	WHEN	COMMENTS
Blood Tests		
Bone Density Test		
Bone Scan		
Carotid Artery Ultrasound		
CAT Scan (Please indicate type)		
Colonoscopy		
Endoscopy		

EKG		
Liver Scan		
Mammogram		
MRI		
X-Ray (Please indicate type)		
Other (describe)		
Other (describe)		
SURGERIES	**WHEN**	**COMMENTS**
Appendectomy		
Tonsillectomy		
Hysterectomy (Partial or Total)		
Dental Surgery		
Gall Bladder Removal		
Hernia		
Tubes in Ears		
Other (describe)		
Other (describe)		

HOSPITALIZATIONS

WHERE HOSPITALIZED	WHEN	REASON

MEDICATIONS

How often have you taken antibiotics?	Less than 5 times	More than 5 times	Comments
Infancy/Childhood			
Teen			
Adulthood			

How often have you taken oral steroids? (e.g. Prednisone, Cortisone, etc)	Less than 5 times	More than 5 times	Comments
Infancy/Childhood			
Teen			
Adulthood			

List all medications. Include all over the counter non-prescription drugs.

Medication Name	Date started	Date stopped	Dosage

List all vitamins, minerals, and any nutritional supplements that you are taking now. If possible, indicate whether the dosage.

Type	Date Started	Date Stopped	Dosage

Are you allergic to any medication, vitamin, mineral, or other nutritional supplement? Yes___ No ___
If yes, please list:_____

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? ('preemie')				
Vaginal Delivery?				
C-Section Delivery?				
Breast fed?				
Bottle fed?				
When pregnant with you, did your mother:				
Smoke tobacco?				
Use recreational drugs?				

Drink alcohol?				
Use estrogen?				
Other prescription or non-prescription medications?				

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, other dairy products?				
Meat, vegetables, & potato diet?				
Vegetarian diet?				
Diet high in white breads?				

As a child, were there foods that you had to avoid because they gave you symptoms? Yes___ No___

If yes, please explain: (Example: 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/ADHD		
Asthma		
Bronchitis		
Seasonal Allergies		
Colic		
Congenital problems		
Ear infections		
Fever blisters		
Frequent colds or flu		
Frequent headaches		
Jaundice		

	YES	AGE
Mumps		
Pneumonia		
Chicken Pox		
Skin disorders (e.g. dermatitis)		
Strep infections		
Tonsillitis		
Upset stomach, digestive problems		
Whooping cough		
Measles		
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___

FEMALE MEDICAL HISTORY

(For women only)

OBSTETRICS HISTORY

Check box if yes, and provide number of pregnancies and/or occurrences of conditions

- ❑ Pregnancies_____
- ❑ Caesarean _____
- ❑ Vaginal deliveries_____
- ❑ Miscarriage _____
- ❑ Abortion _____
- ❑ Living Children_____
- ❑ Post partum depression___
- ❑ Toxemia _____
- ❑ Gestational diabetes_____

GYNECOLOGICAL HISTORY (for women only)

Age at first menses?_____ Date of last menstrual period:____/____/_____

Length of menses:_____ Length of cycle:____

Is your cycle length consistent? Yes____No____

Is your cycle length greater than 32 days? Yes____ No____

Is your cycle length shorter than 24 days? Yes ____ No ____

Please indicate the appropriate number on all questions below (0 as the least/never to 3 as the most/always)

- Pain and cramping during periods 0 1 2 3
- Scanty blood flow 0 1 2 3
- Heavy blood flow 0 1 2 3
- Breast pain and swelling during menses 0 1 2 3
- Irritable and depressed during menses 0 1 2 3
- Acne 0 1 2 3
- Facial hair growth 0 1 2 3
- I experience PMS seven to 10 days before my period 0 1 2 3
- I get headaches or migraines around my period 0 1 2 3

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

Do you notice your symptoms to be more prominent during specific phases of your menstrual cycle (menses, follicular, ovulation, luteal)?_____

