BINGHAM MEMORIAL HOSPITAL
Experience Bingham!

BINGHAM MEMORIAL HOSPITAL
SKILLED NURSING & REHABILITATION CENTER • IDAHO DOCTORS' HOSPITAL

Dear Patient,

Welcome to the Bingham Memorial Center for Functional Medicine. We look forward to meeting you.

WHAT TO EXPECT AT THE BINGHAM MEMORIAL CENTER FOR FUNCTIONAL MEDICINE

Please arrive 30 minutes before your appointment time.

OFFICE CHECK-IN (30 minutes)

Welcome to the Center for Functional Medicine
Update personal information and sign consent forms
Meet Nurse for vital signs

MD CONSULTATION (75 minute appointment)

David J. Bilstrom, MD

LABS-REVIEW OF RECOMMENDED TESTING: RN (30 minute appointment)

Review of lab orders, test description and test prices

LAB VISIT (30 minutes)

After lab, visit the cafe or deli for snack.

PSYCHOSOCIAL CONSULTATION (50 minutes)

Assessment and plan for initial treatment
Review relaxation techniques
Meditation and breath work
Review Adverse Childhood Events (ACE)

HEALTH COACH - WRAP UP AND REVIEW (15 minute appointment)

Exit plan and information review

RECEPTION OFFICE-CHECK OUT (10 minutes)

Schedule follow-up appointment(s)

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HOW TO CONTACT US:

- Our office hours are Mon. 8 AM – 6 PM, Tue. - Thur. 8 AM - 4 PM, Fri. 8 AM - 2 PM
- To reach the Center for Functional Medicine office, please call 208-782-2444.
- Our fax number is 208-785-3115.
- Our email address is functionalmedicine@binghammemorial.org
- If you have a medical emergency, call 911 or go directly to the nearest emergency room.

ADDRESS:

Bingham Memorial Hospital
Center of Functional Medicine
326 Poplar Street
Blackfoot, ID 83221

PRESCRIPTION REFILLS:

It may take up to 24 business hours to process a prescription refill. Please plan ahead to avoid any interruptions in your medications. Prescription refills can be faxed to our office by your pharmacy. Our fax number is 208-782-2444.

FREQUENTLY ASKED QUESTIONS

Will I see other practitioners at the Center for Functional Medicine?

Nutritional therapy is a vital component of your treatment plan. Following your initial medical consultation with a physician, you will meet with one of our nutritionists who will provide recommendations based on your health concerns and tailor your diet based on medical evaluations and test results. You will follow-up with a nutritionist to make changes or updates to your plan based on your progress. In addition, you will be in contact with our Health Coach. The Health Coach will meet you at your first visit and follow up with you by phone or email.

Do you take insurance?

Physician visits are covered by most insurance plans. Coverage for visits with the nutritionist as well as some of the lab tests is determined by your insurance plan. You will talk to our financial counselor to review your coverage prior to your appointment if there is a questions regarding your coverage.

Are Center for Functional Medicine physicians primary care physicians?

Dr. Bilstrom is a specialist and does not provide acute or primary care services. He will work with you closely as a consultant in preventive, nutritional and functional medicine to help you address the roots of chronic health problems. He can confer with your primary care doctor.

Can all the tests I need be done at Bingham Memorial Hospital Laboratory?

Most of the testing can be performed at Bingham Memorial Hospital Laboratory. During your medical consultation, your physician will determine which tests are needed and then our nurses will review testing recommendations, instructions (for instances, fasting or nor-fasting, etc.) and costs, if applicable.

The plan for testing is reviewed with you. You are able to determine what testing to complete based on how much testing you want to do and your out of pocket expense for labs. Testing is frequently done to assess vitamin and mineral levels, hormone evaluations, adrenal function, gastrointestinal health, food allergies, and heavy metals. Many additional tests are available, including genetic testing for a variety of conditions, amino acids, fatty acids, oxidative stress, mitochondrial function and bone health.

Some testing can be performed at home with test kits to collect urine, saliva or stool. Our nurses will review the instructions for completing these tests at home.

While the testing gives a more complete picture of your status, effective care can be implemented without it or testing can be done over time. You should not let this prevent you from seeing one of the doctors.

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PRACTICE POLICIES FOR PATIENTS

Our goal at the Center for Functional Medicine is to provide you with the highest level of personalized care. We are committed to helping you achieve optimal health.

It is important to read all the enclosed information carefully and mail or fax the medical questionnaire to our office at least 7 days prior to your appointment (address on next page). This will allow us to help solve your problems more efficiently and enhance the quality of your care. If your patient packet is late, it may take up to 30 minutes of your appointment time to review your records.

WEBSITE

Information about the Center for Functional Medicine is available through our website, binghammemorial.org/functionalmedicine.

