FMLogics Patient Portal

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Health History Questionnaire

Please complete the following health history questionnaire to the best of your ability. You may need family members to help supply information. Your thoroughness and accuracy in answering all appropriate questions will help the doctor evaluate the root cause of your health concerns and determine an effective treatment program.

Note that it is important to include what you may consider 'minor' symptoms as well as major problems. Failure to list anything that you feel to be irrelevant could directly affect the outcome of your diagnosis and ultimately jeopardize a successful treatment outcome.

This program is HIPAA compliant. What this means to you: Any information that you enter into this program is made available only to you and your clinician, is password protected, and is in compliance with the Privacy Law under the Health Insurance Portability and Accountability Act.

BEFORE YOU BEGIN: Please review the following information before you begin completing your questionnaire.

SAVING YOUR INFORMATION: Click the 'NEXT' button at the top or bottom of each page. This will save any information entered. For security reasons, this form has a one (1) hour time limit and will log you out. Any information that you have entered will be automatically saved after that time.

DO NOT use the web browser back button or navigation tabs to move from your current page. If you do so, your answers will not be saved. Please use the 'PREVIOUS' button if you need to return to a prior page. Always navigate through the form using the 'PREVIOUS' or 'NEXT PAGE' buttons.

LOGGING OUT: The 'LOG OUT' button is located on the last page of the questionnaire. Use the 'NEXT' button on each page to get there. You may return to the form at any time to complete any information that you had to leave blank.

SEND TO CLINICAN: This button finalizes your questionnaire and you will no longer have access to the form.

Thank You.

Begin Questionnaire

General Medical History

Date of Birth	
Address	
Home Phone Number	
Work Phone Number	
Emergency Contact Number	
Cell Phone Number	
Fax Number	
E-Mail	
What is the best way to contact you?	○ **Cell** ○ **Home** ○ **Work** ○ **E-Mail**
Please list your present occupation.	
Please list past occupation(s)	
What are your present job duties?	
Marital Status	○ **Single** ○ **Married** ○ **Divorced** ○ **Widowed**
Number of children	
How did you hear about our office? Who referred you?	
Symptom#1 - Describe your concern in detail. When did it start? How often does it occur? How would you rate the severity of the symptom? (mild, moderate, severe) What makes it better? What makes it worse? Have you experienced this symptom in the past? If so, please explain.	

Symptom#2 - Describe your concern in detail. When did it start? How often does it occur? How would you rate the severity of the symptom? (mild, moderate, severe) What makes it better? What makes it worse? Have you experienced this symptom in the past? If so, please explain.	
Symptom#3 - Describe your concern in detail. When did it start? How often does it occur? How would you rate the severity of the symptom? (mild, moderate, severe) What makes it better? What makes it worse? Have you experienced this symptom in the past? If so, please explain.	
Symptom#4 - Describe your concern in detail. When did it start? How often does it occur? How would you rate the severity of the symptom? (mild, moderate, severe) What makes it better? What makes it worse? Have you experienced this symptom in the past? If so, please explain.	
Symptom#5 - Describe your concern in detail. When did it start? How often does it occur? How would you rate the severity of the symptom? (mild, moderate, severe) What makes it better? What makes it worse? Have you experienced this symptom in the past? If so, please explain.	
List the physicians you have seen for the above concerns.	
Doctor 1	
Doctor 2	
Doctor 3	
Doctor 4	
Doctor 5	
Have you ever had a head injury?	○ **Yes** ○ **No**
If yes, please describe how the injury occurred and which part of the head sustained the injury.	
Please check all integrative medicine treatments that you have received as it relates to the concerns listed.	
☐ **None**	
☐ **Chiropractic**	
☐ **Acupuncture**	
☐ **Iridology**	
☐ **Colonics**	
☐ **Massage**	
☐ **Chelation Therapy (IV-therapy)**	
☐ **Rolfing**	
☐ **Reiki**	
☐ **Nutritional Therapy**	
☐ **Yoga**	
☐ **Hypnosis**	
☐ **Biological Dentistry**	
☐ **Ayurveda**	
☐ **Electromagnetic Therapy**	
☐ **Environmental Medicine**	
☐ **Homeopathy**	
☐ **Light Therapy**	
☐ **Meditation**	
☐ **Biofeedback**	
Other	
Have you have had any of the following illnesses?	If so, when?

Chicken Pox	
Mononucleosis	
Measles	
Mumps	
Hepatitis	
Other	
Have you had any of the following immunizations?	If so, when?
Smallpox Vaccination	
DPT or Tetanus	
Polio immunization	
Mumps immunizations	
Measles immunizations	
Other (please specify)	
Have you had any of the following surgeries?	If so, when?
Tonsillectomy	
Tubes in ears	
Appendectomy	
Gall Bladder	
Hernia	
Hysterectomy	
Other	
Have you had any of the following diagnostic tests performed in the past 5 years?	
☐ **None**	
☐ **Chest X-ray**	
☐ **Mammogram**	
☐ **EKG**	
☐ **Sigmoidoscopy**	
☐ **Colonoscopy**	
☐ **Upper GI series**	
☐ **Barium enema**	
☐ **CAT Scan of Brain**	
☐ **CAT Scan of Spine**	
☐ **MRI**	
☐ **Liver scan**	
☐ **Bone scan**	
☐ **X-rays**	
☐ **Bone density test**	
☐ **Blood tests**	
Other (please specify)	
Chronological Past Medical History. (See below) Please list to the best of your recollection how you were feeling during each decade of your life; physically, mentally, and emotionally. If you feel comfortable, please include any physical, emotional or substance abuse. If you do not feel comfortable listing this information here, you will have the opportunity to discuss this personally at any time while you are under care. This area should include illnesses, surgeries, injuries, and medications	

Birth to age 10 (You may need to ask family members for assistance.)	
Age 11- 20 (females - describe onset of menstrual cycles and history of cycles)	
Age 21 - 30	
Age 31- 40	
Age 41- present	
List any problems your birth mother may have had with pregnancy(s) such as medications, spontaneous abortions, toxemia, diabetes, etc	
Please indicate all medications that you are currently taking by clicking on the drop down menu on the right. If your medication is not listed, please type it in the box below marked OTHER MEDICINE(S)	Click on the drop down button the select a medication. Use the text box to the right of the medication to indicate how long you have been taking it.
Medicine 1	How Long?
Medicine 2	How Long?
Medicine 3	How Long?
Medicine 4	How Long?
Medicine 5	How Long?
Medicine 6	How Long?
Medicine 7	How Long?
Medicine 8	How Long?
Medicine 9	How Long?
Medicine 10	How Long?
Medicine 11	How Long?
Medicine 12	How Long?
Medicine 13	How Long?
Medicine 14	How Long?
Medicine 15	How Long?
Medicine 16	How Long?
Medicine 17	How Long?
Medicine 18	How Long?
Medicine 19	How Long?
Other Medicine(s)	How Long?
Do you have any allergies to medication? (If so, please list them)	
List all supplements (include herbal, vitamin, minerals, fish oil, etc) you are currently taking. Please include dosage and how long you have been taking the supplement(s).	Enter the type of supplement you are taking in the left text box below and how long you have been taking it in the right text box below.
Supplement 1	How Long?
Supplement 2	How Long?
Supplement 3	How Long?
Supplement 4	How Long?
Supplement 5	How Long?
Supplement 6	How Long?
Supplement 7	How Long?
Supplement 8	How Long?
Supplement 9	How Long?
Supplement 10	How Long?
Supplement 11	How Long?
Supplement 12	How Long?
Supplement 13	How Long?
Supplement 14	How Long?
Supplement 15	How Long?
Supplement 16	How Long?
Supplement 17	How Long?