Do you track your basal body temperature or use any fertility awareness monitors? Yes _____ No_____

Do you track or chart your cervical fluid production over the course of your cycle? Yes _____ No_____

Do you currently use contraception? Yes____ No____ If yes, what please indicate which form:

Non-hormonal

- ❑ Condom
- ❑ Diaphragm
- ❑ IUD
- ❑ Partner vasectomy
- ❑ Other (non-hormonal-please describe)_____

Hormonal

- ❑ Birth control pills
- ❑ IUD
- ❑ Other (please describe)_____

If you currently use contraception, please indicate the main reason for its use:

Pregnancy Prevention? Yes____ No____ Symptom Management? Yes____ No____ If yes, please describe_____

Even if you are ***not*** currently using contraception, but have used hormonal birth control in the past, please indicate which type and for how long._____

Are you menopausal? _____ How many years have you been menopausal? _____

Please indicate the appropriate number on all questions below (0 as the least/never to 3 as the most/always)

- Hot flashes 0 1 2 3
- Mental fogginess 0 1 2 3
- Disinterested in sex 0 1 2 3
- Mood swings 0 1 2 3
- Depression 0 1 2 3
- Shrinking breasts 0 1 2 3
- Facial hair growth 0 1 2 3

Do you currently take hormone replacement? Yes___ No___ If yes, what type and for how long?_____

❑ Estrogen ❑ Ogen ❑ Estrace ❑ Premarin ❑ Progesterone ❑ Provera

❑ Other _____

DIAGNOSTIC TESTING

Last PAP test:_____/_____/_____ Normal:_____Abnormal_____

Last Mammogram_____/_____/_____ Breast biopsy? Date:_____/_____/_____

Date of last bone densitiy_____/_____/_____ Results: High____ Low____ Within normal range____

FAMILY HEALTH HISTORY

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

Check Family Members that Apply	**Father**	**Mother**	**Brother(s)**	**Sister(s)**	**Children**	**Maternal Grandmother**	**Maternal Grandfather**	**Paternal Grandmother**	**Paternal Grandfather**
Heart Attack									
Stroke									
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									
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

Check (√) those items that applied to you in the ***past***. **Circle** those that ***presently*** apply

GENERAL

- ❑ Fever
- ❑ Chills/Cold all over
- ❑ Weight Loss
- ❑ Weight Gain
- ❑ Sleep Problems
  - ❑ Problems falling asleep
  - ❑ Problems staying asleep
  - ❑ Nightmares
  - ❑ Sleepwalker
- ❑ Fatigue/Malaise

EAR/NOSE/THROAT/MOUTH:

- ❑ Sore throat
- ❑ Hearing problems
- ❑ Tinnitus/ringing in the ears
- ❑ Mass
- ❑ Left Ear Pain
- ❑ Right Ear Pain
- ❑ Hearing loss
  - ❑ Hearing aids?
- ❑ Tubes in Ears
- ❑ Hayfever
- ❑ Frequent Colds
- ❑ Nasal Congestion
- ❑ Runny Nose
- ❑ Nose Bleeds
- ❑ Mouth Sores
- ❑ Bleeding Gums
- ❑ Dental Pain
- ❑ Hoarseness
- ❑ Sneezing
- ❑ Ear Drainage
- ❑ Post Nasal Drip
- ❑ No Sense of Smell
- ❑ Sore Tongue
- ❑ Canker Sores
- ❑ Dry mouth
- ❑ Chapped lips
- ❑ Cracked lips/corners
- ❑ Fever Blisters

EYES:

- ❑ Blurred Vision
- ❑ Double Vision
- ❑ Vision Loss
- ❑ Blindness
- ❑ Pain
- ❑ Wears Glasses
- ❑ Wears Contacts
- ❑ Redness
- ❑ Itchy eyes
- ❑ Swelling
- ❑ Sensitivity to light
- ❑ Discharge
- ❑ Dark Circles under eyes
- ❑ Cataracts