MEDICAL RECORDS

Medical Records can only be released with your authorization. You are responsible for obtaining previous medical records from other physicians or health care providers who are not affiliated with Bingham Memorial. Please contact your physician or other health care provider to obtain these records. Your records should be express mailed to Bingham Memorial – Center for Functional Medicine, 98 Poplar Street, Blackfoot, ID 83221.

If your care has been with Bingham Memorial providers, your records are available to us through our electronic medical record. You do not need to request a release for these records.

CONSULTATIONS

Your initial visit will include a 90-minute consultation with your physician and a 50-minute psychosocial consultation. Psychosocial/support therapy, and laboratory/diagnostic testing are integral components of your treatment plan. Test results are used to design your personal health care program as well as uncover the root causes of your medical condition. Nutritional supplements are often recommended and we will help you find and select the highest quality products.

INITIAL VISITS

Many of the tests require a 10-hour fast. You can, and should, drink water during this fast and take all prescription medication. Costs of all testing will be reviewed with you by our staff after your medical consultation before labs are drawn. You will receive all final lab results and be guided through their interpretation at your follow-up visits.

CONFIRMATION AND CANCELLATION OF APPOINTMENTS
If you must cancel or re-schedule your appointment, please contact us at least three (3) days prior to your appointment. To cancel or re-schedule your appointment, please contact our office at 208-782-2444.

INSURANCE INFORMATION

Physician visits are covered by most insurance plans. Coverage for visits with the nutritionist and the psychosocial therapist; as well as some of the tests, is determined by your insurance plan. Our financial counselor will talk to you to review your coverage prior to your appointment if necessary.

PAYMENT OPTIONS

If it is determined that services are not covered by insurance. Our office accepts cash, checks or credit cards for services rendered.

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Center for Functional Medicine

Health Questionnaires

Bingham Memorial Hospital
Center for Functional Medicine
326 Poplar Street
Blackfoot, ID 83221

Phone 208-782-2444
Fax 208-785-3115

www.BinghamMemorial.org/functionalmedicine
functionalmedicine@binghammemorial.org

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GENERAL INFORATION

Name	*First*	*Middle*	*Last*
Preferred Name			
Date of Birth			
Age			
Gender	☐ Male	☐ Female	
Genetic Background	☐ African	☐ European	☐ Native American	☐ Mediterranean
	☐ Asian	☐ Ashkenazi	☐ Middle Eastern	☐ ____________
Highest Education Level	☐ High School	☐ Under-Graduate	☐ Post-Graduate
Job Title			
Nature of Business			
Primary Address	*Number, Street*		
	City	*State*	*Zip*
Alternate Address	*Number, Street*		
	City	*State*	*Zip*
Home Phone		Work Phone	
Cell Phone		Fax	
Email			
Emergency Contact	*Name*	*Phone Number*	
Relationship		*Cell Phone*	
	Address	*Work Number*	
	City	*State*	*Zip*
Primary Care Physician	*Name*	*Phone Number*	
	Fax		
Referred by	☐ Book	☐ Website	☐ Media	☐ Family or Friend
	☐ PCP	☐ BMH Physician		☐ Other

ALLERGIES

Medication/Supplement/ Food	Reaction

COMPLAINTS CONCERNS______________________________

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

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

1. ______________________________
2. ______________________________
3. ______________________________

When was the last time you felt well? ______________________________

Did something trigger your change in health?______________________________

What makes you feel worse?______________________________

What makes you feel better?______________________________

Please list your current and ongoing problems in the order of priority:

Describe Problem	Start Date	Mild	Moderate	Severe	Prior Treatment/Approach	Excellent	Good	Fair
Example: Post Nasal Drip			*X*		*Elimination Diet*	*X*		

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MEDICAL HISTORY

DISEASES/DIAGNOSIS/CONDITIONS *Check appropriate box and provide date 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
☐	☐	Other_______________
		CARDIOVASCULAR
☐	☐	Heart Attack
☐	☐	Other Heart Disease
☐	☐	Stroke
☐	☐	Elevated Cholesterol
☐	☐	Arrhythmia (irregular heart rate)
☐	☐	Hypertension (high blood pressure)
☐	☐	Hypotension (low blood pressure)
☐	☐	Rheumatic Fever
☐	☐	Mitral Valve Prolapse
☐	☐	Other_______________
		METABOLIC/ENDOCRINE
☐	☐	Type 1 Diabetes
☐	☐	Type 2 Diabetes
☐	☐	Hypoglycemia
☐	☐	Metabolic Syndrome (Insulin Resistance or Pre-Diabetes)
☐	☐	Hypothyroidism (Low thyroid)
☐	☐	Hyperthyroidism (Overactive thyroid)
☐	☐	Endocrine Problems
☐	☐	Polycystic Ovarian Syndrome (PCOS)
☐	☐	Infertility
☐	☐	Weight Gain
☐	☐	Weight Loss
☐	☐	Frequent Weight Fluctuations
☐	☐	Bulimia
☐	☐	Anorexia
☐	☐	Binge Eating Disorder
☐	☐	Night Eating Syndrome
☐	☐	Eating Disorder (Non-specific)
☐	☐	Other_______________
		CANCER
☐	☐	Lung Cancer
☐	☐	Breast Cancer
☐	☐	Colon Cancer
☐	☐	Ovarian Cancer
☐	☐	Prostate Cancer
☐	☐	Skin Cancer
☐	☐	Other_______________