Supplement 18	How Long?
Supplement 19	How Long?
Supplement 20	How Long?
Have you had any adverse reaction to vitamins, minerals, herbs or other supplements? (If so, please name the substance(s))	
Do you consume alchohol? (If so, what type, how much, and how often?)	
Who is your primary care provider?	
What was the date of your last physical examination?	
What is the date of your last blood test?	
Do you smoke?	◯ **Yes** ◯ **No** ◯ **Previous Smoker**
If yes, how many years?	
What is your blood type?	◯ **A+** ◯ **B+** ◯ **AB+** ◯ **O+** ◯ **A-** ◯ **B-** ◯ **AB-** ◯ **O-**
What is your present weight?	
What is your present height?	
How many days a week do you exercise?	
What type of exercise?	
Please select appropriate family members for the following questions.	
Deceased	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Maternal_Grandmother ☐ Maternal_Grandfather ☐ Paternal_Grandmother ☐ Paternal_Grandfather
Heart Attack	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Maternal_Grandmother ☐ Maternal_Grandfather ☐ Paternal_Grandmother ☐ Paternal_Grandfather
Stroke	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Maternal_Grandmother ☐ Maternal_Grandfather ☐ Paternal_Grandmother ☐ Paternal_Grandfather
Uterine fibroids	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Maternal_Grandmother ☐ Maternal_Grandfather ☐ Paternal_Grandmother ☐ Paternal_Grandfather
Cancer	☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Maternal_Grandmother ☐ Maternal_Grandfather ☐ Paternal_Grandmother ☐ Paternal_Grandfather
Emphysema	☐ Mother ☐ Father ☐ Sister

	☐Brother ☐Maternal_Grandmother ☐Maternal_Grandfather ☐Paternal_Grandmother ☐Paternal_Grandfather
Arthritis	☐Mother ☐Father ☐Sister ☐Brother ☐Maternal_Grandmother ☐Maternal_Grandfather ☐Paternal_Grandmother ☐Paternal_Grandfather
Rheumatoid Arthritis	☐Mother ☐Father ☐Sister ☐Brother ☐Maternal_Grandmother ☐Maternal_Grandfather ☐Paternal_Grandmother ☐Paternal_Grandfather
Lupus	☐Mother ☐Father ☐Sister ☐Brother ☐Maternal_Grandmother ☐Maternal_Grandfather ☐Paternal_Grandmother ☐Paternal_Grandfather
Diabetes	☐Mother ☐Father ☐Sister ☐Brother ☐Maternal_Grandmother ☐Maternal_Grandfather ☐Paternal_Grandmother ☐Paternal_Grandfather
Parkinson's	☐Mother ☐Father ☐Sister ☐Brother ☐Maternal_Grandmother ☐Maternal_Grandfather ☐Paternal_Grandmother ☐Paternal_Grandfather
Alzheimer's or other Dementia(s)	☐Mother ☐Father ☐Sister ☐Brother ☐Maternal_Grandmother ☐Maternal_Grandfather ☐Paternal_Grandmother ☐Paternal_Grandfather
Osteoporosis	☐Mother ☐Father ☐Sister ☐Brother ☐Maternal_Grandmother ☐Maternal_Grandfather ☐Paternal_Grandmother ☐Paternal_Grandfather
Glaucoma	☐Mother ☐Father ☐Sister

	☐Brother ☐Maternal_Grandmother ☐Maternal_Grandfather ☐Paternal_Grandmother ☐Paternal_Grandfather
Breast Cancer	☐Mother ☐Father ☐Sister ☐Brother ☐Maternal_Grandmother ☐Maternal_Grandfather ☐Paternal_Grandmother ☐Paternal_Grandfather
Prostate cancer	☐Mother ☐Father ☐Sister ☐Brother ☐Maternal_Grandmother ☐Maternal_Grandfather ☐Paternal_Grandmother ☐Paternal_Grandfather
High blood pressure	☐Mother ☐Father ☐Sister ☐Brother ☐Maternal_Grandmother ☐Maternal_Grandfather ☐Paternal_Grandmother ☐Paternal_Grandfather
Skin cancer	☐Mother ☐Father ☐Sister ☐Brother ☐Maternal_Grandmother ☐Maternal_Grandfather ☐Paternal_Grandmother ☐Paternal_Grandfather
Depression	☐Mother ☐Father ☐Sister ☐Brother ☐Maternal_Grandmother ☐Maternal_Grandfather ☐Paternal_Grandmother ☐Paternal_Grandfather
Multiple Sclerosis	☐Mother ☐Father ☐Sister ☐Brother ☐Maternal_Grandmother ☐Maternal_Grandfather ☐Paternal_Grandmother ☐Paternal_Grandfather
Alcohol addiction	☐Mother ☐Father ☐Sister ☐Brother ☐Maternal_Grandmother ☐Maternal_Grandfather ☐Paternal_Grandmother ☐Paternal_Grandfather
Smoking addiction	☐Mother ☐Father ☐Sister