CARDIOVASCULAR:

- ❑ Chest pain
- ❑ Difficulty breathing
- ❑ Swelling
- ❑ Palpitations
- ❑ Fainting
- ❑ Heart Murmur
- ❑ High blood pressure
- ❑ Leg cramps
- ❑ Shortness of breath when laying flat
- ❑ Peripheral edema

RESPIRATORY:

- ❑ Wheezing
- ❑ Shortness of breath
- ❑ Cough
- ❑ Shortness of breath with exertion
- ❑ Coughing up blood
- ❑ Snoring
- ❑ Pain with breathing
- ❑ Difficulty breathing

GASTROINTESTINAL

- ❑ Nausea
- ❑ Vomiting
- ❑ Abdominal Pain
- ❑ Change in bowel habits
- ❑ Diarrhea
- ❑ Constipation
- ❑ Undigested food in stool
- ❑ Black tarry stool
- ❑ Vomiting blood
- ❑ Anal bleeding
- ❑ Rectal itching
- ❑ Anal Pain
- ❑ Excessive gas
- ❑ Heartburn/indigestion
- ❑ Loss of appetite
- ❑ Difficulty swallowing
- ❑ Bloating/fullness
- ❑ Belch frequently
- ❑ Peptic/Duodenal Ulcer
- ❑ Gallstones
- ❑ Gallbladder pain
- ❑ Anal fissures
- ❑ Hiatal Hernia
- ❑ Use laxatives

GENITOURINARY:

- ❑ Incontinence/loss of bladder control
- ❑ Urgency
- ❑ Blood in urine
- ❑ Painful urination
- ❑ Night time urination
  - ❑ How many times?_____
- ❑ Change in sexual desire
- ❑ Weak stream
- ❑ Dribbling
- ❑ Altered color/odor of urine
- ❑ Frequency
- ❑ Genital sores
- ❑ Swelling
- ❑ Undescended testicles
- ❑ Penile discharge
- ❑ Hernia
- ❑ Rash
- ❑ Erectile Dysfunction
- ❑ STD exposure/unprotected intercourse

JOINT/MUSCLES/TENDONS

- ❑ Joint pain
- ❑ Joint Stiffness
- ❑ Muscle Weakness
- ❑ Muscle Pain
- ❑ Muscle Cramping
- ❑ Limitation of movement
- ❑ Edema
- ❑ Deformity
- ❑ Pain wakes you
- ❑ Damp weather bothers you

NEUROLOGIC:

- ❑ Dizziness
- ❑ Seizures/involuntary movement
- ❑ Numbness/tingling
- ❑ Headaches:
  - ❑ Frontal
  - ❑ Occipital
  - ❑ Migraine
  - ❑ After meals
  - ❑ When meals are missed
  - ❑ Afternoon
  - ❑ Daytime
  - ❑ Relieved by:
    - ❑ Eating
    - ❑ Medications
    - ❑ Other: _____
- ❑ Tremors
- ❑ Dysarthria
- ❑ Fainting/blackouts
- ❑ Disorientation
- ❑ Paralysis
- ❑ Vertigo
- ❑ Memory loss
- ❑ Dementia
- ❑ Concussion/whiplash

SKIN/HAIR/NAILS:

- ❑ Rash
- ❑ Changing Moles
- ❑ Pigmentation/color change
- ❑ Lesions/sores
- ❑ Excessive facial hair growth in women
- ❑ Hair loss
- ❑ Change in hair texture
- ❑ Insect bites
  - ❑ Bugs love to bite me: Yor N? ____
- ❑ Change in nails
  - ❑ Nails split
  - ❑ White spots/lines on nails
  - ❑ Fungus on nails
- ❑ Injury to nails
- ❑ Scalp lesion or rash
- ❑ Burn
- ❑ Acne
- ❑ Hives
- ❑ Calluses
- ❑ Eczema
- ❑ Psoriasis
- ❑ Dryness/cracking skin
- ❑ Oiliness
- ❑ Itching
- ❑ Bumps on the back of arms & front of thighs
- ❑ Bruise easily
- ❑ Cuts heal slowly
- ❑ Peeling Skin
- ❑ Shingles
- ❑ Crawling Sensation
- ❑ Burning on Bottom of Feet
- ❑ Athletes Foot
- ❑ Cellulite
- ❑ Bumps on back of arms & front of thighs
- ❑ Skin cancer
- ❑ Strong body odor

