Professional Weight Loss and Rebalancing Center

Date: ___/____/______

Name: ____

Address: ____

City: ________________________ State: ___________ ZIP: ____________

Phone: (best number to reach you): ____

Email: ____

Date of Birth: ____/_____/_______ Age: ____ Sex: ____ Height: _________

Marital Status: ____________ Spouse Name: _______________________________

Occupation: ______________ Employer: __________________________________

How did you hear about us? ____

We have a strict "No Fragrance" policy. Please do not wear any scented lotions, perfumes, colognes, body sprays, etc. when coming for an appointment or visit to our clinic. Thank you!

Initial Questionnaire

Is your current state of health preventing you from doing the things you enjoy?

Are you looking for a more comprehensive approach?

Are you willing to take responsibility over your health?

Do you want more energy?

Are you tired when you wake up in the morning?

Is your energy inconsistent throughout the day?

Do you take longer than before to recover from exercise or illness?

Do you eat a diet that is NOT from processed or packaged foods?

Are you noticing a decline in your memory?

Do you have a hard time starting and finishing tasks?

Do you have less than 7 bowel movements per week?

Have you ever had food poisoning or gotten sick while traveling abroad?

Do you have problems with intermittent diarrhea?

Do you experience stomach cramps or pain?

On a scale of 1 to 5 (one being lowest and 5 highest), in order to improve your health, how willing are you to:

- Significantly modify your diet?
- Keep a record of everything you eat each day?
- Engage in regular exercise?
- Modify your lifestyle (reorganize daily schedule, sleep habits, etc.)?
- Practice relaxation techniques?

Current Health Status/Concerns:

Please provide us with current and ongoing problems

PROBLEM	DATE OF ONSET	SEVEREITY/FREQUENCY	TREATMENT APPROACH	SUCCESS
Ex. Headache	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?

____

____

____

____

____

What physicians 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 History

Diseases/Diagnosis/Conditions *Check appropriate box and provide date of onset (mm/yyyy).*

Past	Ongoing	Gastrointestinal	Date
◯	◯	Irritable Bowel Syndrome	
◯	◯	Crohn's Disease	
◯	◯	Ulcerative Colitis	
◯	◯	Gastritis/Peptic Ulcer Disease	
◯	◯	GERD/Reflux	
◯	◯	Celiac Disease	
◯	◯	Gallstones	
◯	◯	Other:	

Past	Ongoing	Cardiovascular	Date
◯	◯	Heart Attack	
◯	◯	Heart Blockages	
◯	◯	Stroke	
◯	◯	Elevated Cholesterol	
◯	◯	Hypertension	
◯	◯	Arrhythmia	
◯	◯	Rheumatic Fever	
◯	◯	Other:	

Past	Ongoing	Cancer	Date
◯	◯	Lung Cancer	
◯	◯	Breast Cancer	
◯	◯	Colon Cancer	
◯	◯	Ovarian Cancer	
◯	◯	Prostate Cancer	
◯	◯	Other:	

Past	Ongoing	Metabolic/Endocrine	Date
◯	◯	Type I Diabetes	
◯	◯	Type 2 Diabetes	
◯	◯	Hypoglycemia	
◯	◯	Metabolic Syndrome - Prediabetes	
◯	◯	Hypothyroid – Low thyroid	
◯	◯	Hyperthyroid – Overactive thyroid	
◯	◯	Polycystic Ovarian Syndrome	
◯	◯	Infertility	
◯	◯	Weight Gain	
◯	◯	Weight Loss	
◯	◯	Frequent Weight Fluctuation	
◯	◯	Bulimia/Binge Eating	
◯	◯	Anorexia	
◯	◯	Eating Disorder (nonspecific)	
◯	◯	Other:	
◯	◯	Other:	

Past	Ongoing	Genital/Urinary	Date
◯	◯	Kidney Stones	
◯	◯	Benign Prostatic Hypertrophy	
◯	◯	Interstitial Cystitis	
◯	◯	Frequent Urinary Tract Infections	
◯	◯	Frequent Yeast Infections	
◯	◯	Erectile/Sexual Dysfunction	
◯	◯	Other:	