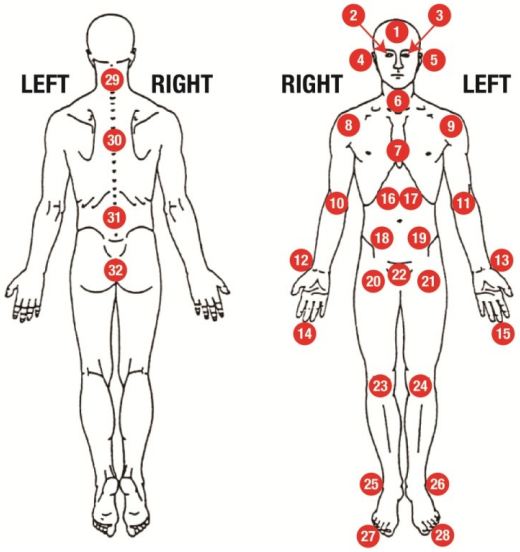
	☐Brother ☐Maternal_Grandmother ☐Maternal_Grandfather ☐Paternal_Grandmother ☐Paternal_Grandfather
Asthma	☐Mother ☐Father ☐Sister ☐Brother ☐Maternal_Grandmother ☐Maternal_Grandfather ☐Paternal_Grandmother ☐Paternal_Grandfather
Pneumonia	☐Mother ☐Father ☐Sister ☐Brother ☐Maternal_Grandmother ☐Maternal_Grandfather ☐Paternal_Grandmother ☐Paternal_Grandfather
Bronchitis	☐Mother ☐Father ☐Sister ☐Brother ☐Maternal_Grandmother ☐Maternal_Grandfather ☐Paternal_Grandmother ☐Paternal_Grandfather
Obesity	☐Mother ☐Father ☐Sister ☐Brother ☐Maternal_Grandmother ☐Maternal_Grandfather ☐Paternal_Grandmother ☐Paternal_Grandfather
Thyroid Disease	☐Mother ☐Father ☐Sister ☐Brother ☐Maternal_Grandmother ☐Maternal_Grandfather ☐Paternal_Grandmother ☐Paternal_Grandfather
Headache	☐Mother ☐Father ☐Sister ☐Brother ☐Maternal_Grandmother ☐Maternal_Grandfather ☐Paternal_Grandmother ☐Paternal_Grandfather
Insomnia	☐Mother ☐Father ☐Sister ☐Brother ☐Maternal_Grandmother ☐Maternal_Grandfather ☐Paternal_Grandmother ☐Paternal_Grandfather
High cholesterol	☐Mother ☐Father ☐Sister

	☐Brother ☐Maternal_Grandmother ☐Maternal_Grandfather ☐Paternal_Grandmother ☐Paternal_Grandfather
Other (please specify)	
If mother deceased, what was the cause of death?	
If father deceased, what was the cause of death?	
Your Personal Health Goals	
What are your expectations as it relates to your visit with us?	
If you could eliminate 3 of your concerns immediately, what would they be?	
Are you willing to make the appropriate changes in order to improve your health?	◯ **Yes** ◯ **No**
List what you are unable to do as a result of your present state of health	
List 3 things that you plan to do once your health has improved	
Did you have cesarean birth?	◯ **Yes** ◯ **No**
Were forceps used for your birth?	◯ **Yes** ◯ **No**
Female Medical History	
-Gynecological History:	
If menses (period) has not started, please check the box to the right and process to the next page by clicking the word NEXT at the bottom of this page.	☐Menses Not Started
Age of first menses: (period)	
Frequency of cycles (e.g. every 28 days)	
Average number of days of the menstrual phase (bleeding)	
Do you experience painful cycles?	◯ **Yes** ◯ **No**
Do you experience abnormal clotting?	◯ **Yes** ◯ **No**
Date of last menstrual period	
Do you currently use contraception?	◯ **Yes** ◯ **No**
- If yes, which type do you use and for how long?	
If you are currently NOT using contraception (hormonal) and have used hormonal birth control in the past, please indicate which type and for how long you used this type of birth control.	
Date of last PAP test	
Please indicate normal or abnormal test results	◯ **Normal** ◯ **Abnormal** ◯ **Unknown**
Date of last Mammogram	
Please indicate normal or abnormal test results	◯ **Normal** ◯ **Abnormal** ◯ **Unknown**
Date of last Bone Density Test	
Please indicate normal or abnormal test results	◯ **Normal** ◯ **Abnormal** ◯ **Unknown**

List any other female problems of concern	
-Obstetric History	
If you have never become pregnant, please check the box to the right and process to the next page by clicking the word NEXT at the bottom of this page.	☐ Never been pregnant
Are you pregnant now?	○ **Yes** ○ **No**
Number of Pregnancies	
Number of Live Births	
Number of Vaginal deliveries	
Number of Caesareans	
Miscarriages	○ **Yes** ○ **No**
- If yes, list the number of miscarriages	
Abortions	○ **Yes** ○ **No**
- If yes, how many abortions?	
History of Toxemia due to pregnancy	○ **Yes** ○ **No**
History of Post Partum Depression	○ **Yes** ○ **No**
History of Gestational Diabetes	○ **Yes** ○ **No**

Pain Diagram

Instructions: Please use the diagram below to indicate the location of your 'present' symptoms.



LOCATION	ACHING	BURNING	NUMBNESS	SHARP	SHOOTING	STABBING	TINGLING
1. Head	☐	☐	☐	☐	☐	☐	☐
2. Eye Rt.	☐	☐	☐	☐	☐	☐	☐
3. Eye Lt.	☐	☐	☐	☐	☐	☐	☐
4. Ear Rt.	☐	☐	☐	☐	☐	☐	☐
5. Ear Lt.	☐	☐	☐	☐	☐	☐	☐
6. Throat/Front of neck	☐	☐	☐	☐	☐	☐	☐
7. Chest	☐	☐	☐	☐	☐	☐	☐
8. Shoulder Rt.	☐	☐	☐	☐	☐	☐	☐
9. Shoulder Lt.	☐	☐	☐	☐	☐	☐	☐
10. Elbow Rt.	☐	☐	☐	☐	☐	☐	☐
11. Elbow Lt.	☐	☐	☐	☐	☐	☐	☐
12. Wrist Rt.	☐	☐	☐	☐	☐	☐	☐
13. Wrist Lt.	☐	☐	☐	☐	☐	☐	☐
14. Hand Rt.	☐	☐	☐	☐	☐	☐	☐

15. Hand Lt.	☐	☐	☐	☐	☐	☐	☐
16. Abdomen Rt. Upper	☐	☐	☐	☐	☐	☐	☐
17. Abdomen Lt. Upper	☐	☐	☐	☐	☐	☐	☐
18. Abdomen Rt. Lower	☐	☐	☐	☐	☐	☐	☐
19. Abdomen Lt. Lower	☐	☐	☐	☐	☐	☐	☐
20. Hip Rt.	☐	☐	☐	☐	☐	☐	☐
21. Hip Lt.	☐	☐	☐	☐	☐	☐	☐
22. Genital	☐	☐	☐	☐	☐	☐	☐
23. Knee Rt.	☐	☐	☐	☐	☐	☐	☐
24. Knee Lt.	☐	☐	☐	☐	☐	☐	☐
25. Ankle Rt.	☐	☐	☐	☐	☐	☐	☐
26. Ankle Lt.	☐	☐	☐	☐	☐	☐	☐
27. Foot Rt.	☐	☐	☐	☐	☐	☐	☐
28. Foot Lt.	☐	☐	☐	☐	☐	☐	☐
29. Back of neck	☐	☐	☐	☐	☐	☐	☐
30. Between shoulder blades	☐	☐	☐	☐	☐	☐	☐
31. Lower back	☐	☐	☐	☐	☐	☐	☐
32. Rectal	☐	☐	☐	☐	☐	☐	☐

Symptoms Review
INSTRUCTIONS: Check all symptoms or conditions you are presently experiencing or have had in the past. You may select both 'past' and 'present' if applicable.

