Name:_____DOB: _____ Date:_____

NEW CLIENT HISTORY AND LIFESTYLE INTAKE

In order for us to completely evaluate your health status, please fill out the following pages. Be as *thorough* as possible. Fill out all sections, even ones that you don't think apply to you (except male/female, of course!). This allows us to assess your metabolic, neurological and structural imbalances.

HEALTH HISTORY

Allergies

Are you allergic to any medications or drugs? Y □ N □
If yes, list names and type of reaction. (Example: penicillin – rash) _____
_____
Have you ever been tested for food allergies? Y □ N □
Do you have any food allergies (i.e., lactose, gluten, nuts)? Y □ N □
If yes, what foods? _____
Do any foods bother you? Y □ N □ (Example: tomatoes – reflux). If yes, what foods? _____
_____
Do you have any environmental allergies? (Example: Dust, ragweed, animals)? Y □ N □
Do you have any seasonal allergies? Y □ N □ Please list all you can think of_____
_____

Diagnoses

List any diagnosis you have had (Example: high blood pressure, hypothyroid, high cholesterol, diabetes, sleep apnea, etc.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Blood Sugar Readings (if applicable)

What was your lowest reading in the past 3 months? _____
What was your highest reading in the past 3 months? _____
What was your blood sugar level today? _____
What was your last Hemoglobin A1C level? _____ Date Checked: _____

Current Medications (prescribed and over-the-counter) – please complete separate sheet.

Do you think medications are helping? Y □ N □
Are you having any side effects? Y □ N □ Explain: _____

Current Supplements (Vitamins) – please complete separate sheet.

Name:_____DOB: _____ Date:_____

Surgery

Type of Surgery	Date	Reason

Hospitalizations

Date	Hospital	How long?	Reason
Example: 1/1/13	Cleve. Clinic	2 days	Gall Bladder

Family History (If unknown, write "unknown").

Family member	Living?	How old?	List health conditions they had in their life (i.e. cancer, thyroid, heart attack, stroke, etc.)
Mom	Y □ N □		
Dad	Y □ N □		
Mat. Grandmother	Y □ N □		
Pat. Grandmother	Y □ N □		
Mat. Grandfather	Y □ N □		
Pat. Grandfather	Y □ N □		
Sibling	Y □ N □		
Sibling	Y □ N □		
Sibling	Y □ N □		

Kids

Name	Age	Health Status	Living with you?
			Y □ N □
			Y □ N □
			Y □ N □
			Y □ N □
			Y □ N □

General Constitution

On a scale of 1 – 10 (with 10 being the highest/best):
What is your present energy level (without pushing yourself)? 1□ 2□ 3□ 4□ 5□ 6□ 7□ 8□ 9□ 10□ High
What was your energy level 1 year ago? Low 1□ 2□ 3□ 4□ 5□ 6□ 7□ 8□ 9□ 10□ High
What was your energy level 5 years ago? Low 1□ 2□ 3□ 4□ 5□ 6□ 7□ 8□ 9□ 10□ High
What time of day do you have the most energy? _____am/pm to _____am/pm
What time of day do you have the least energy? _____ am/pm to _____am/pm
On a scale of 1 – 10 (with 10 being the best):
How would you rate your endurance? Poor 1□ 2□ 3□ 4□ 5□ 6□ 7□ 8□ 9□ 10□ Best

Name:_____DOB: _____ Date:_____

How is your short term memory? Poor 1□ 2□ 3□ 4□ 5□ 6□ 7□ 8□ 9□ 10□ Best
Are you forgetful? Y □ N □ How big of a problem is it? Mild □ Moderate □ Severe □
Do you get brain fog? Y □ N □ How bad does it get? Good 1□ 2□ 3□ 4□ 5□ 6□ 7□ 8□ 9□ 10□ Bad
Do you suffer from fevers? Y □ N □ Chills? Y □ N □
Do you feel any generalized weakness? Y □ N □

Weight/Height History
Current Height: _____ feet _____ inches
Current Weight _____ lbs. Weight 1 year ago _____lbs. Weight 5 years ago _____lbs.
Is your weight going up or down or is it stabilized? Up □ Down □ Stabilized □
What is the most you ever weighed as an adult? _____ lbs. Was this during pregnancy? Y □ N □
Can you explain your weight changes? _____
How much weight would you like to lose in 6 months? Be realistic. _____

