

HEALTH QUESTIONNAIRES

GENERAL INFORMATION

Name	<i>First</i>	<i>Middle</i>	<i>Last</i>
Preferred Name			
Date of Birth			
Age			
Gender	<input type="radio"/> Male <input type="radio"/> Female		
Genetic Background	<input type="checkbox"/> African <input type="checkbox"/> Asian	<input type="checkbox"/> European <input type="checkbox"/> Ashkenazi	<input type="checkbox"/> Native American <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Mediterranean <input type="checkbox"/> _____
Highest Education Level	<input type="radio"/> High School <input type="radio"/> Under-Graduate <input type="radio"/> Post-Graduate		
Job Title			
Nature of Business			
Primary Address	<i>Number, Street</i>	<i>Apt. No.</i>	
	<i>City</i>	<i>State</i>	<i>Zip</i>
Alternate Address	<i>Number, Street</i>	<i>Apt. No.</i>	
	<i>City</i>	<i>State</i>	<i>Zip</i>
Home Phone 1			
Home Phone 2			
Work Phone			
Cell Phone			
Fax			
Email			
Emergency Contact	<i>Name</i>	<i>Phone Number</i>	
	<i>Address</i>	<i>Apt. No.</i>	
	<i>City</i>	<i>State</i>	<i>Zip</i>
Physician	<i>Name</i>	<i>Phone Number</i>	
	<i>Fax</i>		
Referred by	<input type="radio"/> Book <input type="radio"/> Website <input type="radio"/> Media <input type="radio"/> Friend or Family Member <input type="radio"/> Other _____		

PHARMACY INFORMATION

Primary Pharmacy

Name

Phone Number

Address

City

State

Zip

E-mail

Fax*

** It is extremely important that you list the pharmacy's fax number.*

Compounding/
Supplement Pharmacy

Name

Phone Number

Address

City

State

Zip

E-mail

Fax*

** It is extremely important that you list the pharmacy's fax number.*

CREDIT CARD INFORMATION

Patient _____ Date _____

DOB _____

Preferred Method of Payment (please circle one): Cash / Check / Credit Card

If paying by credit card, we accept VISA, MasterCard and Discover

**Note: If Discover is your primary card, please provide another card (i.e., MasterCard or Visa) for transactions (i.e., supplement orders, etc.) that we may need to process. Some pharmacies do not accept Discover.*

PRIMARY CARD

Name on Card _____

Card Type Visa MasterCard Discover

Account Number _____

Expiration Date (mm/yy) _____

CVV# _____

SECONDARY CARD

Name on Card _____

Card Type Visa MasterCard Discover

Account Number _____

Expiration Date (mm/yy) _____

CVV# _____

Medical Questionnaire

ALLERGIES

Medication/Supplement/Food	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

COMPLAINTS/CONCERNS

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

If you had a magic wand and could erase three problems, what would they be?

1. _____
2. _____
3. _____

When was the last time you felt well? _____

Did something trigger your change in health? _____

What makes you feel worse? _____

What makes you feel better? _____

Please list current and ongoing problems in order of priority:

Describe Problem	Mild	Moderate	Severe	Prior Treatment/Approach	Success		
					Excellent	Good	Fair
<i>Example: Post Nasal Drip</i>		X		<i>Elimination Diet</i>	X		

MEDICAL HISTORY

= Past Condition = Ongoing Condition

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

GASTROINTESTINAL

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

CARDIOVASCULAR

- Heart Attack _____
- Other Heart Disease _____
- Stroke _____
- Elevated Cholesterol _____
- Arrhythmia (irregular heart rate) _____
- Hypertension (high blood pressure) _____
- Rheumatic Fever _____
- Mitral Valve Prolapse _____
- Other _____

METABOLIC/ENDOCRINE

- Type 1 Diabetes _____
- Type 2 Diabetes _____
- Hypoglycemia _____
- Metabolic Syndrome _____
(Insulin Resistance or Pre-Diabetes)
- Hypothyroidism (low thyroid) _____
- Hyperthyroidism (overactive thyroid) _____
- Endocrine Problems _____
- Polycystic Ovarian Syndrome (PCOS) _____
- Infertility _____
- Weight Gain _____
- Weight Loss _____
- Frequent Weight Fluctuations _____
- Bulimia _____
- Anorexia _____
- Binge Eating Disorder _____
- Night Eating Syndrome _____
- Eating Disorder (non-specific) _____
- Other _____