Present Past	Present Past	Present Past
☐ ☐Abdominal pain/cramps	☐ ☐Absence of menstrual cycles (Amenorrhea)	☐ ☐Aching ankles, knees, wrists, or shoulders
☐ ☐Acid reflux/GERD	☐ ☐Acne	☐ ☐Alcohol cravings
☐ ☐Allergies, and sensitivities (food and other substances)	☐ ☐Alternating diarrhea and constipation	☐ ☐Anal fissures
☐ ☐Anger easily	☐ ☐Angina pain	☐ ☐Anorexia
☐ ☐Antacid/Proton pump inhibitor use	☐ ☐Anxiety	☐ ☐Arthritis
☐ ☐Asthma/Bronchitis	☐ ☐Backaches	☐ ☐Bad breath (chronic)
☐ ☐Become ill when illness comes around. (Catch everything)	☐ ☐Bedwetting	☐ ☐Behavior/ADHD/Hyperactivity
☐ ☐Bitter taste in the mouth in the morning	☐ ☐Black or tarry stools	☐ ☐Bleeding after intercourse
☐ ☐Bleeding between periods/ frequent spotting	☐ ☐Bleeding, swollen gums	☐ ☐Bloating 1 to 2 hours after eating
☐ ☐Bloating/Bloating and gas	☐ ☐Blood clots	☐ ☐Blood in urine
☐ ☐Blood sugar up and down	☐ ☐Blood, mucus, or pus in stool	☐ ☐Bloodshot eyes
☐ ☐Blurry vision	☐ ☐Body odor	☐ ☐Bowel urgency/Increase frequency (several to many times per day)
☐ ☐Brain fog/fatigue after eating	☐ ☐Breast cancer	☐ ☐Breast soreness during menstrual period
☐ ☐Bruising easily	☐ ☐Bumps on the back of arms	☐ ☐Bumps on the front thighs
☐ ☐Burning mouth and lips	☐ ☐Burning or pain with urination	☐ ☐Burning sensation when eating citrus foods
☐ ☐Burning, stinging eyes	☐ ☐Burping/Belching	☐ ☐Burst of energy at night

☐ ☐Canker Sores (mouth/tongue sores)	☐ ☐Carpel Tunnel Syndrome	☐ ☐Cataracts
☐ ☐Cervical dysplasia	☐ ☐Change in habits of bowel movements	☐ ☐Change of seasons makes symptoms worse
☐ ☐Changes in hair texture and hair growth	☐ ☐Changes in size and color of moles	☐ ☐Chapped dry lips
☐ ☐Chemotherapy past or present (If yes, please select PRESENT)	☐ ☐Chronic digestive symptoms (GERD, IBS, IBD)	☐ ☐Chronic ear infections
☐ ☐Chronic intestinal infections (yeast/parasitic)	☐ ☐Chronic pain in lower neck and upper back	☐ ☐Chronic stomach/abdominal pain
☐ ☐Chronic stress	☐ ☐Chronic systemic (all over) pain	☐ ☐Clothes dry-cleaned
☐ ☐Coated tongue (white, yellow or dark)	☐ ☐Cold hands and feet	☐ ☐Cold Sweats
☐ ☐Colitis	☐ ☐Confusion	☐ ☐Constant clearing of throat
☐ ☐Constipation	☐ ☐Constipation (chronic)	☐ ☐Convulsions
☐ ☐Coughing	☐ ☐Cracks in corner of mouth	☐ ☐Cravings for sweets
☐ ☐Croup as a baby	☐ ☐Dandruff	☐ ☐Dark circles under eyes
☐ ☐Decreased cognitive function (brain fog) most of the time	☐ ☐Dental bone loss	☐ ☐Dependent on sugar and/or alcohol
☐ ☐Depression	☐ ☐Diabetes, metabolic syndrome, insulin resistance	☐ ☐Diagnosed as having irritable bowel syndrome
☐ ☐Diagnosed with a vitamin D deficiency	☐ ☐Diagnosed with an autoimmune disease	☐ ☐Diagnosed with iron deficiency
☐ ☐Diarrhea	☐ ☐Diarrhea (chronic)	☐ ☐Difficult time concentrating
☐ ☐Difficult time gaining weight	☐ ☐Difficult time managing stress	☐ ☐Difficult to sweat
☐ ☐Difficulty breathing	☐ ☐Difficulty swallowing solids or liquids	☐ ☐Dilated capillaries on face (redness)/Rosacea
☐ ☐Diminished Sex drive	☐ ☐Discharge from penis	☐ ☐Dizziness
☐ ☐Dizzy when getting up quick	☐ ☐Dizzy, irritable if you go without food for several hours	☐ ☐Drink beverages and cook in plastic containers
☐ ☐Drink tap water	☐ ☐Drink unfiltered well water	☐ ☐Dry eyes
☐ ☐Dry mouth	☐ ☐Dry, rough, flaky skin	☐ ☐Easily intoxicated by alcohol
☐ ☐Easily startled	☐ ☐Eat out alot	☐ ☐Eat suchi and/or undercooked food
☐ ☐Eczema, psoriasis, dermatitis	☐ ☐Elevated homocysteine	☐ ☐Endometriosis
☐ ☐Enlarged prostate	☐ ☐Erectile dysfunction/impotence	☐ ☐Excess ear wax
☐ ☐Excessive facial hair (Women)	☐ ☐Excessive gas and bloating	☐ ☐Excessive sighing
☐ ☐Excessive thirst	☐ ☐Excessive urination	☐ ☐Exposed to toxins at home and workplace
☐ ☐Extremities are cold or clammy	☐ ☐Face Twitch/TICS	☐ ☐Facial swelling/edema
☐ ☐Fatigue	☐ ☐Fatigue (chronic)/Fibromyalgia	☐ ☐Fatigue after eating
☐ ☐Fatigued in morning/difficulty getting out of bed	☐ ☐Feel groggy most days	☐ ☐Feel wired, but am tired
☐ ☐Feeling as if there is a lump in the throat	☐ ☐Feeling cold; difficulty getting warm	☐ ☐Feeling of excessive fullness 1 to 3 hours after eating
☐ ☐Fever	☐ ☐Fever blisters (cold sores)	☐ ☐Fibroid Tumors/breast
☐ ☐Fibroid tumors/uterus	☐ ☐Fingernails chip, peel, or break easily	☐ ☐Food allergies
☐ ☐Forgetfulness	☐ ☐Foul-smelling stools	☐ ☐Frequent colds or flu
☐ ☐Frequent ear infections	☐ ☐Frequent feeling of indifference	☐ ☐Frequent infections
☐ ☐Frequent mood swings	☐ ☐Frequent nighttime coughing	☐ ☐Frequent nighttime urination
☐ ☐Frequent respiratory infections	☐ ☐Frequent sighing	☐ ☐Frequent sinus infections/congested sinuses
☐ ☐Frequent sore throat	☐ ☐Frequent stuffy, runny nose	☐ ☐Frequent twitching
☐ ☐Frequent urination	☐ ☐Frequent use of antibiotics (If yes , check PRESENT)	☐ ☐Frequent use of laxatives
☐ ☐Frequent yeast infections/problems	☐ ☐Frequent/Chronic infections	☐ ☐Gallbladder removed