Eyes/Vision
Do you ever get blurred vision? Y □ N □ When (Ex: computer, high blood sugars,etc.)? _____
_____
Do you wear glasses? Y □ N □ Contacts? Y □ N □ Reading glasses? Y □ N □
Do you ever get double vision? Y □ N □ When? _____
How is your night vision? Great □ Average □ Poor □
Do you have an eye disease (i.e., glaucoma, cataracts, retinopathy)? Y □ N □
What type? _____
Have you had any eye injuries? Y □ N □ Type and date: _____

Ears/Nose/Mouth/Throat
Did you or do you suffer from chronic sinus problems Y □ N □
Do you have swollen glands in the neck? Y □ N □ Was any testing performed? Y □ N □
Do you have any difficult swallowing? Y □ N □
Does food get stuck in your throat? Y □ N □
Do you have any hearing loss? Y □ N □ Hearing aids? Y □ N □
Did you or do you suffer from any ringing in the ears? Y □ N □
Do you get ear aches or drainage? Y □ N □ How often? _____
Do you get a stuffy or runny nose? Y □ N □
Do you get frequent nose bleeds? Y □ N □
Do you have mouth sores? Y □ N □
Do you have bleeding gums? Y □ N □
Do you have bad breath? Y □ N □
Does your voice change? Y □ N □
Do you get frequent hoarseness? Y □ N □ How often? _____
Do you get sore throats? Y □ N □ How often? _____

Hematologic/Lymphatic/Other
Have you ever been told you were anemic? Y □ N □ If so, which type? _____
Do you bleed easily? Y □ N □
Have you ever had any blood clots? Y □ N □ Where? _____
Have you ever been told you have phlebitis? Y □ N □
Have you ever had a blood transfusion? Y □ N □ Date(s) _____

Name:_____DOB: _____ Date:_____

Have you ever been diagnosed with a bleeding disorder? Y □ N □

Cardiovascular System

Do you have high blood pressure? Y □ N □
Do you have low blood pressure? Y □ N □
Have you ever been diagnosed with heart disease? Y □ N □
Have you ever had chest pains? Y □ N □ Date(s) _____ EKG performed? Y □ N □
Do you ever get heart palpitations? Y □ N □
Have you ever been told you have mitral valve prolapse (MVP)? Y □ N □
Do your feet or ankles swell? Y □ N □
Do you bruise easily? Y □ N □
Do you get shortness of breath? Y □ N □ When? (i.e., exertion, stairs, laying down)_____
_____
Do you have varicose veins? Y □ N □
Do you have spider veins? Y □ N □
Have you ever been diagnosed with an aortic aneurysm? Y □ N □
Do you have plaque build-up in your carotid arteries? Y □ N □
Have you ever spit up blood? Y □ N □ When? _____
Does your heart rate get really high? Y □ N □
Does your heart rate get really low? Y □ N □
Have you ever been told you have atrial fibrillation? Y □ N □
Have you ever been told you have poor circulation? Y □ N □

Sleep Patterns

If you work, what shift do you work? Day □ Afternoon □ Nights □ Start time: ____ End Time: ____
How many hours of sleep do you get each night? _____ How many do you think you need? _____
Describe how you fall asleep: Watch TV □ Read a book □ Go to Bed □ Other: _____
Do you have trouble falling asleep? Y □ N □
If yes, how long does it take you to fall asleep (give me a range: i.e., 15 -30 min.)?_____
If you awaken at night, do you have trouble falling back asleep? Y □ N □ How often? _____
If yes, how long until you to fall back to sleep (give me a range: i.e., 15 -30 min.)?_____
If you dream how often? _____ Do you remember your dreams? Y □ N □
What time do you go to bed? _____ What time do you get up? _____
Are your sleep habits routine? Y □ N □ If not, why? _____
Do you have trouble waking up in the morning? Y □ N □ Sometimes □
Do you feel well rested upon awakening? Y □ N □ Sometimes □
When are you most awake and alert? From _____am/pm to _____am/pm
Do you get tired during the day? Y □ N □ Sometimes □ What times? _____
Do you get a second wind late at night when you want to stay up later? Y □ N □ Sometimes □
If so, how many days per week? _____
Rate your sleep on a scale of 1-10 (with 10 being the best) 1□ 2□ 3□ 4□ 5□ 6□ 7□ 8□ 9□ 10□ Best

