



# VOLSTAD CHIROPRACTIC & INTEGRATED WELLNESS

Keith L. Volstad, DC, CCSP, DABCI, DABCN

275 Toney Penna Drive, Suite 12  
Jupiter, Florida 33458  
[Imchiro1@gmail.com](mailto:Imchiro1@gmail.com)

Office: 561.746.4242  
Fax: 561.746.7405  
[www.JupiterFLChiropractors.com](http://www.JupiterFLChiropractors.com)

**GENERAL INFORMATION** *(If more space is needed when filling in certain sections, please feel free to provide separate sheet)*

Name: *First* \_\_\_\_\_ *Middle* \_\_\_\_\_ *Last* \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female

Primary Address: \_\_\_\_\_ Apt. No.: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Alternate Address: \_\_\_\_\_ Apt. No.: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Best Phone and Times to Reach You: \_\_\_\_\_

Email: \_\_\_\_\_ Fax: \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to you \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Your Genetic Background:  African  Asian  European  Hispanic  Native American

Middle Eastern  Mediterranean  Other \_\_\_\_\_

Highest Education Level:  High School or Equivalent  Graduate  Post-Graduate

Job Title: \_\_\_\_\_

Nature of Business: \_\_\_\_\_

Primary Pharmacy: Name \_\_\_\_\_ Phone \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Fax: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Book  Website  Media  Other \_\_\_\_\_

**Health Concerns & Goals**

*Please list current and/or ongoing areas of concern you would like to address in order of priority.*

**Health Concern or Goal #1** *(Please describe as many details as you can)* \_\_\_\_\_

When did you first notice symptoms appear? \_\_\_\_\_ Was there a trigger? \_\_\_\_\_

Is this condition getting:  Better  Worse  About the same

What treatments have you tried? *Please list everything - home remedies to medical interventions:*

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

If pain is associated with your condition, please check all that apply: *Type of pain*

- Sharp  Dull  Throbbing  Numbness  Aching  Shooting  Burning  
 Tingling  Cramps  Stiffness  Swelling  Other \_\_\_\_\_

How often do you experience this condition? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Anything else you feel is important about this condition? \_\_\_\_\_

**Health Concern or Goal #2** *(Please describe as many details as you can)* \_\_\_\_\_

When did you first notice symptoms appear? \_\_\_\_\_ Was there a trigger? \_\_\_\_\_

Is this condition getting:  Better  Worse  About the same

What treatments have you tried? *Please list everything - home remedies to medical interventions:*

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

If pain is associated with your condition, please check all that apply: *Type of pain*

- Sharp  Dull  Throbbing  Numbness  Aching  Shooting  Burning  
 Tingling  Cramps  Stiffness  Swelling  Other \_\_\_\_\_

How often do you experience this condition? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Anything else you feel is important about this condition? \_\_\_\_\_

**Health Concern or Goal #3** *(Please describe as many details as you can)* \_\_\_\_\_

When did you first notice symptoms appear? \_\_\_\_\_ Was there a trigger? \_\_\_\_\_

Is this condition getting:  Better  Worse  About the same

What treatments have you tried? *Please list everything - home remedies to medical interventions:* \_\_\_\_\_

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

If pain is associated with your condition, please check all that apply: *Type of pain*

- Sharp  Dull  Throbbing  Numbness  Aching  Shooting  Burning  
 Tingling  Cramps  Stiffness  Swelling  Other \_\_\_\_\_