☐ ☐Generalized aches, sharp pains	☐ ☐Get occasional pain on right side of rib cage	☐ ☐Get short of breath easily
☐ ☐Glaucoma	☐ ☐Goiter (enlarged thyroid gland)	☐ ☐Greasy or shiny stools
☐ ☐Gulf War Syndrome	☐ ☐Have a pacemaker	☐ ☐Have amalgam fillings
☐ ☐Have or had food poisoning (If yes, please check PRESENT)	☐ ☐Have or had have cancer (If yes, please check PRESENT)	☐ ☐Hay fever
☐ ☐Headaches	☐ ☐Heart attack/stroke in past (if yes, please check PRESENT)	☐ ☐Heart disease
☐ ☐Heart enlargement	☐ ☐Heart murmur	☐ ☐Heartburn
☐ ☐Heaviness or tightness in the chest	☐ ☐Heavy feeling in legs	☐ ☐Heavy menstrual bleeding
☐ ☐Hemorrhoids	☐ ☐Hernias	☐ ☐Herpes Virus (If yes, check PRESENT)
☐ ☐Hiatal Hernia	☐ ☐High blood pressure	☐ ☐High cholesterol
☐ ☐History of miscarriage(s) (If yes, check PRESENT)	☐ ☐History of alcohol abuse (If yes, check PRESENT)	☐ ☐History of Anemia (If yes, check PRESENT)
☐ ☐History of bowel disease (If yes, check PRESENT)	☐ ☐History of Bronchitis and/or Pneumonia (If yes, check PRESENT)	☐ ☐History of gallbladder attacks/gallstones (If yes, check PRESENT)
☐ ☐History of Gout (If yes, check PRESENT)	☐ ☐History of hepatitis (If yes, check PRESENT)	☐ ☐History of mononucleosis/Epstein Barr virus (If yes, check PRESENT)
☐ ☐History of sexually transmitted disease (If yes, check PRESENT)	☐ ☐History of tuberculosis (If yes, check PRESENT)	☐ ☐HIV infection
☐ ☐Hives	☐ ☐Hoarseness, gravelly voice	☐ ☐Home pesticide treatments
☐ ☐Hormonal imbalance	☐ ☐Hot flashes	☐ ☐Incomplete bowel movements
☐ ☐Incontinence (loss of bladder control)	☐ ☐Increased appetite, hungry after meals	☐ ☐Increased pulse rate while at rest
☐ ☐Indigestion	☐ ☐Infertility	☐ ☐Infrequent urination
☐ ☐Insomnia	☐ ☐Interstitial cystitis	☐ ☐Intolerance to carbohydrates (esp. beans and fiber)
☐ ☐Inward trembling	☐ ☐Irregular periods	☐ ☐Irritability
☐ ☐Irritable before meal time	☐ ☐Itching	☐ ☐Kidney pain
☐ ☐Kidney stones	☐ ☐Lack of energy	☐ ☐Lack of mental alertness
☐ ☐Leg cramps	☐ ☐Light-colored stool	☐ ☐Lightheaded standing up too fast
☐ ☐Light-headed, especially when standing up	☐ ☐Little to no physical activity	☐ ☐Live in a city, large urban area and/or industrialized area
☐ ☐Live in a damp and/or mold environment (If yes, please check PRESENT)	☐ ☐Liver disease	☐ ☐Living space has poor ventilation (airtight)
☐ ☐Loss of color in hair and skin	☐ ☐Loss of patience	☐ ☐Loss of taste for meat
☐ ☐Low blood pressure	☐ ☐Low blood sugar	☐ ☐Low body temperature
☐ ☐Low cholesterol	☐ ☐Low exercise tolerance	☐ ☐Low urine flow that is dark and stong smelling
☐ ☐Lower bowel gas	☐ ☐Lower bowel gas several hours after eating	☐ ☐Lumps in breast
☐ ☐Lumps in testicles	☐ ☐Lyme Disease (If yes, check PRESENT)	☐ ☐Macular Degeneration
☐ ☐Male infertility (low sperm count)	☐ ☐Mind always racing	☐ ☐Missing teeth
☐ ☐Mitral valve prolapse	☐ ☐Mucus and congestion (lungs)	☐ ☐Mucus in stool
☐ ☐Muscle cramping after exercise	☐ ☐Muscle cramping while at rest	☐ ☐Muscle pain
☐ ☐Muscle stiffness in morning	☐ ☐Muscle stiffness with damp weather	☐ ☐Muscles fatigue quickly
☐ ☐Nails are flattened and have concavities	☐ ☐Nails tend to be loose, lift easily, and crack	☐ ☐Nausea
☐ ☐Need caffeine/coffee to help wake up	☐ ☐Need for antacids	☐ ☐Nervous Stomach