Brain

Do you get anxiety attacks? Y □ N □ How often? _____
Do you feel depressed? Y □ N □ Sometimes □
Have you ever been diagnosed with depression? Y □ N □
Do you have a hard time turning your mind off? Y □ N □

Name:_____DOB: _____ Date:_____

Do you have nervousness? Y □ N □
Have you ever been bulimic or anorexic? Y □ N □
Have you ever been told you are bipolar? Y □ N □
Have you ever been diagnosed a schizophrenic? Y □ N □

Genitourinary
Any increase of urinary urgency? Y □ N □ If yes, for how long? _____
How many times do you urinate during the night? 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ Hourly □
Do you have burning or painful urination? Y □ N □
Do you have any urinary incontinence? Y □ N □ If yes, how long? _____
(i.e., get urinary leakage when you cough, laugh, etc.)
Do you wear urinary protection? Y □ N □
Do you have blood in your urine? Y □ N □
Do you strain to empty your bladder? Y □ N □
What color is your urine? _____
Is there dribbling at the end of urination? Y □ N □
Is your urine stream weaker than it used to be? Y □ N □
Have you ever had kidney stones? Y □ N □ # of times: _____
Have you ever had hemorrhoids? Y □ N □ Did they bleed? Y □ N □

Males Only
Do you have a decrease in morning erections? Y □ N □
Do you have any difficulty in achieving erections or maintaining an erection? Y □ N □
How long have you had difficulty with erections? _____
Have you ever been diagnosed with erectile dysfunction (ED)? Y □ N □
Are you on medications for ED? Y □ N □ Type: _____ Dosage: _____
Is it helping? Y □ N □
Do you avoid sexual activity because of physical problems? Y □ N □
Do you have prostate trouble? Y □ N □ Enlarged? Y □ N □
Have you had your PSA checked? Y □ N □ If yes, date: ___/___/_____ Results:_____
Have you had a prostate digital exam? Y □ N □ If yes, date: ___/___/_____
Results: Normal □ Enlarged □
Have you ever had a sexually transmitted disease? Y □ N □ If yes, explain: _____
Do you have AIDS or HIV? Y □ N □
What is the frequency of your present sexual activity? _____
Does your partner use hormone replacement therapy? Y □ N □

Females Only (Please fill out completely)
Age and year periods began (Onset of menarche) _____
Date of LMP (Last Menstrual Period)_____
How many days from start of one period to start of the next?
Early years _____ 20-30 _____ 30-40 _____ 40-50 _____ >50 _____
How many days does(did) your period last? _____ Is/has this been the norm? Y □ N □
Is (was) your cycle regular? Y □ N □ Not Always □
Do (did) you pass any clots? Y □ N □ If yes, was it? mild □ moderate □ or severe □
Is (was) the flow: Heavy □ Medium □ Light □
How many pads _____ tampons _____ are/were used on heavy days?

Name:_____DOB: _____ Date:_____

Do you have cramps BEFORE your period? Y □ N □ If yes, how many days? _____
Do you have cramps DURING period? Y □ N □ If yes, how many days? _____
Do you have spotting (bleeding between periods)? Y □ N □
Have you ever had (circle all that apply)
Fibrocystic breasts Uterine Fibroids Endometriosis Genital Warts HPV
Pelvic Inflammatory Disease Herpes Venereal disease
Are you pregnant now? Y □ N □
Any change in breast size during period? Y □ N □
Do you experience tender breasts? Y □ N □ If yes, when? _____
Do you have any nipple discharge? Y □ N □ If so, what color? _____
Do you do breast self-exams? Y □ N □
Approximate age and year of menopause (if applicable) _____
Do you have hot flashes? Y □ N □ #times during day _____ Mild □ Moderate □ Severe □
Do you have night sweats? Y □ N □ # during night ____ Mild □ Moderate □ Severe □
per week: Hot flashes _____ Night sweats _____
Have you ever taken estrogen or hormone replacement therapy (HRT)? Y □ N □

Name of hormone	Dosage	Pill or Cream
_____	_____	_____
_____	_____	_____
_____	_____	_____