Is your skin sensitive to:

- ❑ Sun
- ❑ Fabrics
- ❑ Detergents
- ❑ Lotions/Creams

LYMPHATIC:

- ❑ Swollen glands
- ❑ Easy bruising
- ❑ Chronic nose bleeds
- ❑ Anemia
- ❑ Multiple transfusions

ENDOCRINE:

- ❑ High blood glucose
- ❑ Hot intolerance
- ❑ Cold intolerance
- ❑ Frequent urination
- ❑ Frequent thirst
- ❑ Excessive sweating
- ❑ Growth issues
- ❑ Steroid use
- ❑ Increased/excessive appetite
- ❑ Hot flashes

- ❑ Blood in urine
- ❑ Problem passing urine

EMOTIONAL:

- ❑ Depressed mood/crying
- ❑ Anxiety/worry
- ❑ Thoughts of suicide
- ❑ Thoughts of homicide
- ❑ Cognitive impairment
- ❑ Mood swings
- ❑ Outbursts
- ❑ Stress
- ❑ Change in behavior
- ❑ Problems in school
- ❑ Hallucinations
- ❑ Hearing voices
- ❑ Convulsions

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)?		
Do you have a white tongue (thrush)?		
Previously or currently wear braces?		
Do you grind your teeth at night?		
Problems chewing?		
Floss regularly?		
Do you have amalgam dental fillings? How many?		
Did you receive these fillings as a child?		

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)

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 illustration below to describe the severity of your pain.

(0= no pain, 10= severe pain)