☐ ☐Nervousness	☐ ☐Never or rarely sweat	☐ ☐Night sweats
☐ ☐Nipple discharge	☐ ☐No sense of smell	☐ ☐Nosebleeds
☐ ☐Numbness, tingling, burning in extremities	☐ ☐Osteopenia/osteoporosis (bone loss)	☐ ☐Ovarian cysts
☐ ☐Overweight/obese	☐ ☐Pain between shoulders	☐ ☐Pain that awakens you from sleep
☐ ☐Pain with bowel movement	☐ ☐Painful intercourse	☐ ☐Pale, anemic, or yellowish skin
☐ ☐Pale, cool, clammy skin	☐ ☐Palpitations/irregular, skipped heartbeat	☐ ☐Panic attacks
☐ ☐Partial hysterectomy	☐ ☐Past stomach (peptic/duodenal) ulcer and/or gastritis	☐ ☐Periodontal (gum) disease
☐ ☐Periods of rapid heartbeats	☐ ☐Pesticide and garden chemical use	☐ ☐Phlebitis
☐ ☐PMS	☐ ☐Poor Appetite	☐ ☐Poor concentration
☐ ☐Poor memory/memory loss	☐ ☐Poor night vision	☐ ☐Poor stamina
☐ ☐Post nasal drip	☐ ☐Premature graying of hair	☐ ☐Previous concussions
☐ ☐Previous or current use of aspirin or other anti-inflammatory medications (iFyes check PRESENT)	☐ ☐Prostate cancer	☐ ☐Pulse increases after eating meals
☐ ☐Quick to cry	☐ ☐Racing heart	☐ ☐Rectal bleeding
☐ ☐Rectal/anal itching	☐ ☐Reduced urine flow, hesitation, dribbling	☐ ☐Regular use of pain medication (If yes, please check PRESENT)
☐ ☐Resist going to bed when tired	☐ ☐Salt craving	☐ ☐Scoliosis (curvature of the spine)
☐ ☐Scrotal pain or swelling	☐ ☐See halo around lights	☐ ☐Seizures
☐ ☐Sense of fullness after meals	☐ ☐Sensitive to caffeine	☐ ☐Sensitive to certain medications
☐ ☐Sensitive to chlorine and bromine	☐ ☐Sensitive to cold temperature	☐ ☐Sensitive to hot temperature
☐ ☐Sensitive to household cleaning products	☐ ☐Sensitive to light touch	☐ ☐Sensitive to MSG
☐ ☐Sensitive to room sprays and/or candles	☐ ☐Sensitive to soaps, detergents, and/or dryer sheets	☐ ☐Sensitive to sulfites (wine, dried fruit)
☐ ☐Sensitive to tobacoo smoke	☐ ☐Sensitive to walking down the detergent aisle	☐ ☐Sensitivity to light/noise
☐ ☐Sensitivity to perfumes/gasoline fumes/chemicals	☐ ☐Senstive to chocolate	☐ ☐Senstive to smog/air pollution
☐ ☐Shortness of breath	☐ ☐Sinus congestion (chronic)	☐ ☐Skin eruptions, boils
☐ ☐Skin rashes	☐ ☐Skin tags	☐ ☐Sleepy after meals
☐ ☐Slow to recover from surgery	☐ ☐Sluggish, foggy thinking	☐ ☐Sneezing spells
☐ ☐Sore on penis	☐ ☐Sour taste in mouth	☐ ☐Spider veins
☐ ☐Sprains, strains, and weak ligaments	☐ ☐Stiff,achy painful joints/swollen joints	☐ ☐Stomach pain just before or after meals
☐ ☐Stomach pain relieved by ingesting carbonated drinks	☐ ☐Stomach pain relieved by ingesting milk/cream	☐ ☐Stomach pains
☐ ☐Stomach upset after eating fatty/greasy foods	☐ ☐Stomach upset by taking vitamins/supplements	☐ ☐Stool (abdominal cramps, urgency or mucus in stool at least one time per week)
☐ ☐Stools poorly formed,greasy and/or foul smelling	☐ ☐Stressed-out most of the time	☐ ☐Strong-smelling urine
☐ ☐Sudden indigestion	☐ ☐Sweet cravings	☐ ☐Swelling in calves, legs or feet
☐ ☐Swelling in knees	☐ ☐Swollen eyelids and face	☐ ☐Swollen lymph nodes
☐ ☐Swollen tongue/lips	☐ ☐Taken prednisone or other anti-inflammatory drugs for two weeks or longer (If yes, check PRESENT)	☐ ☐Tendency to retain water
☐ ☐Tendency to sleep too much	☐ ☐Tendency to startle easily	☐ ☐Tendency to sweat excessively
☐ ☐Tendonitis	☐ ☐Testicular pain	☐ ☐Thinning or loss of outside of eyebrows
☐ ☐Thinning skin	☐ ☐Three or more bowel movements a day	☐ ☐Throat closes up

☐ ☐Thyroid condition	☐ ☐Tinnitus (ringing in ears)	☐ ☐TMJ (jaw)
☐ ☐Tongue feels thick	☐ ☐Tonsillitis	☐ ☐Total hysterectomy
☐ ☐Tremors (shaking)	☐ ☐Tremors (Confusion)	☐ ☐Trouble falling and staying asleep
☐ ☐Uncomfortable after eating fatty foods	☐ ☐Undigested food in stools	☐ ☐Unexplained hair loss
☐ ☐Unexplained weight gain	☐ ☐Unexplained weight loss	☐ ☐Urinary Tract/Kidney infections
☐ ☐Use of IUD	☐ ☐Use of oral contraceptive	☐ ☐Vaginal itching
☐ ☐Varicose veins	☐ ☐Vertigo	☐ ☐Vomiting
☐ ☐Vomiting blood	☐ ☐Wake up at night with heartburn and/or regurgitation	☐ ☐Wake up unrefreshed
☐ ☐Waking up with sore heels	☐ ☐Weakness	☐ ☐Wear dentures
☐ ☐Weight gain	☐ ☐Wheezing	☐ ☐White spots on the nails
☐ ☐Wounds are slow in healing	☐ ☐Yearly flu vaccine	☐ ☐Yellow nails

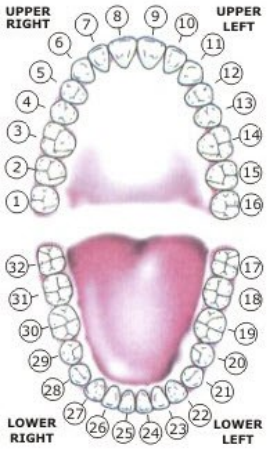
INSTRUCTIONS: Check all symptoms or conditions you are presently experiencing or have had in the past.

☐Anemia (including iron deficiency)
☐Autoimmune disorder(s) (including thyroid disease, type1 diabetes, Sjogren's syndrome)
☐Bone loss (Osteopenia and/or osteoporosis)
☐Chronic fatigue syndrome
☐Chronic liver disease
☐Cognitive disorders (difficulty with thinking, reasoning, and remembering)
☐Eye irritation (including dryness, itching, reddened eyelids, watery)
☐Fibromyalgia
☐History of cancer of the reproductive organs (breast, uterus, prostate, testicular)
☐History of cancer other than reproductive
☐History of kidney disease
☐Immediate family member with an autoimmune disease
☐Irritable bowel syndrome
☐Lactose intolerance
☐Low platelet count
☐Low sperm count
☐Mood disorder (depression, bipolar)
☐Non-Hodgkin's Lymphoma
☐Obesity
☐Parkinson's disease
☐Peripheral neuropathy

Dental History

Dental problems such as past root canals, infections, cavities, a broken tooth, impacted teeth, crowns, abscessed teeth, partials, and/or gum disease may be an underlying cause of some diseases.

INSTRUCTIONS: Click onto the corresponding number beside the diagram to identify any teeth in which you have experienced a problem. Please note that this applies to past and present problems.



☐01 ☐02 ☐03 ☐04 ☐05 ☐06 ☐07 ☐08

☐09 ☐10 ☐11 ☐12 ☐13 ☐14 ☐15 ☐16

☐17 ☐18 ☐19 ☐20 ☐21 ☐22 ☐23 ☐24

☐25 ☐26 ☐27 ☐28 ☐29 ☐30 ☐31 ☐32

Please briefly explain your dental history:

Diet History

INSTRUCTIONS: Carefully review the following list of foods and check any foods you eat 3 or more days a week.