How often do you experience this condition? \_\_\_\_\_

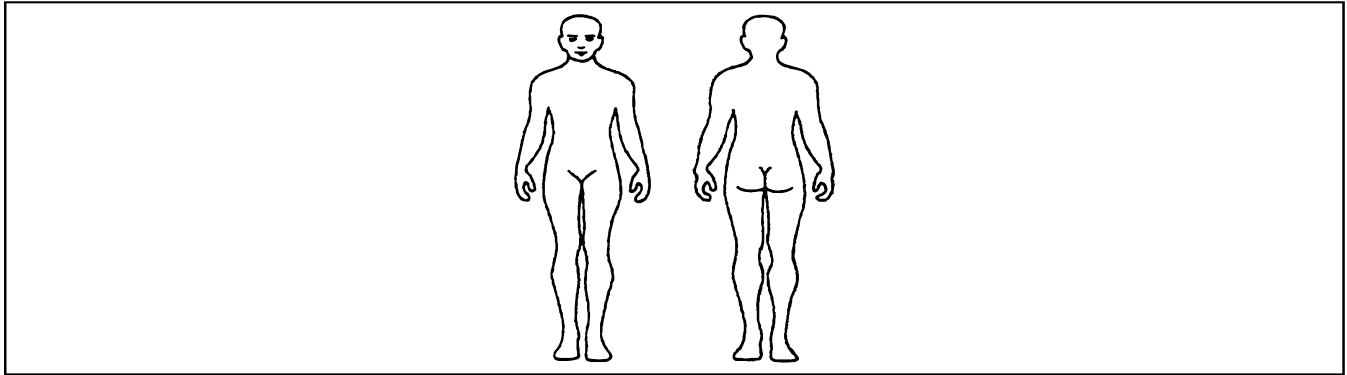
Is it constant or does it come and go? \_\_\_\_\_

Anything else you feel is important about this condition? \_\_\_\_\_

In general, what do you hope to achieve with your visits here? \_\_\_\_\_

When was the last time you felt exceptionally well? \_\_\_\_\_

Please mark any areas of concern with as much detail as you can. Please write anywhere in the box



Other comments you think are important \_\_\_\_\_

**Medical History**

Please list all other healthcare providers with whom you have received treatment within the last 10 years:

Doctor of Chiropractic Name: \_\_\_\_\_ City: \_\_\_\_\_

Treatment Focus: \_\_\_\_\_

M.D. / D.O. Name: \_\_\_\_\_ City: \_\_\_\_\_

Treatment Focus: \_\_\_\_\_

Physical Therapist Name: \_\_\_\_\_ City: \_\_\_\_\_

Treatment Focus: \_\_\_\_\_

Acupuncture Name: \_\_\_\_\_ City: \_\_\_\_\_

Treatment Focus: \_\_\_\_\_

Other: \_\_\_\_\_

Name: \_\_\_\_\_ City: \_\_\_\_\_

Treatment Focus: \_\_\_\_\_

**Medical History continued**

Hospitalizations  None

Date \_\_\_\_\_ - Reason \_\_\_\_\_

\_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_ - \_\_\_\_\_

**Allergies**

Medication/Supplement/Food

Reaction


**Diseases/Diagnosis/Conditions:** Check appropriate box and provide Month/Year of onset  Past Condition  Ongoing Condition

Gastrointestinal

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

Other \_\_\_/\_\_\_

Metabolic/Endocrine

- Type 1 Diabetes \_\_\_/\_\_\_
- Type 2 Diabetes \_\_\_/\_\_\_
- Hypoglycemia \_\_\_/\_\_\_
- Metabolic Syndrome (Insulin Resistance/ 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 \_\_\_/\_\_\_

Cardiovascular

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

Cancer

- Lung Cancer \_\_\_/\_\_\_
- Breast Cancer \_\_\_/\_\_\_
- Colon Cancer \_\_\_/\_\_\_
- Ovarian Cancer \_\_\_/\_\_\_
- Prostate Cancer \_\_\_/\_\_\_
- Skin Cancer \_\_\_/\_\_\_
- Other \_\_\_/\_\_\_

Musculoskeletal/Pain

- Osteoarthritis \_\_\_/\_\_\_
- Fibromyalgia \_\_\_/\_\_\_
- Chronic Pain \_\_\_/\_\_\_
- Tendonitis \_\_\_/\_\_\_
- Tension Headaches \_\_\_/\_\_\_
- TMJ Problems \_\_\_/\_\_\_
- Foot Cramps \_\_\_/\_\_\_
- Joint Deformity \_\_\_/\_\_\_
- Joint Pain \_\_\_/\_\_\_
- Other \_\_\_/\_\_\_

