Center for Holistic Medicine

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 help us formulate a treatment plan.

First Name: _____ Middle Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: (_____) _____-_____ Birth Date: _____/____/____ Age: _____
month day year

Work Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Place of Birth:_____ (city and state; provide country if outside U.S.)

Occupation: _____ Height: ___′ ____ ″ Weight: _____ Sex: _____

Referred by: _____

Today's Date _____

1. Please check appropriate box(es):

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

2. Please list current problems in order of priority, and fill in the other boxes as completely as possible:

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

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

4. Do you have any pets or farm animals? ☐ Yes ☐ No
   If yes, where do they live? ☐ Indoors ☐ Outdoors ☐ Both indoors and outdoors

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

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

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

8. How important is religion (or spirituality) for you and your family's life?
   ☐ Not at all important
   ☐ Somewhat important
   ☐ Extremely important

9. How much time have you lost from work or school in the past year?
   ☐ 0–2 days
   ☐ 3–14 days
   ☐ More than 15 days

10. Previous jobs:
    _____
    _____

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

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		
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**
a. Back Injury		
b. Broken Bone (describe)		
c. Head Injury		
d. Neck Injury		
e. Other (describe)		
DIAGNOSTIC STUDIES	**WHEN**	**COMMENTS**
a. Barium Enema		
b. Bone Scan		
c. CAT Scan of Abdomen		
d. CAT Scan of Brain		
e. CAT Scan of Spine		
f. Chest X-ray		
g. Colonoscopy		
h. EKG		
i. Liver Scan		
j. Neck X-ray		
k. NMR/MRI		
l. Sigmoidoscopy		
m. Upper GI Series		
n. Other (describe)		
OPERATIONS	**WHEN**	**COMMENTS**
a. Appendectomy		
b. Dental Surgery		
c. Gallbladder		
d. Hernia		
e. Hysterectomy		
f. Tonsillectomy		
g. Other (describe)		
h. Other (describe)		

13. Hospitalizations:

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

e.		

14. How often have you have taken antibiotics?

	LESS THAN 5 TIMES	MORE THAN 5 TIMES
Infant/Child		
Teen		
Adult		

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

	LESS THAN 5 TIMES	MORE THAN 5 TIMES
Infant/Child		
Teen		
Adult		

16. What medications are you taking now? Include nonprescription drugs.

MEDICATION NAME	DATE STARTED	DOSAGE
a.		
b.		
c.		
d.		
e.		
f.		
g.		
h.		

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 dosage in mg or IU and the form (e.g., calcium carbonate vs. calcium lactate) when possible.

VITAMIN/MINERAL/ SUPPLEMENT NAME	DATE STARTED	DOSAGE
a.		
b.		
c.		
d.		
e.		
f.		
g.		

18. Infancy/Childhood:

QUESTION	YES	NO	DON'T KNOW	COMMENT

a. Were you a full-term baby?				
A preemie?				
b. Were you breast-fed?				
Bottle-fed?				
c. As a child, did you eat a lot of sugar and/or candy?				

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 each food/drink that is part of your current diet.

	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	
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	
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
    ☐ Vegetarian ☐ Vegetarian ☐ Other (describe below):
    ☐ Diabetic ☐ Blood type diet _____
    ☐ Dairy restricted _____

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

24. Do you have symptoms <u>immediately after</u> eating, such as belching, bloating, sneezing, hives, etc.?
    ☐ Yes ☐ No
    If yes, are these symptoms associated with any particular food or supplement(s)? ☐ Yes ☐ No
    If yes, please name the food or supplement and symptom(s) (Example: milk – gas and diarrhea):
    _____
    _____

25. Do you feel you have <u>delayed</u> 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 <u>worse</u> when you eat a lot of :
    ☐ High-fat foods ☐ Refined sugar (junk food)
    ☐ High-protein foods ☐ Fried foods
    ☐ High-carbohydrate foods (breads, pastas, potatoes) ☐ 1 or 2 alcoholic drinks
    ☐ Other: _____

27. Do you feel much <u>better</u> when you eat a lot of :
    ☐ High-fat foods ☐ Refined sugar (junk food)
    ☐ High-protein foods ☐ Fried foods
    ☐ High-carbohydrate foods (breads, pastas, potatoes) ☐ 1 or 2 alcoholic drinks
    ☐ 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	√	c. Color	√
More than 3x/day		Medium brown consistently	
1–3x/day		Very dark or black	
4–6x/week		Greenish	
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
    ☐ Occasionally
    ☐ Excessive
    ☐ Present with pain
    ☐ Foul smelling
    ☐ Little odor

33. Have you ever used alcohol? ☐ Yes ☐ No
    If yes, how often do you now drink alcohol?
    ☐ No longer drinking alcohol
    ☐ Average 1–3 drinks/week
    ☐ Average 4–6 drinks/week
    ☐ Average 7–10 drinks/week
    ☐ Average more than 10 drinks/week
    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: _____.
    What type of nicotine have you used? ☐ Cigarette ☐ Smokeless ☐ Cigar ☐ Pipe ☐Patch/Gum

36. Are you exposed to secondhand 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

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? ☐ 1 time ☐ 2 times ☐ 3 times ☐ 4 or more times
    When you exercise, how long is each session? ☐ Less than 15 minutes ☐ 16–30 minutes
    ☐ 31–45 minutes ☐ More than 45 minutes
    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: _____

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

FOR WOMEN ONLY (questions 50–58):

49. Have you ever been pregnant? (If no, skip to question 51.) ☐ Yes ☐ No

Number of miscarriages: _____ Number of abortions: _____ Number of preemies: _____

Number of term births: _____ Birth weight of largest baby: ___ Birth weight of 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? ☐ Yes ☐ No 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. Place a check mark by each symptom that occurs now ***or*** that has occurred in the past 6 months.