CANCER

- Lung Cancer _____
- Breast Cancer _____
- Colon Cancer _____
- Ovarian Cancer _____
- Prostate Cancer _____
- Skin Cancer _____
- Other _____

GENITAL AND URINARY SYSTEMS

- Kidney Stones _____
- Gout _____
- Interstitial Cystitis _____
- Frequent Urinary Tract Infections _____
- Frequent Yeast Infections _____
- Erectile Dysfunction
or Sexual Dysfunction _____
- Other _____

MUSCULOSKELETAL/PAIN

- Osteoarthritis _____
- Fibromyalgia _____
- Chronic Pain _____
- Other _____

INFLAMMATORY/AUTOIMMUNE

- Chronic Fatigue Syndrome _____
- Autoimmune Disease _____
- Rheumatoid Arthritis _____
- Lupus SLE _____
- Immune Deficiency Disease _____
- Herpes-Genital _____
- Severe Infectious Disease _____
- Poor Immune Function _____
(frequent infections)
- Food Allergies _____
- Environmental Allergies _____
- Multiple Chemical Sensitivities _____
- Latex Allergy _____
- Other _____

RESPIRATORY DISEASES

- Asthma _____
- Chronic Sinusitis _____
- Bronchitis _____
- Emphysema _____
- Pneumonia _____
- Tuberculosis _____
- Sleep Apnea _____
- Other _____

SKIN DISEASES

- Eczema _____
- Psoriasis _____
- Acne _____
- Melanoma _____
- Skin Cancer _____
- Other _____

MEDICAL HISTORY (CONTINUED)

= Past Condition = Ongoing Condition

NEUROLOGIC/MOOD

- Depression _____
- Anxiety _____
- Bipolar Disorder _____
- Schizophrenia _____
- Headaches _____
- Migraines _____
- ADD/ADHD _____

- Autism _____
- Mild Cognitive Impairment _____
- Memory Problems _____
- Parkinson's Disease _____
- Multiple Sclerosis _____
- ALS _____
- Seizures _____
- Other Neurological Problems _____

PREVENTIVE TESTS AND DATE OF LAST TEST

Check box if yes and provide date

- Full Physical Exam _____
- Bone Density _____
- Colonoscopy _____
- Cardiac Stress Test _____
- EBT Heart Scan _____
- EKG _____
- Hemocult Test-stool test for blood _____
- MRI _____
- CT Scan _____
- Upper Endoscopy _____
- Upper GI Series _____
- Ultrasound _____

SURGERIES

Check box if yes and provide date of surgery

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

INJURIES

Check box if yes

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

BLOOD TYPE: 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

Age at First Period: _____ Menses Frequency: _____ Length: _____ Pain: Yes No Clotting: Yes No

Has your period ever skipped? _____ For how long? _____

Last Menstrual Period: _____

Use of hormonal contraception such as: Birth Control Pills Patch Nuva Ring How long? _____

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

WOMEN'S DISORDERS/HORMONAL IMBALANCES

- Fibrocystic Breasts Endometriosis Fibroids Infertility
 Painful Periods Heavy periods PMS

Last Mammogram: _____ Breast Biopsy/Date: _____

Last PAP Test: _____ Normal Abnormal

Last Bone Density: _____ Results: High Low Within Normal Range

Are you in menopause? Yes No

Age at Menopause _____

- Hot Flashes Mood Swings Concentration/Memory Problems Vaginal Dryness Decreased Libido
 Heavy Bleeding Joint Pains Headaches Weight Gain Loss of Control of Urine Palpitations
 Use of hormone replacement therapy. How long? _____

MEN'S HISTORY *(for men only)*

Have you 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). How many times at night? _____
 Urgency/Hesitancy/Change in Urinary Stream Loss of Control of Urine