Example:_____**Neck**_____

0 1 2 3 4 5 (6) 7 8 9 10

Area 1._____

1 2 3 4 5 6 7 8 9 10

Area 2._____

1 2 3 4 5 6 7 8 9 10

Area 3._____

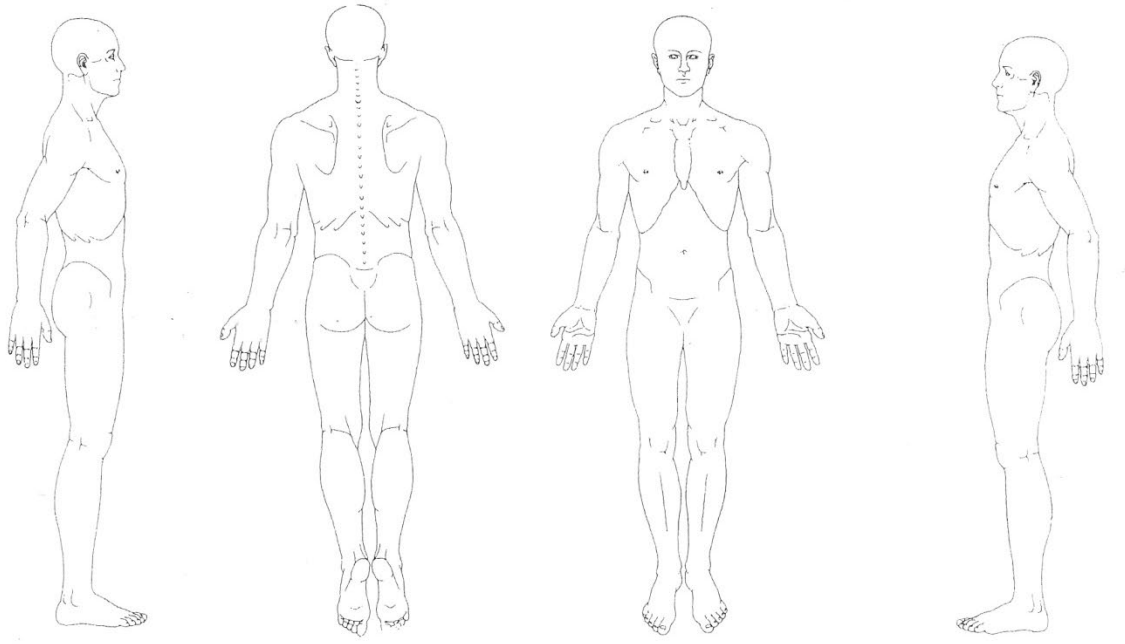
1 2 3 4 5 6 7 8 9 10

Area 4._____

1 2 3 4 5 6 7 8 9 10

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



Right Side Back Front Left side

NUTRITIONAL HISTORY

Have you made any changes in your eating habits because of your health? Yes____ No_____

FOOD DIARY

Please describe your current diet below.

Usual Breakfast	Usual Lunch	Usual Dinner

Do you snack between meals? If so, what is your "go to" snack? _____

How much water do you drink on a daily basis? _____Do you make a point to stay hydrated? Yes or No

Do you take an electrolyte replacement? Yes or No

Please indicate the appropriate number on all questions below (0 as the least/never to 3 as the most/always)

- Edema and swelling in ankles and wrists 0 1 2 3
- Muscle Cramping 0 1 2 3
- Poor Muscle Endurance 0 1 2 3
- Frequent urination 0 1 2 3
- Frequent thirst 0 1 2 3
- Crave salt 0 1 2 3
- Abnormal sweating from minimal activity 0 1 2 3
- Alteration in bowel regularity 0 1 2 3
- Shallow, rapid breathing 0 1 2 3

How much of the following do you consume each week?

Cups of caffeinated coffee	
Cups of decaffeinated coffee or tea	
Cups of tea containing caffeine	
Soda with caffeine	
Soda without caffeine	
Diet Soda	

Salty foods	
Slices of bread (rolls/bagels, etc)	
Cheese	
Raw nuts or seeds	
Fish	
Candy	
Ice Cream	

Do you currently follow a special diet or nutritional program? Yes____ No_____

- ❑ Paleo
- ❑ Keto
- ❑ Dairy Free
- ❑ Gluten Free
- ❑ Vegetarian
- ❑ Vegan
- ❑ Blood type diet
- ❑ Other (describe)_____

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:

- ❑ High fat foods
- ❑ High protein foods
- ❑ High carbohydrate foods (breads, pasta, potatoes)
- ❑ Refined sugar (junk food)
- ❑ Fried foods
- ❑ 1 or 2 alcoholic drinks
- ❑ Other_____

Do you feel **better** when you eat a lot of:

- ❑ High fat foods
- ❑ High protein foods
- ❑ High carbohydrate foods (breads, pasta, potatoes)
- ❑ Refined sugar (junk food)
- ❑ Fried foods
- ❑ 1 or 2 alcoholic drinks
- ❑ Other_____

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) _____

_____

Do you have an aversion to certain foods? Yes _____ No _____

If yes, what food(s) _____

_____

GASTROINTESTINAL HEALTH ASSESSMENT

Please indicate the appropriate number for each symptom.