Past Condition	*Ongoing Condition*	**GENITAL AND URINARY SYSTEM**
☐	☐	Kidney Stones
☐	☐	Gout
☐	☐	Interstitial Cystitis
☐	☐	Frequent Urinary Tract Infections
☐	☐	Frequent Yeast Infections
☐	☐	Erectile Dysfunction
☐	☐	Sexual Dysfunction
☐	☐	Other_______________
		MUSCULOSKELETAL/PAIN
☐	☐	Osteoarthritis
☐	☐	Fibromyalgia
☐	☐	Chronic Pain
☐	☐	Other_______________
		INFLAMMATORY/AUTOIMMUNE
☐	☐	Chronic Fatigue Syndrome
☐	☐	Autoimmune Disease
☐	☐	Rheumatoid Arthritis
☐	☐	Lupus SLE
☐	☐	Immune Deficiency Disease
☐	☐	Herpes-Genital
☐	☐	Severe Infectious Function
☐	☐	Poor Immune Function (Frequent Infections)
☐	☐	Food Allergies
☐	☐	Environmental Allergies
☐	☐	Multiple Chemical Sensitivities
☐	☐	Latex Allergy
☐	☐	Hashimoto's Thyroiditis
☐	☐	Lyme Disease, Chronic
☐	☐	PANDAS (Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections)
☐	☐	Polymyalgia Rheumatica
☐	☐	Polymyositis
☐	☐	Psoriatic Arthritis
☐	☐	Raynaud's Disease
☐	☐	Sjogren's Syndrome
☐	☐	Vitiligo
☐	☐	Multiple sclerosis
☐	☐	Other_______________
		RESPIRATORY DISEASES
☐	☐	Asthma
☐	☐	Chronic Sinusitis
☐	☐	Bronchitis
☐	☐	Emphysema
☐	☐	Pneumonia
☐	☐	Tuberculosis

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MEDICAL HISTORY *(continued)*

Past Condition | *Ongoing Condition*

SKIN DISEASES

- ☐ ☐ Eczema
- ☐ ☐ Psoriasis
- ☐ ☐ Acne
- ☐ ☐ Melanoma
- ☐ ☐ Skin Cancer
- ☐ ☐ Other______________________________

NEUROLOGICAL

- ☐ ☐ Depression
- ☐ ☐ Anxiety
- ☐ ☐ Bipolar Disorder
- ☐ ☐ Schizophrenia

Past Condition | *Ongoing Condition*

NEUROLOGICAL (CONT.)

- ☐ ☐ Headaches
- ☐ ☐ Migraines
- ☐ ☐ ADD/ADHD
- ☐ ☐ Autism
- ☐ ☐ Mild Cognitive Impairment
- ☐ ☐ Memory Problems
- ☐ ☐ Parkinson's Disease
- ☐ ☐ Multiple Sclerosis
- ☐ ☐ ALS
- ☐ ☐ Seizures
- ☐ ☐ Other______________________________

PREVENTATIVE TESTS AND DATE OF LAST TEST

Check box if yes and provide date

- ☐ Full Physical Exam ____________________
- ☐ Bone Density ____________________
- ☐ Colonoscopy ____________________
- ☐ Cardiac Stress Test____________________
- ☐ EBT Heart Scan ____________________
- ☐ EKG____________________
- ☐ Hemoccult Test-stool test for blood____________
- ☐ MRI ____________________
- ☐ CT Scan ____________________
- ☐ Upper Endoscopy____________________
- ☐ Upper Endoscopy____________________
- ☐ Upper GI Series ____________________
- ☐ Ultrasound ____________________
- ☐ Other____________________

INJURIES

Check box if yes and provide date

- ☐ Back Injury
- ☐ Head Injury
- ☐ Neck Injury
- ☐ Broken Bones
- ☐ Other ____________________

SURGERIES

Check box if yes and provide date of surgery

- ☐ Appendectomy____________________
- ☐ Hysterectomy +/- Ovaries ____________
- ☐ Gall Bladder____________________
- ☐ Hernia ____________________
- ☐ Tonsillectomy____________________
- ☐ Dental Surgery ____________________
- ☐ Joint Replacement – Knee/Hip ____________
- ☐ Heart Surgery - Bypass Valve ____________
- ☐ Angioplasty or Stent ____________
- ☐ Pacemaker ____________________
- ☐ Other ____________________
- ☐ None