Genital & Urinary Systems

- Kidney Stones \_\_\_/\_\_\_
- Gout \_\_\_/\_\_\_
- Interstitial Cystitis \_\_\_/\_\_\_
- Frequent Urinary Tract Infections \_\_\_/\_\_\_
- Frequent Yeast Infections \_\_\_/\_\_\_
- Erectile or Sexual Dysfunctions \_\_\_/\_\_\_

**Diseases/Diagnosis/Conditions: continued**

Inflammatory/Autoimmune

- Chronic Fatigue Syndrome \_\_\_/\_\_\_
- Autoimmune Disease \_\_\_/\_\_\_
- Rheumatoid Arthritis \_\_\_/\_\_\_
- Lupus SLE \_\_\_/\_\_\_
- Immune Deficiency Disease \_\_\_/\_\_\_
- Herpes-Genital \_\_\_/\_\_\_
- Cold Sores \_\_\_/\_\_\_
- 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 \_\_\_/\_\_\_

Head, Eyes, & Ears

- Conjunctivitis \_\_\_/\_\_\_
- Distorted Sense of Smell \_\_\_/\_\_\_
- Distorted Taste \_\_\_/\_\_\_
- Ear Fullness \_\_\_/\_\_\_
- Ear Pain \_\_\_/\_\_\_
- Hearing Loss \_\_\_/\_\_\_
- Hearing Problems \_\_\_/\_\_\_
- Headache \_\_\_/\_\_\_
- Migraine \_\_\_/\_\_\_
- Sensitivity to Loud Noises \_\_\_/\_\_\_
- Vision Problems (*other than glasses*) \_\_\_/\_\_\_
- Macular Degeneration \_\_\_/\_\_\_
- Vitreous Detachment \_\_\_/\_\_\_
- Retinal Detachment \_\_\_/\_\_\_
- Other \_\_\_/\_\_\_

Nails

- Bitten \_\_\_/\_\_\_
- Brittle \_\_\_/\_\_\_
- Curve Up \_\_\_/\_\_\_
- Frayed \_\_\_/\_\_\_
- Fungus-Fingers \_\_\_/\_\_\_
- Fungus-Toes \_\_\_/\_\_\_
- Pitting \_\_\_/\_\_\_
- Ragged Cuticles \_\_\_/\_\_\_
- Ridges \_\_\_/\_\_\_
- Soft \_\_\_/\_\_\_
- Thickening of Finger Nails \_\_\_/\_\_\_
- Thickening of Toenails \_\_\_/\_\_\_
- White Spots/Lines \_\_\_/\_\_\_
- Other \_\_\_/\_\_\_

Skin Diseases

- 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 \_\_\_/\_\_\_
- Hives \_\_\_/\_\_\_
- Jock Itch \_\_\_/\_\_\_
- Lackluster Skin \_\_\_/\_\_\_
- Moles w/ Color/Size Change \_\_\_/\_\_\_
- Oily Skin \_\_\_/\_\_\_
- Pale Skin \_\_\_/\_\_\_
- Patchy Dullness \_\_\_/\_\_\_
- Rash \_\_\_/\_\_\_
- Red Face \_\_\_/\_\_\_
- Sensitive to Poison Ivy/Oak \_\_\_/\_\_\_
- Shingles \_\_\_/\_\_\_
- Skin Darkening \_\_\_/\_\_\_
- Strong Body Odor \_\_\_/\_\_\_
- Hair Loss \_\_\_/\_\_\_
- Vitiligo \_\_\_/\_\_\_
- Eczema \_\_\_/\_\_\_
- Psoriasis \_\_\_/\_\_\_
- Melanoma \_\_\_/\_\_\_
- Skin Cancer \_\_\_/\_\_\_