0	Never
1	Occasionally
2	Sometimes
3	Frequently
4	Always

Section 1—Swallowing

- Difficulty swallowing supplements 0 1 2 3 4
- Difficulty swallowing large bites of food 0 1 2 3 4
- A need to chew food excessively before swallowing 0 1 2 3 4
- Difficulty producing saliva when chewing 0 1 2 3 4
- Dry mouth 0 1 2 3 4

Section 2—Intestinal Motility

- Inconsistent regularity in bowel movements 0 1 2 3 4
- Constipation 0 1 2 3 4
- Bowel Straining with bowel movements 0 1 2 3 4
- Diarrhea 0 1 2 3 4
- Need to use stool softeners, laxatives, or enemas 0 1 2 3 4

Section 3—Digestion of Protein in the Stomach

- Difficulty digesting high protein foods (meats, eggs, nuts, etc) 0 1 2 3 4
- Excessive belching or burping 0 1 2 3 4
- Offensive breath 0 1 2 3 4
- Sense of fullness during and after meals 0 1 2 3 4
- Bloating within the first 30-60 minutes after meals 0 1 2 3 4

Section 4—Stomach Lining Irritation or Ulcer 0 1 2 3 4

- Stomach pain, burning, or aching 1-4 hours after eating 0 1 2 3 4
- Need to use antacids after meals 0 1 2 3 4
- Heartburn when lying down or bending forward 0 1 2 3 4
- Heartburn after spicy foods, alcohol, citrus, or caffeine 0 1 2 3 4

Section 5—Difficulty Digesting Fibers and Starches by Pancreatic Enzymes

- Difficulty digesting fibers and starches (veggies, fruits, beans Rice, etc) 0 1 2 3 4
- Bloating within the first 1-2 hours after meals 0 1 2 3 4
- Pain and tenderness on the left side of the rib cage after meals 0 1 2 3 4
- Frequent loss of appetite 0 1 2 3 4

Section 6—Difficulty Digesting Fats from Gallbladder Release of Bile

- Abdominal bloating and distress after fatty, oily, or fried foods 0 1 2 3 4
- Burping, fishy taste after taking fish oils or eating fish 0 1 2 3 4
- Pain between shoulder blades or right rib cage after eating fatty Foods 0 1 2 3 4
- Nausea or sensations of vomiting after meals 0 1 2 3 4
- Dry or flaky skin and/or hair 0 1 2 3 4
- History of Gallbladder attacks or stones 0 1 2 3 4
- Unexplained itchy skin 0 1 2 3 4
- Gallbladder Removal? Yes____ No _____

Section 7—Evaluation of bowel movement and stool

- Undigested food found in stool 0 1 2 3 4
- Mucus found in stool 0 1 2 3 4
- Floating stool 0 1 2 3 4
- Excessively foul smelling stool 0 1 2 3 4
- Clay colored stool 0 1 2 3 4
- Blood in stool or black colored stool 0 1 2 3 4
- Blood on toilet paper after wiping 0 1 2 3 4

Section 8—Intestinal Permeability/leaky gut

- Increasing frequency of reactions to foods 0 1 2 3 4
- Inflammation, swelling and pain throughout the body 0 1 2 3 4
- Unpredictable bloating and swelling 0 1 2 3 4
- Frequent bloating and distention after eating 0 1 2 3 4

Section 9—Small-Intestinal Bacterial Overgrowth

- Abdominal distention after consumption of fiber, starches, and sugars 0 1 2 3 4
- Abdominal distention with probiotics or natural supplements 0 1 2 3 4

Section 10—Malabsorption

- Do you feel like you are not absorbing your nutrients? 0 1 2 3 4
- Losing weight and have difficulty gaining weight? 0 1 2 3 4
- Losing muscle mass 0 1 2 3 4
- Bruise easily or have bleeding gums 0 1 2 3 4
- Muscle spasms 0 1 2 3 4

- Swelling of the tongue 0 1 2 3 4
- Deep muscle or bone pain 0 1 2 3 4

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

Frequency	√	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	
Consistency	√	Yellow, light brown	
Soft and well formed		Greasy, shiny appearance	
Often floats			
Difficult to pass			
Diarrhea			
Thin, long or narrow			
Small and hard			
Loose but not watery			
Alternating between hard and loose/watery			

METABOLIC HEALTH ASSESSMENT

Please indicate the appropriate number for each symptom.