BLOOD TYPE

- ☐ A
- ☐ B
- ☐ AB
- ☐ O
- ☐ RH+
- ☐ Unknown

HOSPITALIZATION

☐ None

Date	*Reason*

COMMENTS

____

____

____

GYNECOLOGIC HISTORY (for women only)

OBSTETRIC HISTORY *Check box if yes and provide number of*

☐ Pregnancies__________ ☐ Caesarean _____________ ☐ Vaginal Deliveries __________
☐ Miscarriage__________ ☐ Abortion ______________ ☐ Living Children ____________

☐ Post-Partum Depression ☐ Toxemia ☐ Gestational Diabetes ☐ Baby Over 8 Pounds
☐ Breast Feeding for how long?______________

MENSTRUAL HISTORY

Age at First Period:Menses Frequency:____Length:____Pain: ☐ Yes ☐ No Clotting: ☐ Yes ☐ No
Describe menstrual flow: ☐ Heavy ☐ Moderate ☐ Mild ☐ Not present
Color of menstrual flow: ☐ Dark ☐ Bright red ☐ Slightly reddish
Cramping: ☐ Severe ☐ Moderate ☐ Mild ☐ Before period ☐ During period ☐ At end of period
Has your period ever skipped?_____ For how long?_______
When did your last menstrual period start:_______________
Use of hormonal contraception such as: ☐ Birth control Pills ☐ Patch ☐ Nuva Ring - How long?_____
Do you use contraception? ☐ Yes ☐ No ☐ Condom ☐ Diaphragm ☐ IUD ☐ Partner Vasectomy
Could you be pregnant now? ☐ Yes ☐ No

WOMEN'S DISORDERS/HORMONAL IMBALANCES

☐ Fibrocystic Breasts ☐ Endometriosis ☐ Fibroids ☐ Infertility ☐ Ovarian Cysts
☐ PMS ☐ Yeast Infection - How many?_________
Last Mammogram:__________________ ☐ Breast Biopsy/Date:______________
Last PAP Test: ______________________ ☐ Normal ☐ Abnormal
Last Bone Density:__________________ Results: ☐ High ☐ Low ☐ Within Normal Range
Are you in Menopause? ☐ Yes ☐ No
Age at Menopause?___________
☐ Hot Flashes ☐ Mood Swings ☐ Concentration/Memory Problems ☐ Vaginal Dryness ☐ Decreased Libido
☐ Heavy Bleeding ☐ Joint Pains ☐ Headaches ☐ Weight Gain ☐ Loss of Control of Urine ☐ Palpitations
☐ Use of hormone replacement therapy How long?________________ Type?________________________

MEN'S HISTORY (for men only)

Have you had a PSA done? ☐ Yes ☐ No
PSA Level: ☐ 0-2 ☐ 2-4 ☐ 4-10 ☐ >10
☐ Prostate Enlargement ☐ Prostrate Infection ☐ Change in Libido ☐ Impotence
☐ Difficulty Obtaining an Erection ☐ Difficulty Maintaining and Erection
☐ Nocturia (urination at night) - How many times at night?_______________
☐ Urgency/Hesitancy/Change in Urinary Stream ☐ Loss of Control of Urine

GI HISTORY

Foreign Travel ☐ Yes ☐ No Where?_______________

Wilderness Camping ☐ Yes ☐ No Where? _______________

Have you ever had severe: ☐ Gastroenteritis ☐ Diarrhea

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

Do you feel bloated after meals? ☐ Yes ☐ No

PATIENT BIRTH HISTORY

☐ Term ☐ Premature ☐ Vaginal Delivery ☐ C-Section

Pregnancy Complications: _______________

Birth Complications:

☐ Breast Fed How long?___________ ☐ Bottle Fed ☐ Difficulty Tolerating Formula

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

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

CHILDHOOD HISTORY

☐ Asthma ☐ Abdominal Pain ☐ Allergies ☐ ADD/ADHD ☐ Eczema ☐ Psoriasis ☐ Acne

☐ Fatigue ☐ Headaches ☐ Constipation ☐ Mononucleosis ☐ Ear Infections - How many?

☐ Sinus Infection- How many?_________ ☐ Strep Throat- How many? _________

☐ Age of 1st antibiotic?_________ ☐ Number of times on antibiotics?_________

ADVERSE CHILDHOOD EVENTS (ACE)

☐ Divorce ☐ Separations ☐ Substance Abuse ☐ Incarceration ☐ Death of a Close Family Member

☐ Physical Abuse ☐ Verbal Abuse ☐ Sexual Abuse ☐ Trauma ☐ Other _______________

DENTAL HISTORY

☐ Silver Mercury Fillings How many?________

☐ Gold Fillings ☐ Root Canals ☐ Implants ☐ Tooth Pain ☐ Bleeding Gums

☐ Gingivitis ☐ Problems with chewing ☐ Other _______________

Do you floss regularly? ☐ Yes ☐ No

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MEDICATIONS

CURRENT MEDICATIONS

Medications	Dose	Frequency	Start Date (month/year)	Reason for Use

PREVIOUS MEDICATIONS *(Last 10 years)*

Medications	Dose	Frequency	Start Date (month/year)	Reason for Use

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

Medications	Dose	Frequency	Start Date (month/year)	Reason for Use

NUTRITIONAL SUPPLEMENTS (Cont.)