GI HISTORY

Foreign Travel? Yes No Where? _____

Wilderness Camping? Yes No Where? _____

Have you ever had severe: Gastroenteritis Diarrhea

Do you feel like you digest your food well? Yes No

Do you feel bloated after meals? Yes No

PATIENT BIRTH HISTORY

Term Premature

Pregnancy Complications: _____

Birth Complications: _____

Breast Fed. How long? _____ Bottle-fed

Age at introduction of: Solid Foods: _____ Dairy: _____ Wheat: _____

Did you eat a lot of candy or sugar as a child? Yes No

DENTAL HISTORY

DENTAL SURGERY

Silver Mercury Fillings How many? _____

Gold Fillings Root Canals Implants Tooth Pain Bleeding Gums

Gingivitis Problems with Chewing

Do you floss regularly? Yes No

FAMILY HISTORY

Check family members that apply

	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age (if still alive)												
Age at death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Spondylitis)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Diseases (such as Lupus)												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												

SOCIAL HISTORY

NUTRITION HISTORY

Have you ever had a nutrition consultation? Yes No

Have you made any changes in your eating habits because of your health? Yes No Describe: _____

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

Check all that apply:

Low Fat Low Carbohydrate High Protein Low Sodium Diabetic No Dairy No Wheat

Gluten Restricted Vegetarian Vegan Ultrametabolism

Specific Program for Weight Loss/Maintenance Type: _____ Other _____

Height (feet/inches) _____

Current Weight _____

Usual Weight Range +/- 5 lbs _____

Desired Weight Range +/- 5 lbs _____

Highest adult weight _____

Lowest adult weight _____

Weight Fluctuations (> 10 lbs.) Yes No

Body Fat % _____

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

Have you ever had your metabolism (resting metabolic rate) checked? Yes No If yes, what was it? _____

Do you avoid any particular foods? Yes No If yes, types and reason _____

If you could only eat a few foods a week, what would they be? _____

Do you grocery shop? Yes No If no, who does the shopping? _____

Do you read food labels? Yes No _____

Do you cook? Yes No If no, who does the cooking? _____

How many meals do you eat out per week? 0-1 1-3 3-5 >5 meals per week

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

Fast eater

Erratic eating pattern

Eat too much

Late night eating

Dislike healthy food

Time constraints

Eat more than 50% meals away from home

Travel frequently

Non-availability of healthy foods

Do not plan meals or menus

Reliance on convenience items

Poor snack choices

Significant other or family members don't like healthy foods

Significant other or family members have special dietary needs or food preferences

Love to eat

Eat because I have to

Have a negative relationship to food

Struggle with eating issues

Emotional eater (eat when sad, lonely, depressed, bored)

Eat too much under stress

Eat too little under stress

Don't care to cook

Eating in the middle of the night

Confused about nutrition advice

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

SMOKING

Currently Smoking? Yes No How many years? _____ Packs per day: _____

Attempts to quit: _____

Previous Smoking: How many years? _____ Packs per day? _____

Second Hand Smoke Exposure? _____

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 ever 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 ever 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? 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

Caffeine Intake: Yes No | Coffee cups/day: 1 2-4 > 4 | Tea cups/day: 1 2-4 > 4

Caffeinated Sodas or Diet Sodas Intake: Yes No

12-ounce can/bottle 1 2-4 > 4 per day

List favorite type (Ex. Diet Coke, Pepsi, etc.): _____

Are you currently using any recreational drugs? Yes No Type _____

Have you ever used IV or inhaled recreational drugs? Yes No

EXERCISE

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

Activity	Type	Frequency Per Week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength			
Other (yoga, pilates, gyrotonics, etc.)			
Sports or Leisure Activities (golf, tennis, rollerblading, etc.)			

Rate your level of motivation for including exercise in your life? Low Medium High

List problems that limit activity: _____

Do you feel unusually fatigued after exercise? Yes No

If yes, please describe: _____

Do you usually sweat when exercising? Yes No

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 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 Describe: _____
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 of 1-10
Work _____ Family _____ Social _____ Finances _____ Health _____ Other _____
Do you practice meditation or relaxation techniques? Yes No How often? _____
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

SLEEP/REST

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

ROLES/RELATIONSHIP

Marital status Single Married Divorced Gay/Lesbian Long Term Partnership Widow

List Children:

Child's Name	Age	Gender

Who is Living in Household? Number: _____ Names: _____

Their Employment/Occupations: _____

Resources for emotional support?