Other \_\_\_/\_\_\_

Other \_\_\_/\_\_\_

**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

**Blood Type**

- A     B     AB     O     Rh+
- unknown

**Injuries**

*check box if yes and provide date/description*

Back Injury \_\_\_/\_\_\_

Head Injury \_\_\_/\_\_\_

Neck Injury \_\_\_/\_\_\_

Broken Bones \_\_\_/\_\_\_

Other \_\_\_/\_\_\_

**Diseases/Diagnosis/Conditions: continued**

**Female Reproductive**

- Breast Cysts \_\_\_/\_\_\_
- Breast Lumps \_\_\_/\_\_\_
- Breast Tenderness \_\_\_/\_\_\_
- Ovarian Cysts \_\_\_/\_\_\_
- Poor Libido \_\_\_/\_\_\_
- Vaginal Discharge \_\_\_/\_\_\_
- Vaginal Odor \_\_\_/\_\_\_
- Vaginal Itch \_\_\_/\_\_\_
- Vaginal Pain with Sex \_\_\_/\_\_\_

**Surgeries**

*Check box if yes and provide date of surgery*

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

**Male Reproductive**

- Discharge from penis \_\_\_/\_\_\_
- Ejaculation Problem \_\_\_/\_\_\_
- Genital Pain \_\_\_/\_\_\_
- Impotence \_\_\_/\_\_\_
- Prostate or Urinary Infection \_\_\_/\_\_\_
- Lumps in Testicles \_\_\_/\_\_\_
- Poor Libido (Sex Drive) \_\_\_/\_\_\_
- Other \_\_\_/\_\_\_

**Preventive Tests**

*Check box if yes and provide date of most recent test*

- Blood Tests \_\_\_/\_\_\_
- Full Physical Exam \_\_\_/\_\_\_
- X-Ray \_\_\_/\_\_\_ *Body*
- Part?* \_\_\_\_\_
- Dental X-Ray \_\_\_/\_\_\_
- Bone Density \_\_\_/\_\_\_
- Colonoscopy \_\_\_/\_\_\_
- Cardiac Stress Test \_\_\_/\_\_\_
- EKG \_\_\_/\_\_\_
- Hemocult Test (stool test for blood) \_\_\_/\_\_\_
- MRI \_\_\_/\_\_\_
- CT Scan \_\_\_/\_\_\_
- Upper Endoscopy \_\_\_/\_\_\_
- Upper GI Series \_\_\_/\_\_\_
- Ultrasound \_\_\_/\_\_\_
- Other \_\_\_/\_\_\_

**Gynecologic History (for women only)**

**Obstetric History** Check box if yes and provide relevant quantity

- Pregnancy \_\_\_\_\_  Vaginal Delivery \_\_\_\_\_  Caesarean Delivery \_\_\_\_\_  Miscarriage \_\_\_\_\_  Abortion \_\_\_\_\_
- Living Children \_\_\_\_\_  Post-Partum Depression \_\_\_\_\_  Toxemia \_\_\_\_\_  Gestational Diabetes \_\_\_\_\_
- Baby over 8 lbs. \_\_\_\_\_  Premature \_\_\_\_\_  Low Birth Weight (< 6lbs) \_\_\_\_\_
- Breast Feeding Your Child How long? \_\_\_\_\_  Oral Contraceptives \_\_\_\_\_ How long? \_\_\_\_\_

**Menstrual History**

Age at first period: \_\_\_\_\_ Menses Frequency: \_\_\_\_\_ Length between menses: \_\_\_\_\_ Pain:  Yes  No  
 Clotting:  Yes  No Has your period ever skipped?  Yes  No How long? \_\_\_\_\_

Last Menstrual Period: \_\_\_\_\_

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

**Women's Disorders/Hormonal Imbalances**

- Fibrocystic Breasts  Breast Cancer \_\_\_/\_\_\_  Endometriosis  Fibroids  Infertility
- Painful Periods  Heavy Periods  PMS

Last Mammogram \_\_\_/\_\_\_ Anything Abnormal? \_\_\_\_\_  Breast Biopsy \_\_\_/\_\_\_

Thermogram \_\_\_/\_\_\_/\_\_\_ Last PAP Test \_\_\_/\_\_\_/\_\_\_  Normal  Abnormal

Date of Last Bone Density: \_\_\_/\_\_\_/\_\_\_ Results:  High  Low  Within Normal Range