☐Agave	☐Aged cheese	☐Alcohol (wine, beer, hard liquor, cocktails)
☐Alkalized (ionized) Water	☐Almonds	☐Apples
☐Apricot	☐Artichokes	☐Artificial Sweeteners
☐Asparagus	☐Avocado	☐Baked Goods (pastries, deserts etc.)
☐Bananas	☐Barley	☐Basil
☐Beets	☐Black Beans	☐Black Pepper
☐Blackstrap Molasses	☐Blueberries	☐Bok Choy
☐Bottled Water	☐Bread (wheat, rye, barley, oats)	☐Breakfast Cereals
☐Broccoli	☐Brown Rice (unrefined)	☐Brown Rice Syrup
☐Brussels Sprouts	☐Buckwheat	☐Butter (Dairy)
☐Cabbage	☐Caffeinated Coffee	☐Candy
☐Cane Juice/Sugar	☐Canola Oil	☐Cantaloupe
☐Carrots	☐Cashews	☐Cauliflower
☐Cayenne Pepper	☐Celery	☐Cheese
☐Cheese (low-fat)	☐Chicken	☐Chili Pepper (dried)
☐Chocolate	☐Cilantro	☐Cinnamon
☐Cloves	☐Cod	☐Collards
☐Coriander Seeds	☐Corn	☐Cottenseed Oil
☐Cranberries	☐Cream	☐Cucumber
☐Cumin Seeds	☐Decaffeinated Coffee	☐Diet Soda
☐Dill	☐Distilled Water	☐Dry Roasted Nuts
☐Eggplant	☐Eggs	☐Energy Drinks
☐Fast Food	☐Fennel	☐Figs
☐Filtered Water	☐Flaxseed	☐Fried Foods
☐Frozen Food	☐Fructose	☐Fruit Juices (apple, orange, grapefruit)
☐Garbanzo Beans (chickpeas)	☐Garlic	☐Ginger
☐Gluten-free Products (bread, pasta, etc.)	☐Grapefruit	☐Grapes
☐Green Beans	☐Green Tea	☐Halibut
☐Herbal Tea	☐Honey	☐Hot Tea
☐Iced Tea	☐Instant Breakast Foods	☐Kale
☐Kidney Beans	☐Kiwifruit	☐Lamb
☐Leeks	☐Lemon/Limes	☐Lentils

☐ Lettuce	☐ Lima Beans	☐ Liver
☐ Maple Syrup	☐ Margarine	☐ Mayonnaise
☐ Milk (cow)	☐ Milk (goat)	☐ Milk Beverages (almond, soy, rice)
☐ Millet	☐ Miso	☐ Molasses
☐ MSG	☐ Mushrooms	☐ Mustard Greens
☐ Mustard Seeds	☐ Navy Beans	☐ Nutritional Shakes/Drinks/Bars
☐ Oatmeal	☐ Olive Oil	☐ Olives
☐ Onions	☐ Oranges	☐ Oregano
☐ Papaya	☐ Parsley	☐ Pasta (gluten containing)
☐ Peach	☐ Peanuts	☐ Pears
☐ Peas (dried,split)	☐ Peppermint	☐ Pineapple
☐ Pinto Beans	☐ Plums	☐ Pork
☐ Powdered Drink Mixes (instant iced tea, artificially powdered drinks)	☐ Pre-mixed Baked Goods (cake mixes, pancake mixes, etc)	☐ Prunes
☐ Pumpkin Seeds	☐ Quinoa	☐ Radishes
☐ Raisins	☐ Raspberries	☐ Red Meat
☐ Reverse Osmosis Water	☐ Rosemary	☐ Rye
☐ Safflower Oil	☐ Sage	☐ Salad Dressings (commercial/bottled)
☐ Salmon	☐ Sardines	☐ Scallops
☐ Sea Vegetables (e.g. kelp, dulse, nori)	☐ Sesame Seeds	☐ Shrimp
☐ Snack Foods (chips, pretzels, etc.)	☐ Soft Drinks (soda)	☐ Soy Sauce
☐ Soybeans/soy products	☐ Sparkling Water	☐ Spelt
☐ Spinach	☐ Spring Water	☐ Stevia
☐ Strawberries	☐ Sugar	☐ Summer Squash (zucchini)
☐ Sunflower Seeds	☐ Sweet Green, Yellow, and Red Peppers	☐ Sweet Potatoes
☐ Swiss Chard	☐ Tap Water	☐ Tempeh
☐ Thyme	☐ Tofu	☐ Tomato Juice
☐ Tomatoes	☐ Tuna	☐ Turkey
☐ Turmeric	☐ Turnips	☐ Vegetable Shortening
☐ Venison	☐ Walnuts	☐ Watermelon
☐ Well Water	☐ Wheat (bulgur)	☐ White Potatoes
☐ White Rice	☐ Winter Squash (e.g. acorn, butternut, spaghetti)	☐ Yams
☐ Yogurt		

Please use the text box below to list other foods that are not listed above:

Environmental Toxin Exposure Evaluation

Thousands of toxic chemicals in the environment (and workplace) can produce adverse effects on health status. Please review the list of toxins and check the substance that applies to you. Remember to answer the question(s) located at the bottom of the page.

☐ Acrylic nail applications	☐ Aerosols	☐ Air fresheners
☐ Aniline dyes	☐ Around or use herbicides	☐ Celluloid
☐ Chemical industry employee	☐ Coolant for transformers	☐ Deodorizers
☐ Dewaxing	☐ Do old home renovations	☐ Drying/packing
☐ Dyes	☐ Eat foods with food additives	☐ Eat fried foods
☐ Eat non-organic citrus fruits	☐ Emergency worker (firefighter, police)	☐ Enamelers
☐ Exposure to fungicides	☐ Exposure to non-organic dry cleaning fluids	☐ Exposure to pesticides
☐ Flame retardants	☐ Floor polishers	☐ Food preservatives