Section 1:

- Acne and unhealthy skin 0 1 2 3 4
- Excessive hair loss 0 1 2 3 4
- Overall sense of bloating 0 1 2 3 4
- Bodily swelling for no reason 0 1 2 3 4
- Hormone imbalances 0 1 2 3 4
- Weight gain 0 1 2 3 4
- Poor bowel function 0 1 2 3 4
- Excessively foul-smelling sweat 0 1 2 3 4

Section 2:

- Crave sweets during the day 0 1 2 3 4
- Irritable if meals are missed-aka being “hangry” 0 1 2 3 4
- Depend on coffee to keep going/get started 0 1 2 3 4
- Get light-headed if meals are missed 0 1 2 3 4
- Eating relieves fatigue 0 1 2 3 4
- Feel shaky, jittery, or have tremors 0 1 2 3 4
- Agitated, easily upset, nervous 0 1 2 3 4
- Poor memory, forgetful between meals 0 1 2 3 4
- Blurred vision 0 1 2 3 4

Section 3:

- Fatigue after meals 0 1 2 3 4
- Crave sweets during the day 0 1 2 3 4
- Eating sweets does not relieve cravings for sugar 0 1 2 3 4
- Must have sweets after meals 0 1 2 3 4
- Waist girth is equal or larger than hip growth 0 1 2 3 4
- Frequent urination 0 1 2 3 4
- Increased thirst and appetite 0 1 2 3 4
- Difficulty losing weight 0 1 2 3 4

Section 4:

- Cannot stay asleep 0 1 2 3 4
- Crave salt 0 1 2 3 4
- Slow starter in the morning 0 1 2 3 4
- Afternoon fatigue 0 1 2 3 4
- Dizziness when standing up quickly 0 1 2 3 4
- Afternoon headaches 0 1 2 3 4
- Headaches with exertion or stress 0 1 2 3 4
- Weak nails 0 1 2 3 4
- Cannot fall asleep 0 1 2 3 4
- Perspire easily 0 1 2 3 4

- Under a high amount of stress 0 1 2 3 4
- Weight gain when under stress 0 1 2 3 4
- Wake up tired even after 6 or more hours of sleep 0 1 2 3 4
- Excessive perspiration or perspiration with little or no Activity 0 1 2 3 4

Section 5:

- Tired/sluggish 0 1 2 3 4
- Feel cold—hands, feet, all over 0 1 2 3 4
- Require excessive amounts of sleep to function 0 1 2 3 4
- Increase in weight even with low-calorie diet 0 1 2 3 4
- Gain weight easily 0 1 2 3 4
- Difficult, infrequent bowel movements 0 1 2 3 4
- Depression/lack of motivation 0 1 2 3 4
- Morning headaches that wear off as the day progresses 0 1 2 3 4
- Outer third of eyebrows thin 0 1 2 3 4
- Thinning of hair on scalp, face, or genitals, or excessive hair Loss 0 1 2 3 4
- Dryness of skin and/or scalp 0 1 2 3 4
- Mental sluggishness 0 1 2 3 4
- Heart palpitations 0 1 2 3 4
- Inward trembling 0 1 2 3 4
- Increased pulse even at rest 0 1 2 3 4
- Nervous and emotional 0 1 2 3 4
- Insomnia 0 1 2 3 4
- Night sweats 0 1 2 3 4
- Difficulty gaining weight 0 1 2 3 4

LIFESTYLE HISTORY

TOBACCO HISTORY

Have you ever used tobacco? Yes ____ No _____

If yes, what type? Cigarette ___ Smokeless ___ Cigar ___ Pipe ___ Patch/Gum ___

How much?_____

Number of years?_____If not a current user, year quit_____

Attempts to quit: _____

Are you exposed to 2nd hand smoke regularly? If yes, please explain:_____

_____

ALCOHOL INTAKE

Have you ever used alcohol? Yes____ No____

If yes, how often do you now drink alcohol?