Are you in menopause?  Yes  No Age of onset of menopause: \_\_\_\_\_

*check box if you are experiencing*

- Hot Flashes  Mood Swings  Concentration/Memory Problems  Vaginal Dryness
- Decreased Libido  Heavy Bleeding  Joint Pains  Headaches  Weight Gain
- Loss of Control of Urine  Palpitations  Painful Intercourse
- Use of hormone replacement therapy How Long? \_\_\_\_\_ What hormones and dosage? \_\_\_\_\_

**Men's History (for men only)**

Have you had a PSA done?  Yes  No Date of last test? \_\_\_/\_\_\_/\_\_\_ Highest PSA Level:  0-2  2-4  4-10  >10

*check all that apply:*

- Do you regularly have morning erections?  Yes  No  Increased fat accumulation  Headaches
- Emotional reactions  Prostate enlargement  Prostate infection  Change in libido  Impotence
- Difficulty obtaining an Erection  Difficulty maintaining an erection  Prostate Cancer
- Nocturia (*urination at night*) How many times a night? \_\_\_\_\_  Urgency/Hesitancy/Change in Urinary Stream
- Loss of Control of Urine  Testicular injury  Testosterone replacement  More fatigue and/or muscle soreness

**Medications**

**Current Medications (Both prescription and over-the-counter)**

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

**Previous Medications: Last 10 Years**

Medication	Dose	Frequency	Start Date (month/year)	End Date (month/year)	Reason For Use

**Nutritional Supplements: (Vitamins, Minerals, Herbs, & Homeopathy)** *If more space is needed, please write on separate sheet.*

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

Have your medications or supplements ever caused you unusual side effects or problems?  Yes  No

Describe: \_\_\_\_\_

Have you had prolonged (3 days or longer) or regular use of NSAIDS (i.e. Advil, Aleve, Motrin, Aspirin, etc.)?  Yes  No

Have you had prolonged or regular use of Tylenol?  Yes  No

For what reason, and for how long, did you use pain relievers? \_\_\_\_\_

How much do you use NSAIDS now? Daily \_\_\_\_\_ Weekly \_\_\_\_\_ Monthly \_\_\_\_\_

Have you had prolonged or regular use of Acid Blocking Drugs (i.e. Tagamet, Zantac, Prilosec, etc.)?  Yes  No

Have you taken antibiotics **more than** 1 x per year?  Yes  No

Have you had long-term use of antibiotics? (More than 10 days.)  Yes  No

How many times have you taken antibiotics throughout your lifetime? \_\_\_\_\_

Have you ever used steroids (i.e. prednisone, nasal allergy inhalers, skin/joint creams, etc.)?  Yes  No

**Gil History**

Foreign travel?  Yes  No *Where?* \_\_\_\_\_

Wilderness Camping  Yes  No *Where?* \_\_\_\_\_

Have you had severe:  Gastroenteritis  Diarrhea  Crohn's/Ulcerative colitis  Parasites

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 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      Do you brush regularly?  Yes  No  
 What toothpaste do you use? \_\_\_\_\_ Have you had Fluoride treatments?  Yes  No

**Diet**

Do you have known adverse food reactions, allergies, or sensitivities?  Yes  No *If yes, describe symptoms and list all foods:* \_\_\_\_\_

Do you have an adverse reaction to caffeine?  Yes  No

When you drink caffeine do you feel:  Irritable or Wired     Aches & Pains     Headaches

Do you adversely react to: *Check all that apply*

- Monosodium Glutamate (MSG)     Aspartame (NutraSweet)     Preservatives (ex. sodium benzoate)
- Cheese     Citrus foods     Chocolate     Alcohol     Red Wine     Caffeine     Bananas     Garlic     Onion
- Sulfite containing foods (wine, dried fruit, salad bars)     Other: \_\_\_\_\_

**Environmental & Detoxification Assessment** Which of these significantly affect you? *Check all that apply*

Cigarette Smoke     Perfumes/Colognes     Auto Exhaust Fumes     Other: \_\_\_\_\_

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

How often do you use your cell phone? \_\_\_\_\_ hrs/day    How often do you use your computer? \_\_\_\_\_ hrs/day    \_\_\_\_\_ hrs/wk