☐Gardener	☐Heat transfer fluid	☐High to moderate use of waxes (ie. floor, auto etc)
☐Household cleaners that contain toxic chemicals	☐Hydraulic fluids	☐Inks
☐Install Swimming Pools	☐Lacquers	☐Leather Tooling/Dying
☐Linoleum	☐Lithography	☐Live close to landfill-hazardous waste sites
☐Live near a dye plant	☐Live near a highway and/or railroad	☐Live near a plastic plant
☐Live near nickel refinery	☐Live or work around old playgrounds	☐Livestock worker
☐Longshoreman	☐Make enamels	☐Make or use cosmetics with aluminum
☐Make or use perfumes	☐Make soaps	☐Manufacture of reinforced plastic boats
☐Manufacture or wear bronzers (tanners)	☐Manufacture or wear rayon	☐Manufacture or work with degreasing
☐Manufacture plastic products or high use of household plastics	☐Modurate to heavy use of spot removers	☐Neoprene cement
☐Ore processing	☐Paint	☐Paint removers
☐Paint strippers	☐Paint thinners	☐Permanent-press fabrics/chemicals
☐Photogravure	☐Polymers	☐Polyurethane exposure
☐Printing Press	☐Refinery workers	☐Resins
☐Road construction worker	☐Rotogravures	☐Service Station attendant
☐Shoemaker /Shoe Dye Exposure	☐Silk manufacturing	☐Smoking or breathing secondhand smoke
☐Spray paints	☐Stains	☐Trucker
☐Use antacids	☐Use antiperspirants	☐Use art supplies
☐Use buffered aspirin	☐Use disinfectants	☐Use household cleaners with ammonia
☐Use Insect repellent	☐Use kerosene as heat source	☐Use of chemical skin peels
☐Use of lice treatment	☐Use of mothballs	☐Use of plastic shower stalls
☐Use or live near use of fumigants	☐Use or make plastic shower curtains	☐Use pots and pans with aluminum
☐Use talc powder	☐Use varnishes	☐Vehicle exhaust
☐Warehouse worker	☐Wear contact lenses	☐Work around automobile exhaust
☐Work around or with dyes/live near dye industry	☐Work around sawdust	☐Work as pilot/flight attendent
☐Work as X-ray medical personnel	☐Work at a gas station	☐Work in a tire company/business
☐Work in construction (including sewers, wells)	☐Work in or around a cotton plant	☐Work in or around metal fabricating
☐Work in textiles	☐Work near or at nuclear reactors/plant	☐Work on or near a farm
☐Work or worked as a field worker	☐Work or worked as a roofer	☐Work or worked in a paper company
☐Work or worked in the rubber industry	☐Work with acrylics	☐Work with adhesives/glues
☐Work with asphalt floor tiles	☐Work with auto clutch, brake, transmission	☐Work with bearings, castings, and pewter
☐Work with ceramics	☐Work with fertilizer	☐Work with insulation for electrical wires
☐Work with lead storage batteries	☐Work with or around explosives	☐Work with or around fireworks
☐Work with or moderate/high use of wood preservatives	☐Work with or use metal cleaners	☐Work with photographic film
☐Work with pressure-treated lumber	☐Work with sheet and pipe metal	☐Work with stained glass
☐Worked as a fumigator	☐Worked or work as an aerial pesticide applicator	☐Worked or work as an engraver
☐Worked or work with color printing		

Do any members of your household work with environmental toxins? ○ **Yes** ◉ **No**

Do you have a whole house water filtration system? ○ **Yes** ◉ **No**

Home water supply: ○ **Well water** ◉ **Public water**

Emotional and Psychological History

Emotions are commonly underestimated when related to their impact on health. They are an important component of your overall health status. Answering the following questions will assist your clinician in providing you with optimal health care. Please be reminded that any information you provide in this questionnaire is treated confidentially and is protected under HIPAA laws.

INSTRUCTIONS: Carefully review the following list of emotions and check any emotion you experience on a regular basis. Remember to respond to the inquiry at the bottom of the page.

☐ Anger	☐ Antisocial tendencies	☐ Anxiety
☐ Bitterness	☐ Cloudy thinking	☐ Concerned with material things over spiritual
☐ Considered Lazy	☐ Controlling, Bossy personality	☐ Critical of self and others
☐ Cry easily	☐ Defensiveness	☐ Depression
☐ Detached, apathy	☐ Disappointment	☐ Dread
☐ Excessive laughter	☐ Excessively talkative	☐ Fear
☐ Fear of letting go	☐ Fear that people are out to get you	☐ Feel pulled in too many direction
☐ Feeling lost	☐ Feeling out of control	☐ Feeling stuck in life
☐ Feeling stuck or frozen	☐ Fits of rage	☐ Fright
☐ Frustration	☐ Get agitated easily	☐ Grief
☐ Guilt	☐ Heartbreak	☐ Holding on to old ideas/the past
☐ Hopelessness	☐ Humiliation	☐ Hypochondria
☐ Impatience/antsy	☐ Inability to assimilate new information	☐ Inadequacy
☐ Indecisiveness	☐ Insecurity	☐ Irritability
☐ Jealousy	☐ Judgemental	☐ Lack of confidence
☐ Lack of courage	☐ Lack of joy	☐ Like to stay at home alone (reclusive)
☐ Living through others	☐ Low self-esteem	☐ Moodswings
☐ Neatness freak	☐ Negative outlook	☐ Negativity
☐ Nervousness	☐ No desire for anything	☐ Not feeling good enough
☐ Not feeling safe	☐ Not feeling worthy of living life fully	☐ Obsessive/Compulsive
☐ Over-compassionate	☐ Overwhelmed	☐ Powerlessness
☐ Regrets	☐ Rejection	☐ Resentment
☐ Resistant to change	☐ Restlessness	☐ Sadness
☐ Self-Defeating	☐ Sentimental	☐ Shame
☐ Shortness of temper	☐ Stifled Feeling	☐ Strong preference for being alone
☐ Suicidal tendencies	☐ Suspicion	☐ Tend to avoid others
☐ Tend to be Argumentative	☐ Tend to be clingy	☐ Tend to be Shy
☐ Tend to overthink things	☐ Tend to Procrastinate	☐ Timid personality
☐ Victimized	☐ Worry	

If you have been treated for any of the emotional symptoms you have selected, please use the text box below to indicate when and how you were treated.

Food and Substance Allergy

Please select the food(s) and/or substance(s) in which you are aware that you are allergic.

☐ Almonds	☐ Birch Pollen	☐ Cashews
☐ Eggs	☐ Fish	☐ Grass
☐ Latex (rubber)	☐ Milk and dairy products	☐ MSG
☐ Peanuts	☐ Ragweed	☐ Shellfish
☐ Soy	☐ Sulfite	☐ Wheat

Please use the text box below to list other food(s) or substance(s) not listed above:

Health History Questionnaire

Have you purposely omitted information from this questionnaire that you wish to discuss with your clinician personally?

○ Yes ◉ No

Please use the text box below for any additional comments or concerns that you would like your clinician to know about your health history.

This is the last page of the questionnaire. Your answers have been saved. If you are not ready to submit your questionnaire to your clinician and wish to do so at a later time, please click 'Log Out' .You can log back in to enter additional information at a future time.

If you are ready to submit this questionnaire to your clinician, please click 'Send to Clinician'. Your clinician will be advised that you have completed the questionnaire and you will no longer have access to it.

Previous Page | Logout | Send to Clinician