Past	Ongoing	Musculoskeletal	Date
◯	◯	Osteoarthritis	
◯	◯	Fibromyalgia	
◯	◯	Chronic Pain	
◯	◯	Gout	
◯	◯	Degenerative Disk Disease	
◯	◯	Other:	

Past	Ongoing	Autoimmune / Allergies	Date
◯	◯	Chronic Fatigue Syndrome	
◯	◯	Autoimmune Disease	
◯	◯	Rheumatoid Arthritis	
◯	◯	Systemic Lupus	
◯	◯	Immune Deficiency Disease	
◯	◯	Hashimoto's Thyroiditis	
◯	◯	Frequent Infections	
◯	◯	Hepatitis	
◯	◯	Environmental Allergies	
◯	◯	Chemical Sensitivities	
◯	◯	Latex Allergies	
◯	◯	Other:	
◯	◯	Other:	

Past	Ongoing	Skin Disease	Date
◯	◯	Eczema	
◯	◯	Psoriasis	
◯	◯	Acne	
◯	◯	Melanoma	
◯	◯	Other:	

Past	Ongoing	Respiratory	Date
◯	◯	Asthma	
◯	◯	Chronic Sinusitis	
◯	◯	Chronic Bronchitis	
◯	◯	Emphysema/COPD	
◯	◯	Frequent Pneumonia	
◯	◯	Tuberculosis	
◯	◯	Sleep Apnea	
◯	◯	Other:	

Past	Ongoing	Neurologic/Mood	Date
◯	◯	Depression	
◯	◯	Anxiety	
◯	◯	Bipolar Disorder	
◯	◯	Schizophrenia	
◯	◯	Headaches	
◯	◯	Migraine	
◯	◯	ADD/ADHD/Autism	
◯	◯	Mild Cognitive Impairment	
◯	◯	Memory Problems	
◯	◯	Parkinson's Disease	
◯	◯	Multiple Sclerosis	
◯	◯	Lou Gehrig's (ALS)	
◯	◯	Seizure/Epilepsy	
◯	◯	Alzheimer's	
◯	◯	Other:	

Past	Ongoing	Miscellaneous	Date
○	○	Mononucleosis	
○	○	Epstein Barr	
○	○	Chicken Pox/Shingles	
○	○	Viral Hepatitis (B/C)	
○	○	Meningitis	
○	○	Other:	

Past History and Procedures:

Check box and provide date (mm/yyyy)

	Previous Testing	Date
○	Bone Density	
○	Colonoscopy	
○	Cardiac Stress Test	
○	Echocardiogram	
○	EBCT Heart Calcium Score	
○	EKG	
○	MRI	
○	CT Scan	
○	Upper Endoscopy	
○	Upper GI Series	
○	Ultrasound	
○	Mammogram	
○	Other:	
○	Other:	
○	Other:	

	Surgeries	Date
○	Appendectomy	
○	Hysterectomy/Ovaries	
○	Gallbladder	
○	Hernia and Type	
○	Tonsillectomy	
○	Dental Surgery - Amalgams	
○	Joint Replacement (Knee/Hip)	
○	Heart Surgery	
○	Angioplasty / Stent	
○	Pacemaker	
○	Other:	
○	Other:	

	Injuries	Date
○	Back Injury	
○	Neck Injury	
○	Head Injury	
○	Other:	

Hospitalizations: ◯ None

Date	Reason

CURRENT MEDICATIONS:

Medication	Dose and Frequency	How Long?

NUTRITIONAL SUPPLEMENTS AND OVER THE COUNTER (OTC):

Supplement and Brand	Dose and Frequency	How Long?

Family Health History:

Please indicate current and past history to the best of your knowledge.
Please check family members that apply.

	Father	Mother	Brothers	Sisters	Children	M.Gm	M.Gf	P.Gm	P.Gf
Age (if still living)									
Heart Attack									
Age at death (if deceased)									
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									

Family Health History (continued):

Please indicate current and past history to the best of your knowledge.
Please check family members that apply.