Have you ever turned yellow (jaundiced)?  Yes  No

Have you ever been told you have Gilbert's syndrome or a liver disorder?  Yes  No

*If yes, 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 (if known) \_\_\_\_\_

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 exposure?  Yes  No

Do you have any pets or farm animals?  Yes  No

What detergents/soaps do you use (Brand names)? \_\_\_\_\_

What deodorant? \_\_\_\_\_

What beauty products do you use (Lotions, Hair products, Make-up, etc.)? \_\_\_\_\_

**Family History**

<i>Check family members that apply</i>	Mother	Father	Brother(s)	Sister(s)	Children	Grandmothers	Grandfathers	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 / Mood Disorder																				
Other:																				

**Social History**

Weight Stats

Height \_\_\_\_\_ft. \_\_\_\_\_in. Current Weight \_\_\_\_\_ Usual Weight Range (+/- 5lbs) \_\_\_\_\_  
 Desired Weight Range (+/- 5lbs) \_\_\_\_\_ Highest Adult Weight \_\_\_\_\_ Lowest Adult Weight \_\_\_\_\_  
 Have you experienced weight fluctuations greater than 10 lbs?  Yes  No Body fat % \_\_\_\_\_  
 Is your weight, in the recent past, increasing, decreasing, or staying the same? *If changing describe* \_\_\_\_\_

Nutrition History

Have you ever had a nutrition consultant?  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  Macrobiotic  Paleo  
 Specific Program for Weight Loss/Maintenance Type: \_\_\_\_\_  Other \_\_\_\_\_  
 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 & 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 eat organic foods?  Yes  No

What percentage of your food is organic (pesticide free, non-GMO, etc.)? \_\_\_\_\_

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

*check all factors that apply to your current lifestyle and eating habits*

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

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

What foods would be the hardest to reduce or eliminate? \_\_\_\_\_

### Smoking

Currently smoking?  Yes  No How many years? \_\_\_\_\_ Packs per day: \_\_\_\_\_ Attempts to quit: \_\_\_\_\_

Previous smoking? How many years? \_\_\_\_\_ Packs per day: \_\_\_\_\_ Date quit: \_\_\_\_\_

Secondhand smoke exposure? \_\_\_\_\_ From where? \_\_\_\_\_

### Social History continued

#### Alcohol Intake

How many drinks currently per week? 1 Drink = 5 oz. wine, 12 oz. beer, or 1 oz. spirit

None  1 -3  4 – 6  7 – 10  > 10 If 'None' – Skip to 'Other Substances'

Most common beverage? \_\_\_\_\_

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 Cups/day:  Coffee  Tea -  1  2 – 4  > 4 a day

Caffeinated sodas or diet sodas intake:  Yes  No  
 12 oz. soda per day:  1  2-4  > 4 a day Favorite soda: \_\_\_\_\_  
 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

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 your 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

**Social History continued**

**Stress / Coping**

Have you ever sought counseling?  Yes  No Describe \_\_\_\_\_  
 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  
 How do you deal with stress? \_\_\_\_\_  
 Daily Stressors: Rate on a scale of 1-10 Work \_\_\_\_ Family \_\_\_\_ Social \_\_\_\_ Finances \_\_\_\_ Health \_\_\_\_ Other \_\_\_\_  
 Do you practice meditation or relaxation technique?  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  
 If yes, please explain \_\_\_\_\_

Do you regularly give gratitude for everything in your life?  Yes  No  
 How would you describe your overall attitude towards life? \_\_\_\_\_  
 Do you have a spiritual practice?  Yes  No Describe \_\_\_\_\_

Sleep / Rest

Average number of hours you sleep per night:  > 10  8 -10  6 – 8  < 6  
 What time do you typically go to sleep? \_\_\_\_\_: \_\_\_\_\_<sup>AM</sup>/<sub>PM</sub> Do you have trouble going to sleep?  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