Check all that 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 AND 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 List all: _____ No

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 Foods (wine, dried fruit, salad bars) Preservatives (ex. sodium benzoate)
- Other: _____

Which of these significantly affect you? Check all that apply:

- Cigarette Smoke Perfumes/Colognes Auto Exhaust Fumes Other: _____

In your work or home environment, are you exposed to: Chemicals Electromagnetic Radiation Mold

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
- Heavy Metals 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 farm animals? Yes No

SYMPTOM REVIEW

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

GENERAL

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

HEAD, EYES & EARS

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

MUSCULOSKELETAL

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

Muscle Twitches:

- Around Eyes
- Arms or Legs

- Muscle Weakness
- Neck Muscle Spasm
- Tendonitis
- Tension Headache
- TMJ Problems

MOOD/NERVES

- Agoraphobia
- Anxiety
- Auditory Hallucinations
- Black-out
- Depression

Difficulty:

- Concentrating
- With Balance
- With Thinking
- With Judgment
- With Speech
- With Memory

- Dizziness (Spinning)
- Fainting
- Fearfulness
- Irritability
- Light-headedness
- Numbness
- Other Phobias
- Panic Attacks
- Paranoia
- Seizures
- Suicidal Thoughts
- Tingling
- Tremor/Trembling
- Visual Hallucinations

EATING

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

DIGESTION

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

Intolerance to:

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

SKIN PROBLEMS

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

ITCHING SKIN

- Skin in General
- Anus
- Arms
- Ear Canals
- Eyes
- Feet
- Hands
- Legs
- Nipples
- Nose
- Penis
- Roof of Mouth
- Scalp
- Throat

SKIN, DRYNESS OF

- 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
 - Toenails
- White Spots/Lines

RESPIRATORY

- Bad Breath
- Bad Odor in Nose
- Cough-Dry
- Cough-Productive
- Hoarseness
- Sore Throat
- Hay Fever:
 - Spring
 - Summer
 - Fall
 - Change Of Season
- Nasal Stuffiness
- Nose Bleeds
- Post Nasal Drip
- Sinus Fullness
- Sinus Infection
- Snoring
- Wheezing
- Winter Stuffiness

CARDIOVASCULAR

- Angina/chest pain

- Breathlessness
- Heart Murmur
- Irregular Pulse
- Palpitations
- Phlebitis
- Swollen Ankles/Feet
- Varicose Veins

URINARY

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

MALE REPRODUCTIVE

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

FEMALE REPRODUCTIVE

- Breast Cysts
- Breast Lumps
- Breast Tenderness
- Ovarian Cyst
- Poor Libido (Sex Drive)
- Vaginal Discharge
- Vaginal Odor
- Vaginal Itch
- Vaginal Pain with Sex
- Premenstrual:
 - Bloating Breast Tenderness
 - Carbohydrate Cravings
 - Chocolate Cravings
 - Constipation
 - Decreased Sleep
 - Diarrhea
 - Fatigue
 - Increased Sleep
 - Irritability
- Menstrual:
 - Cramps
 - Heavy Periods
 - Irregular Periods
 - No Periods
 - Scanty Periods
 - Spotting Between

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 several 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 a relaxation technique 5 4 3 2 1
- Engage in regular exercise 5 4 3 2 1
- Have periodic lab tests to assess your progress 5 4 3 2 1

Comments _____

Rate on a scale of 5 (very confident) to 1 (not confident at all):

How confident are you of your ability to organize and follow through on the above health related activities? - 5 4 3 2 1

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities? _____

Rate on a scale of 5 (very supportive) to 1 (very unsupportive):

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? - 5 4 3 2 1

Comments _____

Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact):

How much on-going support and contact (e.g., telephone consults, e-mail correspondence) from our professional staff would be helpful to you as you implement your personal health program? - 5 4 3 2 1

Comments _____