GENERAL	Mild	Mod-erate	Severe
Cold hands and feet			
Cold intolerance			
Daytime sleepiness			
Difficulty falling asleep			
Early waking			
Fatigue			
Fever			
Flushing			
Heat intolerance			
Night waking			
Nightmares			
No dream recall			
HEAD, EYES & EARS			
Conjunctivitis			
Distorted sense of smell			
Distorted taste			
Ear fullness			
Ear 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			

MUSCULOSKELETAL	Mild	Mod-erate	Severe
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			
Muscle twitches in arms or legs			
Muscle weakness			
Neck muscle spasm			
Tendonitis			
Tension headache			
TMJ problems			
MOOD/NERVES			
Agoraphobia			
Anxiety			
Auditory hallucinations			
Blackout			
Depression			
Difficulty with: Concentrating			
Balance			
Thinking			
Judgment			
Speech			
Memory			
Dizziness (spinning)			
Fainting			
Fearfulness			
Irritability			

MOOD/NERVES (continued)	Mild	Mod-erate	Severe
Light-headedness			
Numbness			
Other phobias			
Panic attacks			
Paranoia			
Seizures			
Suicidal thoughts			
Tingling			
Tremor/trembling			
Visual hallucinations			
EATING			
Binge eating			
Bulimia			
Can't gain weight			
Can't lose weight			
Carbohydrate craving			
Carbohydrate intolerance			
Poor appetite			
Salt craving			
DIGESTION			
Anal spasms			
Bad teeth			
Bleeding gums			
Bloating of lower abdomen			
Bloating of whole abdomen			
Blood in stools			
Burping			
Canker sores			
Cold sores			
Constipation			
Cracking at corner of lips			
Dentures with poor chewing			
Diarrhea			
Difficulty swallowing			
Dry mouth			
Farting			

DIGESTION (continued)	Mild	Mod-erate	Severe
Fissures			
Foods "repeat" (reflux)			
Heartburn			
Hemorrhoids			
Intolerance to: Lactose			
All milk products			
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			
SKIN PROBLEMS			
Acne on back			
Acne on chest			
Acne on face			
Acne on shoulders			
Athlete's foot			
Bumps on back of upper arms			
Cellulite			
Dark circles under eyes			
Ears get red			
Easy bruising			

SKIN PROBLEMS (continued)	Mild	Mod-erate	Severe
Eczema			
Herpes (genital)			
Hives			
Jock itch			
Lackluster skin			
Moles with 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			
SKIN, ITCHING			
Anus			
Arms			
Ear canals			
Eyes			
Feet			
Hands			
Legs			
Nipples			
Nose			
Penis			
Roof of mouth			
Scalp			
Skin in general			
Throat			

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

RESPIRATORY	Mild	Mod-erate	Severe
Bad breath			
Bad odor in nose			
Cough (dry)			
Cough (productive)			
Hay fever (spring)			
Hay fever (summer)			
Hay fever (fall)			
Hay fever (change of season)			
Hoarseness			
Nasal stuffiness			
Nosebleeds			
Postnasal drip			
Sinus fullness			
Sinus infection			
Snoring			
Sore throat			
Wheezing			
Winter stuffiness			
CARDIOVASCULAR:			
Angina/chest pain			
Breathlessness			
Heart attack			
Heart murmur			
High blood pressure			
Irregular pulse			
Mitral valve prolapse			
Palpitations			
Phlebitis			
Swollen ankles/feet			
Varicose veins			

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

FEMALE REPRODUCTIVE (continued)	Mild	Mod-erate	Severe
Premenstrual: Bloating			
Breast tenderness			
Carbohydrate craving			
Chocolate craving			
Constipation			
Decreased sleep			
Diarrhea			
Fatigue			
Increased sleep			
Irritability			
Menstrual: Cramps			
Heavy periods			
Irregular periods			
No periods			
Scanty periods			
Spotting between			

What are the major health concerns you would like to discuss during your appointment?

3-Day Diet Diary

Instructions for Completing the Diet Diary

It is important to keep an accurate record of your usual food and beverage intake as a part of this study. Please complete this 3-Day Diet Diary for 3 consecutive days with 1 day being a weekend day.

- Record information as soon as possible after the food has been consumed.
- Do not change your eating behavior at this time unless your doctor advises you to. The purpose of this food record is to analyze your present eating habits.
- Describe the food or beverage consumed. For example: milk – whole, 2%, nonfat; toast – whole-wheat, white, buttered; chicken – fried, baked, breaded.
- Record the amount of each food consumed using standard measurements as much as possible, such as 8 ounces, 1/2 cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon sugar, potato with 2 teaspoons butter, etc.
- Please record all beverages, including water. List them in the "Beverage" category.
- Please record all bowel movements and their consistency (regular, loose, firm, etc.).

Diet Diary

Name _____ **Date** _____

Time	Food	Amount

Time	Beverage	Amount

Bowel Movements

Time	Consistency