Spouses name: \_\_\_\_\_

Child's Name	Age	Gender

Who is living in your Household? Number \_\_\_\_\_ Names \_\_\_\_\_

Their Employment/Occupation: \_\_\_\_\_

Resources for emotional support? Check all that apply

Spouse  Family  Friends  Religious/Spiritual  Pets  Other: \_\_\_\_\_

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 spouse/boyfriend/girlfriend				
With your children				
With your parents				

**Readiness Assessment**

In order to improve your health, how willing are you to: Rate on a scale of: 5 (very willing) to 1 (not willing)

- Significantly improve your diet \_\_\_\_\_  5  4  3  2  1
- Take several nutritional supplements each day \_\_\_\_\_  5  4  3  2  1
- Start preparing your own meals \_\_\_\_\_  5  4  3  2  1
- Modify your lifestyle \_\_\_\_\_  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
- Get regular bodywork such as chiropractic or massage \_\_\_\_\_  5  4  3  2  1

Setting regular appointments \_\_\_\_\_  5  4  3  2  1  
Read books or articles to learn about your health and solutions \_\_\_\_\_  5  4  3  2  1  
Be fully responsible for your own healing \_\_\_\_\_  5  4  3  2  1

Comments: \_\_\_\_\_

How confident are you of your ability to organize and follow through on the above health related activities?  
Rate on a scale of: 5 (very confident) to 1 (not confident at all)  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?

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? Rate on a scale of: 5 (very supportive) to 1 (very unsupportive)  5  4  3  2  1 Comments: \_\_\_\_\_

How much ongoing support and contact (office visits) from the Doctor would be helpful to you as you implement your personal health program? Rate on a scale of: 5 (very frequent) to 1 (very infrequent contact)  5  4  3  2  1  
Please list how often you would be willing to make appointments if needed \_\_\_\_\_

Comments: \_\_\_\_\_

#### **4-Day Diet Diary Instructions**

There is a 4-day diet diary at the end of this packet. It is important to keep an accurate record of your usual food and beverage intake as a part of your treatment plan. Please complete this Diet Diary for 4 consecutive days including one weekend day. Please feel free to carry it with you as it is often easier to write down what you consume shortly after you consume it, rather than wait until the end of the day.

- **Do not change your eating behavior at this time, as the purpose of this food record is to analyze your present eating habits.**
- Record information as soon as possible after the food has been consumed.
- Describe the food or beverage as accurately as possible e.g., milk – what kind? (whole, 2%, or nonfat); toast – (whole wheat, white, buttered); chicken - (fried, baked, or breaded); coffee – (decaffeinated w/ sugar & ½ ‘n’ ½)
- Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, ½ cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.
- Record all beverages, **including water**, coffee, tea, sports drinks, sodas/diet sodas, etc.
- Include any additional comments about your eating habits in this form (ex. craving sweet, skipped meal and why, when the meal was at a restaurant, etc.)
- Please note all bowel movements and their consistency (regular, loose, firm, etc.)

#### **ASQ – Appraisal and Symptom Questionnaire – (Abbreviated)**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

The Health Appraisal and Symptom Questionnaire is designed to elucidate symptoms that help to identify the underlying causes of illness, as well as help track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days.

**POINT SCALE:**

0 = Never or almost never have the symptom  
 1 = Occasionally have it, effect is not severe

2 = Occasionally have, effect is significant  
 3 = Frequently have it, effect is significant  
 4 = Frequently have it, effect is very significant

Digestive Tract

- Nausea or vomiting
- Diarrhea (loose stools or >3x/day)
- Constipation (not going everyday)
- Bloating feeling or abdominal swelling
- Belching or passing gas
- Heartburn or GERD
- Intestinal/stomach pain
- Reactions to foods
- Gallstones or pain after fatty meals
- Bad breath
- Blood or mucous in stool
- Other \_\_\_\_\_

Total \_\_\_\_\_

Ears

- Itchy ears
- Earaches, ear infections
- Drainage from ear
- Ringing in ears, hearing loss

Total \_\_\_\_\_

Emotions

- Mood swings
- Anxiety, irritability
- Anger or emotional outbursts
- Depression

Total \_\_\_\_\_

Energy/Activity

- Fatigue, sluggishness
- Apathy, lethargy
- Hyperactivity
- Restlessness
- Restless legs
- General feeling of ill health