Medications	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 ever had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ☐ Yes ☐ No
Have you had prolonged use of Tylenol? ☐ Yes ☐ No
Have you had prolonged or regular use of acid blocking drugs (Tagamet, Zantac, Prilosec, etc.) ☐ Yes ☐ No
Frequent antibiotics ☐ Yes ☐ No
Long term antibiotic ☐ Yes ☐ No
Use of steroids (prednisone, nasal allergy inhalers) in the past ☐ Yes ☐ No
Use of Oral contraceptives ☐ Yes ☐ No

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FAMILY HISTORY

Check family members that apply	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Maternal Grandfather	Aunt	Uncle	Other
Age (if still alive)												
Age at death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Prostate Cancer												
Skin Cancer												
Heart Disease												
Hypertension												
Thyroid Disease												
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)												

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FAMILY HISTORY (Cont.)

Check family members that apply	Mother	Father	brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Maternal Grandfather	Aunt	Uncle	Other
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												
Osteoporosis												
Seizures												

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SOCIAL HISTORY

NUTRITION HISTORY

Have you ever had a nutrition consultation? ☐ Yes ☐ No

Have you made any changes to your eating habits because of your health? ☐ Yes ☐ No

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 ☐ High Fat ☐ Mediterranean ☐ Paleolithic

☐ Specific Program for Weight Loss/Maintenance Type:_______________ ☐ Other_______________

Height (Feet/Inches) ______________	Current Weight ______________
Usual Weight Range +/- 5 lbs ______________	Desired Weight Range +/- ______________
Highest Adult Weight ______________	Lowest Adult Weight ______________
Weight Fluctuations (>10 lbs) ☐ Yes ☐ No	Body Fat % ______________

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

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

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

____

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

____

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

Do you read food labels? ☐ Yes ☐ No

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

How many meals do you eat out per week? ☐ 0-1 ☐ 1-3 ☐ 4-5 ☐ >5 meals per week

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

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

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

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SMOKING

☐ Currently Smoking? ☐ Yes ☐ No If yes, how many years?_______ Packs per day:_________________

Attempts to quit:_______________

Previous Smoking: How many years?___________ Packs per day:_____________

Second Hand Smoke Exposure?________________________

DRINKING

How many drinks currently per week? *1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits*

☐ None ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ >10 *If none, skip to "Other Substances"*

Previous alcohol intake? ☐ Yes (☐Mild ☐ Moderate ☐ High) ☐ None

Have you ever been told that you should cut down on 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 thought about getting help to control or stop your drinking? ☐ Yes ☐ No

OTHER SUBSTANCES

Caffeine Intake: ☐ Yes ☐ No Coffee cups/day: ☐ 1 ☐ 2-4 ☐>4 How do you take your coffee? __________

Tea cups/day: ☐ 1 ☐ 2-4 ☐ >4

Caffeinated Sodas or Diet Sodas Intake: ☐ Yes ☐ No

12-ounce can/bottle: ☐ 1 ☐ 2-4 ☐ >4

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

Are you currently using any recreational drugs? ☐Yes ☐ No If yes, type:_________________________________

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

EXERCISE

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

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

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

List problems that limit activity:____

____

Do you feel unusually fatigued after exercise in your life? ☐ Yes ☐ No

If yes, please describe: ____

____

Do you usually sweat when exercising? ☐ Yes ☐ No

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PSYCHOSOCIAL

Do you feel significantly less vital that you did a year ago? ☐ Yes ☐ No

Are you happy? ☐ Yes ☐ No

Do you feel your life has meaning and purpose? ☐ Yes ☐ No

Do you believe stress is presently reducing the quality of your life? ☐ Yes ☐ No

Do you like the work you do? ☐ Yes ☐ No

Have you ever experienced major losses in your life? ☐ Yes ☐ No

Do you spend the majority of your time and money to fulfill responsibilities and obligations? ☐ Yes ☐ No

Would you describe your experience as a child in your family as happy and secure? ☐ Yes ☐ No

STRESS/COPING

Have you ever had counseling? ☐ Yes ☐ No

Are you currently in therapy? ☐ Yes ☐ No Describe:____

Do you feel you have an excessive amount of stress in your life? ☐ Yes ☐ No

Do you feel you can easily handle the stress in your life? ☐ Yes ☐ No

Daily Stressors: Rate on scale of 1-10

Work______ Family______ Social______ Finances______ Health______ Other______

Do you practice meditation or relaxation techniques? ☐ Yes ☐ No How often?___________