- ❑ No longer drink alcohol
- ❑ Average 1-3 drinks per week
- ❑ Average 4-6 drinks per week

- ❑ Average 7-10 drinks per week
- ❑ Average >10 drinks per week

Do you notice a tolerance to alcohol (can you “hold” more than others?) Yes____ No____

Have you ever had a problem with alcohol? Yes____ No____

If yes, indicate time period (month/year) From_____ to _____

OTHER SUBSTANCES

Do you currently or have you previously used recreational drugs? Yes____ No____

If yes, what type(s) and method? (IV, inhaled, smoked, etc)_____

_____

To your knowledge, have you ever been exposed to toxic metals in your job or at home? Yes___No___

If yes, indicate which

- ❑ Lead
- ❑ Arsenic
- ❑ Aluminum
- ❑ Cadmium
- ❑ Mercury

SLEEP & REST HISTORY

Average number of hours that you sleep at night? Less than 10__ 8-10___ 6-8___ less than 6___

What is your typical bedtime routine? _____

_____

Do you:

- ❑ Have trouble falling asleep?
- ❑ Have trouble staying asleep?
- ❑ Feel rested upon waking?
- ❑ Snore?
- ❑ Use sleeping aids?

EXERCISE HISTORY

Do you exercise regularly? Yes____ No____

If yes, please indicate:	Times/week				Length of session			
Type of exercise	1x	2x	3x	4x/+	≤15	16-30 min	31-45 min	>45
Jogging/Walking								
HIIT								
Strength Training								
Pilates/Yoga/Barre								
Sports (tennis, golf, water sports, etc)								
Other (please indicate)								

If no, please indicate what problems limit your activity (e.g., lack of motivation, fatigue after exercising, etc)

_____

_____

SOCIAL HISTORY

Because stress has a direct effect on your overall health and wellbeing that often leads to illness, immune system dysfunction, and emotional disorders, it is important that your health care provider is aware of any stressful influences that may be impacting your health. Informing your doctor allows him/her to offer you supportive treatment options and optimize the outcome of your health care.

STRESS/PSYCHOSOCIAL HISTORY

Are you overall happy? Yes____ No____

Do you feel you can easily handle the stress in your life? Yes ____ No _____

If no, do you believe that stress is presently reducing the quality of your life? Yes____ No____

If yes, do you believe that you know the source of your stress? Yes____ No____

If yes, what do you believe it to be?_____

Do you practice any stress management techniques (mindfulness meditation, gratitude journaling, exercise, etc)?_____

Have you ever contemplated suicide? Yes____ No____

If yes, how often? _____ When was the last time?_____

Have you ever sought help through counseling? Yes____ No____

If yes, what type? (e.g., pastor, psychologist, etc)_____

Did it help?_____

How well have things been going for you?

	Very well	Fine	Poorly	Very poorly	Does not apply
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					

Which of the following provide you emotional support? *Check all that apply*

❑ Spouse ❑ Family ❑ Friends ❑ Religious/Spiritual ❑ Pets ❑ Other _____

Have you ever been involved in abusive relationships in your life? Yes ___ No___

Have you ever been abused, a victim of a crime, or experienced a significant trauma? Yes ___ No___

Did you feel safe growing up? Yes ___ No___

Was alcoholism or substance abuse present in your childhood home? Yes ___ No___

Is alcoholism or substance abuse present in your relationships now? Yes ___ No___

How important is religion (or spirituality) for you and your family's life?

a. _____ not at all important b. _____ somewhat important c. _____ extremely important

Hobbies and leisure activities:

_____

_____

_____

Is there anything that you would like to discuss with the doctor today that you feel you cannot indicate here? Yes_____ No_____

READINESS ASSESSMENT

Rate on a scale of: 5 (very willing) to 1 (not willing).

In order to improve your health, how willing are you to:

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

Comments _____

_____

_____

Thank you for taking the time to complete this health history medical 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,
Dr. Samantha