Total \_\_\_\_\_

Eyes

- Watery or itchy eyes
- Swollen, reddened or sticky eyelids
- Bags or dark circles under eyes

Blurred or tunnel vision (*does not include near-or-far-sightedness*)

Total \_\_\_\_\_

Head

- Headaches
- Faintness
- Dizziness or vertigo

Total \_\_\_\_\_

Heart

- Irregular or skipped heartbeat
- Rapid or pounding heartbeat
- Chest pain

Total \_\_\_\_\_

Joints/Muscles

- Pain or aches in joints
- Arthritis
- Stiffness or limitation of movement
- Pain or aches in muscles
- Feeling of weakness or tiredness
- Muscle cramping

Total \_\_\_\_\_

Lungs

- Chest congestion
- Asthma, bronchitis
- Shortness of breath
- Difficulty breathing
- Inability to take deep breaths

Total \_\_\_\_\_

Mind

- Poor memory
- Confusion, poor comprehension
- Poor concentration
- Poor physical coordination
- Difficulty in making decisions
- Stuttering or stammering
- Stuttered speech
- Slurred speech
- Insomnia
- Learning disabilities

Total \_\_\_\_\_

Nose

- Stuffy nose
- Sinus problems
- Hay fever
- Sneezing attacks
- Excessive mucus formation

Total \_\_\_\_\_

Skin

- Acne
- Hives
- Hair loss/thinning
- Rash or reddened skin

Excessive sweating

- Edema
- Dry or oily skin (circle which)
- Dry, cracked nails
- Body odor offensive or strong

Total \_\_\_\_\_

Weight

- Binge eating
- Craving certain foods
- Excessive weight
- Compulsive eating
- Water retention
- Underweight

Total \_\_\_\_\_

Mouth/Throat

- Chronic coughing
- Gagging, frequent throat clearing
- Sore throat, hoarseness, loss of voice
- Swollen/discolored tongue, gums, lips
- Canker sores
- Sticky coating on tongue
- Dry, cracked lips

Total \_\_\_\_\_

Immune

- Frequent illness

Teeth infection/bleeding  
 Frequent or urgent urination  
 Urinary tract infections  
 Genital itch/discharge or STD outbreak  
 Total \_\_\_\_\_

Hormones  
 Awake feeling un-refreshed/tired  
 Craving salty/sweet foods (circle which)  
 Low or High Libido (circle)  
 Facial or unusual hair growth  
 Flushing or hot flashes  
 Painful/abnormal periods (females)

Cold hand/feet  
 Frequent thirst  
 Dizziness when standing  
 Total \_\_\_\_\_  
**Grand Total** \_\_\_\_\_

Diet Diary: Name \_\_\_\_\_ Date \_\_\_\_\_

Day 1

Meal	Time	Food / Beverage / Amount	Comments
Breakfast			
Lunch			
Dinner			
Snacks & Other			

Bowel movements (#, form, color) \_\_\_\_\_  
 Stress/Mood/Emotions \_\_\_\_\_  
 Other Comments \_\_\_\_\_



Day 2

Meal	Time	Food / Beverage / Amount	Comments
Breakfast			
Lunch			
Dinner			
Snacks & Other			

Bowel movements (#, form, color) \_\_\_\_\_  
Stress/Mood/Emotions \_\_\_\_\_  
Other Comments \_\_\_\_\_

Day 3

Meal	Time	Food / Beverage / Amount	Comments
Breakfast			
Lunch			
Dinner			
Snacks & Other			

Bowel movements (#, form, color) \_\_\_\_\_

Stress/Mood/Emotions \_\_\_\_\_

Other Comments \_\_\_\_\_

Day 4

Meal	Time	Food / Beverage / Amount	Comments
<b>Breakfast</b>			
<b>Lunch</b>			
<b>Dinner</b>			
<b>Snacks &amp; Other</b>			

Bowel movements (#, form, color) \_\_\_\_\_

Stress/Mood/Emotions \_\_\_\_\_

Other Comments \_\_\_\_\_