Check all that apply: ☐ Yoga ☐☐ Mediation ☐ Imagery ☐ Breathing ☐ Tai Chi ☐ Prayer Other:_________

Have you ever been abused, a victim of a crime, or experienced trauma? ☐ Yes ☐ No

SLEEP/REST

Average number of hours you sleep per night: ☐ >10 ☐ 8-10 ☐ 6-8 ☐ <6

Do you have problems with insomnia? ☐ Yes ☐ No

Do you have trouble falling asleep? ☐ Yes ☐ No

Do you wake in the middle of the night? ☐ Yes How many times?______ ☐ No

Do you feel rested upon awakening? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No

Do you use sleeping aids? ☐ Yes ☐ No Explain:____

ROLES/RELATIONSHIP

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Long term partnership ☐ Widow

List Children: Child's Full Name	Age	Gender

Who is living in household? Number:________ Names:____

TheirEmployment/Occupations:____

Resources for emotional support?

Check all that apply: ☐ Spouse ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets Other:_________________

Are you satisfied with your sex life? ☐ Yes ☐ No

How well have things been going for you?	Very Well	Fine	Poorly	N/A
- Overall				
- At school				
- In your job				
- In your social life				
- With close friends				
- With sex				
- With your attitude				
- With your boyfriend/girlfriend				
- With your children				
- With your parents				
- With your spouse				

ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT______________________________

Do you have known adverse food reactions or sensitivities? ☐ Yes ☐ No If yes, describe symptoms:

____

Do you have any food allergies or sensitivities? ☐ Yes List all:______________________________

Do you have any adverse reaction to caffeine? ☐ Yes ☐ No

When you drink caffeine do you feel: ☐ Irritable or Wired ☐ Aches and Pains

Do you adversely react to (Check all that apply)

☐ Monosodium Glutamate (MSG) ☐ Aspartame (NutraSweet) ☐ Caffeine ☐ Bananas ☐ Garlic ☐ Onion

☐ Cheese ☐ Citrus Foods ☐ Chocolate ☐ Alcohol ☐ Red Wine

☐ Sulfite Containing Foods (wine, dried fruit, salad bars) ☐ Preservatives (ex. Sodium Benzoate)

☐ Other: ____

Which of these significantly affect you? *(Check all that apply)*

☐ Cigarette Smoke ☐ Perfumes/Colognes ☐ Auto Exhaust Fumes ☐ Other: __________________________

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

Have you ever turned yellow (jaundiced)? ☐ Yes ☐ No

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

Explain:____

Do you have a known history of significant exposure to any harmful chemicals such as the following:

☐ Herbicides ☐ Insecticides (frequent visits to exterminator) ☐ Pesticides ☐ Organic Solvents

☐ Heavy Metals ☐ Other____

Chemical Name, Date, Length of Exposure:____

Do you dry clean you 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 pets or farm animals? ☐ Yes ☐ No

Does your home use well water? ☐ Yes ☐ No

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SYMPTOM REVIEW

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

HEAD, EYES, EARS, NOSE, THROAT

- ☐ Conjunctivitis
- ☐ Distorted sense of smell
- ☐ Distorted taste
- ☐ Ear fullness
- ☐ Ear pain
- ☐ Ear ringing/buzzing
- ☐ Post nasal drip
- ☐ Nasal stuffiness
- ☐ Nose bleeds
- ☐ Eye pain
- ☐ Hearing loss
- ☐ Hearing problems
- ☐ Headache
- ☐ Vision problems
- ☐ Teeth grinding
- ☐ Thyroid problems
- ☐ Pain behind eyes
- ☐ Migraine
- ☐ Bad odor in nose
- ☐ Sore throat
- ☐ Sensitivity to loud noises
- ☐ Macular degeneration
- ☐ Vitreous detachment
- ☐ Retinal detachment

CARDIOVASCULAR

- ☐ Angina/chest pain
- ☐ Breathlessness
- ☐ Irregular heartbeats
- ☐ Purple nails
- ☐ Heart murmur
- ☐ Irregular pulse
- ☐ Palpitations
- ☐ Phlebitis
- ☐ Swollen ankles/feet
- ☐ Varicose veins
- ☐ Leg cramps when walking
- ☐ Leg cramps at night
- ☐ Low blood pressure
- ☐ Anemia
- ☐ Poor circulation
- ☐ Swollen hands
- ☐ Swollen face
- ☐ High blood pressure
- ☐ High cholesterol

DIGESTION

- ☐ Anal spasms
- ☐ Bad teeth
- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Bloating of lower abdomen
- ☐ Bloating of whole abdomen
- ☐ Bloating after meals
- ☐ Blood in stools
- ☐ Burping
- ☐ Mouth sores
- ☐ Constipation
- ☐ Cracking at the corner of lips
- ☐ Cramps
- ☐ Dentures w/ poor chewing
- ☐ Diarrhea
- ☐ Alternating diarrhea and constipation
- ☐ Difficulty swallowing
- ☐ Dry mouth
- ☐ Excess flatulence/ gas
- ☐ Fissures
- ☐ Food "repeating" (reflux)
- ☐ Gallbladder problems
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Upper abdominal pain
- ☐ Vomiting