Approximate age and year of estrogen/HRT _____ For how many years? _____
Are you still on HRT? Y □ N □ Does your partner use HRT? Y □ N □
Date of last mammogram and findings: Negative □ Positive □ For what? _____
How many mammograms have you had in your life? _____
Date of last pelvic/gynecological exam and result: Negative □ Positive □ For what? _____
Date of last pap test and result: Negative □ Positive □ For what?_____
Do you experience itching or burning of the vaginal area? Y □ N □
Do you experience vaginal discharge? Y □ N □
If yes: Amount _____ Color _____ When did this begin?_____
Do you get yeast infections? Y □ N □ If yes, how often?_____ Date of last one: _____
Do you have pain/discomfort with sexual intercourse? Y □ N □ If yes, explain:_____
Have you ever had a sexually transmitted disease? Y □ N □ If yes, explain: _____
Do you have AIDS or HIV? Y □ N □

Birth Control Methods & Pregnancy History (females only)**:**
Have you used an IUD? Y □ N □ If yes, what type? _____
Describe any problems with IUD: _____
Have you used any form of Birth Control Pill, Patch or Shot? Please indicate which type & how long:
Pill □ How long? _____ Shot □ How long? _____ Patch □ How long?: _____
How old were you when you started birth control? ____ How many total years on birth control? _____
Describe any problems while on Birth Control (i.e., weight gain)?_____
Do you find your present birth control method satisfactory for your health? Y □ N □
Have you ever been pregnant? Y □ N □
Number of Pregnancies: 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7+ □
How old were you during pregnancies? _____
Describe any complications with pregnancies/deliveries? _____

Name:_____DOB: _____ Date:_____

Did you breastfeed? Y □ N □ If yes, how long? _____
What is the frequency of your present sexual activity? _____

GastroIntestinal

Do you get belly aches or stomach pain? Y □ N □
If yes, how many times? per week: _____ per month: _____ Mild □ Moderate □ Severe □
Do you get bloated after you eat? Y □ N □
If yes, when do you notice? 15 min. after meal □ 1 hour after meal □ 2+ hours after meal □
How long does it take to go away? _____
When did this start? _____
Do you pass gas? Y □ N □ Foul smelling? Y □ N □ Burping/belching? Y □ N □
Do you get heartburn/gastric reflux? Y □ N □
Have you ever been told you have a hiatal hernia? Y □ N □
Have you ever had ulcers? Y □ N □
Do you get nausea? Y □ N □ If so, when? _____
Do you have any vomiting? Y □ N □
If so, is there ever any blood in your vomit? Y □ N □
Have you ever had a liver problem? Y □ N □ Type: _____
Have you ever had hepatitis? Y □ N □ If yes, type: Hep. A □ Hep. B □ Hep. C □
Have you ever had gallbladder problems? Y □ N □
Have you ever had your gallbladder removed? Y □ N □ Date(year): _____
Have you ever had any colon problems (i.e., Crohns, colitis, diverticulitis, IBS, etc.)? Y □ N □
Have you ever had appendicitis? Y □ N □ Did you have it removed? Y □ N □
Have you ever had pancreatitis? Y □ N □
Have you ever noticed a loss in your appetite? Y □ N □ When? _____
Have you ever noticed an increase in your appetite? Y □ N □ When? _____
Do you feel hungry all of the time? Y □ N □

Bowel Movements

How many bowel movements do you have per day? ____ If not daily, how many per week? _____
Well formed? Y □ N □ Hard? Y □ N □ Small marble size? Y □ N □ Runny? Y □ N □
How many times per week for solid stools? _____ Runny or loose stools? _____
What is the color? Clay □ Lt. Brown □ Med. Brown □ Dark Brown □ Black □ Tan □ Red □
Do they sink? Y □ N □ Sometimes □ Unknown □
Do they float? Y □ N □ Sometimes □ Unknown □
Did you ever get ribbon-shaped stools? Y □ N □ How often? _____
Did you ever get “pencil” looking stools? Y □ N □ How often? _____
Have you ever had blood in your stool? Y □ N □ If yes, how long? _____
If yes, what was the color of the blood? Bright red □ Darker color □
Are bowel movements painful? Y □ N □ How often? _____ per week _____ per month

Respiratory

Do you have a chronic cough? Y □ N □
Do you spit up blood? Y □ N □
Have you had pneumonia? Y □ N □ # of times: _____ Last episode: _____
Do you have wheezing attacks? Y □ N □

Name:_____DOB: _____ Date:_____

Have you had pleurisy (inflammation of the lung lining)? Y □ N □ When? _____
Do you have difficulty breathing? Y □ N □
Do you have asthma? Y □ N □ Are you on medication for it now? Y □ N □
Have you ever been diagnosed with emphysema or COPD? Y □ N □