	Father	Mother	Brothers	Sisters	Children	M.Gm	M.Gf	P.Gm	P.Gf
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									
Substance abuse (such as alcoholism)									
Parkinson's									
Pneumonia/Bronchitis									
Psoriasis									
Psychiatric disorders									
Schizophrenia									
Sleep Apnea									
Smoking addiction									
Stroke									
Other:									

Digestive History:

Foreign Travel? ______ If so, where? ____

Wilderness Camping? ______

Have you ever had an infectious gastroenteritis? ____ What organism? __________________

Bowel Movements:

FREQUENCY	
1 or less per week	◯
2 to 3 times per week	◯
4 to 6 times per week	◯
1 to 3 times per day	◯
More than 3 times per day	◯

CONSISTENCY	
Soft and well formed	◯
Often floats	◯
Difficult to pass	◯
Diarrhea	◯
Thin, long or narrow	◯
Small and hard	◯
Loose but not watery	◯
Alternating between hard and loose/watery	◯

COLOR	
Medium brown consistently	◯
Very dark or black	◯
Greenish color	◯
Blood is visible	◯
Varies a lot	◯
Dark brown consistently	◯
Yellow, light brown	◯
Greasy, shiny appearance	◯

INTERNAL GAS	
Daily	◯
Occasionally	◯
Excessive	◯
Present with Pain	◯
Foul Smelling	◯
Little Odor	◯

Exercise

Do you exercise regularly? _____

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

Activity	Type	Frequency per week	Duration in Minutes
Stretching/Jogging/Walking			
Cardio/Aerobics			
Strength Training			
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? ______________________________________

If yes, please describe: ____

____

Do you usually sweat when exercising? _____

Lifestyle History

Tobacco:

Current Smoking? _____ How many years? _____ Packs per day? ______
Smokeless Tobacco? _____ How many years? _____
Attempts to quit? _____
Previous Smoking? _____ How long ago? _____
Second Hand Smoke? _____

Alcohol Intake:

How many drinks currently per week? (*1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits)*
If "None," skip to Other Substances

☐ None ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐>10

Previous Alcohol Intake? _____ If so, ☐ Mild ☐ Moderate ☐ High

Have you been told you should cut down your alcohol intake? ☐
Do you get annoyed when people ask you about your drinking? ☐
Do you feel guilty about your alcohol consumption? ☐
Do you ever take an eye opener? ☐
Do you notice a tolerance to alcohol (can you hold more than others)? ☐
Have you ever been unable to remember what you did during a drinking episode? ☐
Do you get into arguments or physical fights when you have been drinking alcohol? ☐
Have you ever been arrested or hospitalized because of drinking? ☐
Have you ever thought about getting help to control or stop your drinking? ☐

Other Substances:

Are you currently using any recreational drugs? _____ Type: ____________________
Have you ever used IV or inhaled recreational drugs? _____ Type: ____________________

CHECKLIST: Review of Systems

General-

☐ Weight loss or gain ☐ Fatigue ☐ Fever or chills ☐ Weakness

☐ Trouble sleeping ☐ Frequent illnesses

Skin-

☐ Rashes ☐ Lumps ☐ Itching ☐ Dryness ☐ Color changes

☐ Hair and nail changes ☐ Acne ☐ Excessive Sweating

Head-

☐ Headache ☐ Head injury ☐ Faintness ☐ Dizziness ☐ Insomnia

☐ Face twitch ☐ Hair Loss

Ears-

☐ Decreased hearing ☐ Ringing in ears (tinnitus) ☐ Earache ☐ Drainage

☐ Hearing voices ☐ Frequent infections

Eyes-

☐ Vision ☐ Glasses or contacts ☐ Pain ☐ Redness, Watery, Itchy

☐ Glaucoma ☐ Flashing lights ☐ Specks ☐ Blurry or double vision

☐ Cataracts ☐ Last eye exam _________ ☐ Conjunctivitis ☐ Visual hallucinations

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Nose-

☐ Stuffiness ☐ Discharge ☐ Itching ☐ Hay fever ☐ Nosebleeds

☐ Sinus problems ☐ Sneezing attacks ☐ Excessive mucus formation ☐ No sense of smell