Intolerance to:

- ☐ Lactose
- ☐ All dairy products
- ☐ Wheat
- ☐ Gluten (wheat, rye, barley)
- ☐ Corn
- ☐ Eggs
- ☐ Fatty foods
- ☐ Yeast
- ☐ Liver disease/Jaundice (yellow eyes/skin)

- ☐ Abnormal liver function tests
- ☐ Lower abdominal pain
- ☐ Mucus in stools
- ☐ Periodontal disease
- ☐ Sore tongue
- ☐ Strong stool odor
- ☐ Undigested food in stools

BOWEL HABITS

- ☐ Black/Tarry stools
- ☐ Blood in stools
- ☐ Constipation
- ☐ Diarrhea/loose stools
- ☐ Hemorrhoids
- ☐ Use of laxatives
- ☐ Mucus in stools
- ☐ Cramping/ pain in intestines
- ☐ Rectal bleeding

My Bowel Movements are:

- ☐ Regular
- ☐ 1-2 per day
- ☐ Irregular
- ☐ Once per______days

RESPIRATORY

- ☐ Asthma
- ☐ Cough- dry
- ☐ Cough- productive
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Pneumonia

Hay fever:

- ☐ Spring
- ☐ Summer
- ☐ Fall (change of season)

- ☐ Emphysema
- ☐ I get cold easily
- ☐ I sigh frequently
- ☐ Sinus infection
- ☐ Sinus infection recurrent
- ☐ Snoring
- ☐ Wheezing

URINARY

- ☐ Bed wetting
- ☐ Hesitancy (trouble getting started)
- ☐ Blood in urine
- ☐ Cloudy urine
- ☐ Frequent urination
- ☐ Poor flow
- ☐ Infection
- ☐ Kidney disease

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SYMPTOM REVIEW (Cont.)

- ☐ Leaking/incontinence
- ☐ Pain/burning
- ☐ Prostate infection
- ☐ Urgency

ANXIETY/WORRY

- ☐ Agoraphobia
- ☐ Anger
- ☐ Auditory hallucinations
- ☐ Black-out
- ☐ Depression

Difficulty:

- ☐ Concentrating
- ☐ With balance
- ☐ With thinking
- ☐ With judgment
- ☐ With speech
- ☐ With memory

- ☐ Dizziness (spinning)
- ☐ Fainting
- ☐ Fear
- ☐ General sadness
- ☐ History of abuse
- ☐ I can't let go
- ☐ I feel stressed often
- ☐ Irritability
- ☐ Light-headedness
- ☐ Nervousness
- ☐ Numbness
- ☐ Nervousness
- ☐ Other phobias
- ☐ Panic attacks
- ☐ Paranoia
- ☐ Seizures
- ☐ Suicidal tendencies
- ☐ Tingling
- ☐ Tremor/trembling
- ☐ Visual hallucinations
- ☐ Worry

SLEEP PATTERNS

- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ I take a sleep aid
- ☐ What time do your sleep problems occur most?________
- ☐ Excessive dreaming
- ☐ Nightmares
- ☐ Early waking
- ☐ No dream recall

EATING

- ☐ Appetite - poor
- ☐ Appetite - excessive
- ☐ Binge eating
- ☐ Bulimia
- ☐ Can't gain weight
- ☐ Can't lose weight
- ☐ Can't maintain healthy weight
- ☐ Frequent dieting
- ☐ Salt cravings
- ☐ Carbohydrate craving (breads, pastas)
- ☐ Sweet cravings (candy, cookies, cakes)
- ☐ Chocolate cravings
- ☐ Caffeine dependency
- ☐ Citrus/sour craving
- ☐ Spicy/hot craving

BODY TEMPERATURE

- ☐ Cold hands & feet
- ☐ Cold intolerance
- ☐ Low body temperature
- ☐ Heat intolerance
- ☐ Afternoon feverishness
- ☐ Alternating chills & feverishness
- ☐ I sweat without exertion
- ☐ Cold natured
- ☐ Cold hands
- ☐ Cold feet
- ☐ Warm natured
- ☐ Fever or sensation of feverishness
- ☐ I have night sweats
- ☐ Flushing