Endocrine
Do you have any parathyroid gland problems? Y □ N □
Have you ever been told you have a goiter or nodule on your thyroid? Y □ N □ When? _____
Do you have excessive thirst? Y □ N □
Does the heat bother you? Y □ N □
Does cold weather bother you? Y □ N □
Do your hands and feet get cold? Y □ N □
Do you startle easily or do loud noises make you jump? Y □ N □
Do you have dry skin? Y □ N □ Mild □ Moderate □ Severe □
Do you have any swollen glands? Y □ N □ Where? _____

Musculoskeletal
Do you have a spinal curvature or scoliosis? Y □ N □
Do you have arthritis? Y □ N □ If yes, where? _____
What is your pain level? Best 1□ 2□ 3□ 4□ 5□ 6□ 7□ 8□ 9□ 10□ Worst
Do you have joint pain? Y □ N □ What joints? _____
What is your pain level? Best 1□ 2□ 3□ 4□ 5□ 6□ 7□ 8□ 9□ 10□ Worst
Does your joint pain move around (i.e., from knees to shoulder)? Y □ N □
Do you have muscle pain? Y □ N □ Where? _____
Do you get muscle cramps? Y □ N □ Where? _____
Do you cramp when active? Y □ N □ What activity? _____
Do you cramp when resting (i.e., in bed)? Y □ N □
Do you have any muscle/joint weakness? Y □ N □
Do you have difficulty walking? Y □ N □ If yes, why? _____

Neurologic
Do you have headaches? Y □ N □ If yes, how many per week? _____ Per month? _____
Do you get migraine headaches? Y □ N □ If yes, how many per week? _____ Per month? _____
Do you get morning headaches? Y □ N □
Do you get afternoon headaches? Y □ N □
Have you ever had a seizure? Y □ N □
Do you feel you have lost coordination? Y □ N □
Do you experience numbness or tingling? Y □ N □ If so, where? _____
Do you feel you have tremors? Y □ N □
Have you ever had a head injury? Y □ N □ Concussion? Y □ N □ If so, when? _____
Do you get dizzy? Y □ N □
Do you get lightheaded? Y □ N □ Does it happen if you stand up too quickly? Y □ N □
Do you have fainting spells? Y □ N □
Have you ever had a stroke or TIA? Y □ N □
Are you slow to heal after cuts? Y □ N □
Have you ever had cancer? Y □ N □ Type(s): _____

Name:_____DOB: _____ Date:_____

Have you ever had infectious MONO? Y □ N □
Have you ever had any of these diseases? (Circle all that apply)
Chicken Pox Mumps Measles
Were you vaccinated? Y □ N □
Have you ever had shingles? Y □ N □

Integumentary (Skin/Breast
Do you have any rashes? Y □ N □ Where? _____
Do you have an itching or crawling sensation? Y □ N □ Where?_____
Do you have any of the following on your body? (Circle all that apply)
Hives Eczema Psoriasis Open Wounds
Do you have any changes in skin color? Y □ N □
Is your hair thinning? Y □ N □ If so, how severe is the problem? Mild □ Moderate □ Severe □
Do you have fungus on your toenails? Y □ N □ Finger nails? Y □ N □
Do you have brittle nails (nails that break easy)? Y □ N □

LIFESTYLE HISTORY

Tobacco
Do you currently use tobacco? Y □ N □ Type:
cigars □ # per day _____ How many years? _____
cigarettes □ # packs per day _____# per week_____ How many years? _____
chewing tobacco □ how many times in a day? _____ How many years? _____
Have you ever tried to quit the use of tobacco? Y □ N □ How many times? _____
Did you ever use tobacco? Y □ N □ When? _____ How long? _____ How much? _____
Were you (or are you) exposed to second-hand smoke? Y □ N □
Do you use recreational drugs (i.e, marijuana, cocaine, etc.)? Y □ N □