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Throat and Mouth-

☐ Tongue issues ☐ Gums issues ☐ Bleeding ☐ Dentures ☐ Sore tongue

☐ Dry mouth ☐ Sore throat ☐ Hoarseness ☐ Thrush ☐ Non-healing sores

☐ Swollen lips/tongue ☐ Difficulty swallowing ☐ TMJ ☐ Cracked lips

☐ Bad breath

Neck-

☐ Lumps ☐ Swollen glands ☐ Pain ☐ Stiffness

Breasts-

☐ Lumps ☐ Pain ☐ Discharge ☐ Breast-feeding

Respiratory-

☐ Chronic cough (dry or wet, productive) ☐ Sputum (color and amount)

☐ Coughing up blood (hemoptysis) ☐ Shortness of breath (dyspnea)

☐ Wheezing ☐ Painful breathing

Cardiovascular-

☐ Chest pain or discomfort ☐ Tightness ☐ Palpitations ☐ Swelling (edema)

☐ Shortness of breath with activity (dyspnea) ☐ Irregular or skipped heart beats

☐ Sudden awakening from sleep with shortness of breath (Paroxysmal Nocturnal Dyspnea)

☐ Difficulty breathing lying down (orthopnea) ☐ Murmur

Gastrointestinal-

☐ Swallowing difficulties ☐ Heartburn ☐ Change in appetite ☐ Nausea/vomiting

☐ Change in bowel habits ☐ Rectal bleeding ☐ Constipation ☐ Diarrhea

☐ Yellow eyes or skin (jaundice) ☐ Bloating ☐ Gas ☐ Intestinal/stomach pain

☐ Black/tarry stools ☐ Bloody stools

Urinary-

☐Frequency ☐ Urgency ☐ Burning or pain ☐ Blood in urine (hematuria)

☐ Incontinence ☐ Change in urinary strength ☐ Frequent urination (polyuria)

Genital-

☐ Pain with sex☐ Hernia ☐ Penile discharge ☐ Sores ☐ Masses or pain

☐ Erectile dysfunction ☐ Diminished libido ☐ STD’s

Female-

☐ Pain with sex ☐ Vaginal dryness ☐ Hot flashes ☐ Vaginal discharge

☐ Itching or rash ☐ STD’s ☐ Decreased libido

☐ Last menstrual period: Are you pregnant? _______

Vascular-

☐ Calf pain with walking (Claudication) ☐ Leg cramping ☐ Varicose veins

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Musculoskeletal-

☐ Muscle pain or aches ☐ Joint stiffness ☐ Back pain ☐ Redness of joints

☐ Swelling of joints ☐ Trauma ☐Arthritis ☐ Muscle weakness

Neurologic-

☐ Dizziness ☐ Fainting ☐ Seizures ☐ Weakness ☐ Numbness

☐ Tingling ☐ Tremor ☐ Slurred speech/stuttering ☐ Poor physical coordination

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Hematologic-

☐ Ease of bruising ☐ Ease of bleeding

Endocrine-

☐ Heat or cold intolerance ☐ Sweating ☐ Lethargy ☐ Excessive thirst (polydipsia)

☐ Hyperactivity ☐ Restlessness

Psychiatric-

☐ Nervousness ☐ Depression ☐ Memory loss ☐ Stress

☐ Mood swings ☐ Anxiety ☐ Anger/irritability/aggressiveness

☐ Poor memory ☐ Confusion/poor comprehension ☐ Poor concentration

☐ Difficulty making decisions ☐ Learning disability

Weight/Eating-

☐ Binge eating/drinking ☐ Craving certain foods ☐ Excessive weight gain

☐ Excessive weight loss ☐ Compulsive eating

Do you currently follow a special diet or nutritional program? _______

☐ Gluten-free ☐ Diabetic ☐ Dairy Restricted ☐ Vegetarian ☐ Vegan

☐ High Protein/Atkins

Other: ____

SIGNED: ____________________________________ *DATE:* ______________