Beverages – Liquids:
Water: How many ounces of water (by itself) do you drink per day? _____
What type of water? Filtered □ City / Well □ Spring □ Distilled □
Milk: Do you drink milk? Y □ N □ Type: Skim □ 1% □ 2% □ Whole □ Soy □ Almond □
How many glasses per day? _____ Per week? _____
Decaffeinated Beverages: Do you drink any caffeine-free beverages? Y □ N □
Type: Decaf Coffee Y □ N □ How many cups? _____ Day _____ Week
Decaf – Herbal Tea Y □ N □ How many cups? _____Day _____ Week
No-Caffeine Sodas Y □ N □ How many cups? _____ Day _____ Week
Caffeinated Beverages: Do you drink any caffeinated beverages? Y □ N □
Type: Coffee: How many cups? _____ Day _____ Week
Tea: How many cups? _____Day _____Week
Soda/Diet Soda: How many cups? _____Day _____Week
Name of soda: _____
Alcohol: Do you consume any alcoholic beverages? Y □ N □

Type	# per Day	# Per Week	# Per Month	# Per Year
Beer □	_____	_____	_____	_____

Name:_____DOB: _____ Date:_____

Wine □	_____	_____	_____	_____
Mixed Drinks □	_____	_____	_____	_____

Dietary Patterns:

Infant Diet: Breast Fed? Y □ N □ Bottle Fed? Y □ N □
Childhood Diet: American? Y □ N □ Vegetarian? Y □ N □ Other? explain)_____
Adult Diet: American? Y □ N □ Vegetarian Y □ N □ Other? (explain) _____
Present Diet: American? Y □ N □ Vegetarian Y □ N □ Other? (explain) _____
Do you follow a low-fat diet? Y □ N □ Not sure □
How many meals do you eat per day? _____
What % of your meals are eaten at home? _____% What % are eaten out? _____%
What % of the food you eat is cooked? _____% What % is raw? _____%
Do you eat/consume any: Soy/tofu products? Y □ N □ If yes, how often?_____
Do you use any soy nutritional supplements? Y □ N □
What foods or mixtures do you avoid and why do you avoid them? _____
Do you have food cravings? Y □ N □. If so, which foods or type of foods do you usually crave?
_____
_____
What food do you sometimes crave (if any)? _____

Exercise Habits

Are you doing any type of exercise? Y □ N □ Consistently? Y □ N □
What type (ex. swimming, walking, aerobic, weights)? _____

Type	# times per week	Length of time
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all doctors you currently see:

Primary doctor: _____
For what condition(s) are you seeing him/her?_____

Doctor #2: _____
For what condition(s) are you seeing him/her?_____

Doctor #3: _____
For what condition(s) are you seeing him/her?_____

Have you ever had any of the following tests?

□ CAT Scan	Date(s) _____	Area(s) _____	Reason _____
□ MRI	Date(s) _____	Area(s) _____	Reason _____
□ Bone scan	Date(s) _____	Area(s) _____	Reason _____
□ X-Rays	Date(s) _____	Area(s) _____	Reason _____

Name:_____DOB: _____ Date:_____

□ Ultrasound Date(s) _____ Area(s) _____ Reason _____
□ Bone density Date(s) _____ Area(s) _____ Reason _____
□ EKG Date(s) _____ Area(s) _____ Reason _____
□ Stress EKG Date(s) _____ Area(s) _____ Reason _____
□ Other Test Type: _____Date(s) _____ Area(s) _____ Reason _____
□ Other Test Type: _____Date(s) _____ Area(s) _____ Reason _____
□ Other Test Type: _____Date(s) _____ Area(s) _____ Reason _____

What was the date of your last blood work? _____

On a scale of 1 to 10 with 10 being the most willing mark the number that best describes your motivation to:

Significantly modify your diet? Least 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ Most

Take several nutritional vitamins each day? Least 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ Most

Keep a record of everything that you eat? Least 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ Most

Modify your lifestyle (diet,sleep,habits)? Least1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10Most

Practice relaxation techniques? Least 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ Most

Engage in regular exercise? Least 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ Most

Have periodic lab tests to assess progress? Least 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ Most

At the present time, how supportive do you think people in your household will be to your implementing the above changes? Least 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ Most

Where do you think you will be health-wise in 1 year if you do not get help now?_____
_____
Where do you think you will be health-wise in 5 years if you do not get help now? _____
_____
On a scale of 1-10 (10 being the most motivated), how motivated are you to getting your health back?
Least 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ Most

Is health your top priority? Y □ N □ If no, why not? _____
_____

Name:_____DOB: _____ Date:_____

Additional Information: Is there anything you would like to add that I did not ask you?

_____

_____

_____

_____

_____

_____

Health Goals

What are your health goals if we accept you into care? Be specific and realistic!
Examples: more energy, better sleep, reduced medications, weight loss, improved digestion

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____