SKIN PROBLEMS

- ☐ Acne on back
- ☐ Acne on chest
- ☐ Acne on face
- ☐ Acne on shoulders
- ☐ Athlete's foot
- ☐ Bumps on back of upper arms
- ☐ Cellulite
- ☐ Dark circles under eyes
- ☐ Dry skin
- ☐ Ears get red
- ☐ Easy bruising
- ☐ Eczema
- ☐ Hair loss
- ☐ Hives
- ☐ Jock itch
- ☐ Lack of sweating
- ☐ Lackluster skin
- ☐ Mole w/ color/size change
- ☐ Oily skin
- ☐ Pale skin
- ☐ Patchy dullness
- ☐ Psoriasis
- ☐ Rash
- ☐ Red face
- ☐ Sensitivity to bites
- ☐ Sensitivity to poison ivy/oak
- ☐ Shingles
- ☐ Skin darkening
- ☐ Strong body odor
- ☐ Vitiligo

NAILS

- ☐ Bitten
- ☐ Brittle
- ☐ Don't grow well
- ☐ Fungus - fingers
- ☐ Fungus - toes
- ☐ Ridges
- ☐ Soft
- ☐ Thickening of fingernails
- ☐ Thickening of toenails
- ☐ White spots/lines

MUSCULOSKELETAL

- ☐ Back muscle spasms
- ☐ Bursitis
- ☐ Calf cramps
- ☐ Chest tightness
- ☐ Foot cramps
- ☐ Joint deformity
- ☐ Joint pain
- ☐ Joint redness
- ☐ Joint stiffness
- ☐ Joint \swelling
- ☐ Muscle pain
- ☐ Muscle spasms
- ☐ Muscle stiffness
- ☐ Muscle twitches - around eyes

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SYMPTOM REVIEW (Cont.)

- ☐ Muscle twitches - arms or legs
- ☐ Muscle weakness
- ☐ Tendonitis
- ☐ Tension headache
- ☐ TMJ problems

FEMALE REPRODUCTIVE

- ☐ Breast cysts
- ☐ Breast lumps
- ☐ Breast tenderness
- ☐ Ovarian cyst
- ☐ Poor libido (sex drive)
- ☐ Vaginal discharge
- ☐ Vaginal odor
- ☐ Vaginal itch
- ☐ Vaginal pain with sex
- ☐ Vaginal odor
- ☐ Vaginal itch
- ☐ Vaginal pain with sex

Premenstrual:

- ☐ Bloating
- ☐ Breast tenderness
- ☐ Carbohydrate cravings
- ☐ Chocolate cravings
- ☐ Constipation
- ☐ Decreased sleep
- ☐ Diarrhea
- ☐ Fatigue
- ☐ Increased sleep
- ☐ Irritability

Menstrual:

- ☐ Cramps
- ☐ Heavy periods
- ☐ Irregular periods
- ☐ No periods
- ☐ Scanty periods
- ☐ Spotting between

MALE REPRODUCTIVE

- ☐ Discharge from penis
- ☐ Ejaculation problem
- ☐ Genital pain
- ☐ Infertility
- ☐ Impotence
- ☐ Prostate or urinary infection
- ☐ Lumps in testicle
- ☐ Poor libido (sex drive)
- ☐ Strength of erection (1-10)

____

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Rate these areas on a scale from 0 to 10

Energy Level............................	**Low**	0	1	2	3	4	5	6	7	8	9	10	**High**
Anxiety/Worry..........................	**Low**	0	1	2	3	4	5	6	7	8	9	10	**High**
Stress Level..............................	**Low**	0	1	2	3	4	5	6	7	8	9	10	**High**
Sleep Quality............................	**Low**	0	1	2	3	4	5	6	7	8	9	10	**High**
Memory....................................	**Low**	0	1	2	3	4	5	6	7	8	9	10	**High**
Concentration (focus)	**Low**	0	1	2	3	4	5	6	7	8	9	10	**High**
Mood...	**Low**	0	1	2	3	4	5	6	7	8	9	10	**High**
Irritability	**Low**	0	1	2	3	4	5	6	7	8	9	10	**High**
Physical Health........................	**Low**	0	1	2	3	4	5	6	7	8	9	10	**High**
Mental Health..........................	**Low**	0	1	2	3	4	5	6	7	8	9	10	**High**

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READINESS ASSESSMENT

Rate on a scale of 5 (very willing) to 1 (not willing):

In order to improve your health, how willing are you to:

Significantly modify your diet	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Take several nutritional supplements each day	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Keep a record of everything you eat each day	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Modify your lifestyle (e.g., work demands, sleep habits)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Practice a relaxation technique	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Engage in regular exercise	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Have periodic lab tests to assess your progress	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Comments ____________________

____

____

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

How confident are you of your ability to organize and follow through on the above health related activities?

☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

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

____

____

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

At the present time, how supportive do you think the people in your household will be to your implementing the above changes?

☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Comments ____________________

____

____

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

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

☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Comments ____________________

____

____

3-DAY DIETARY INSTRUCTIONS

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 3 consecutive days including one weekend day.

- Describe the food or beverage as accurately as possible e.g., milk- what kind? (whole, 2%, nonfat); toast (whole wheat, white, buttered); chicken (fried, baked, breaded); coffee (decaffeinated with sugar and ½ and 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 one teaspoon of 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 on this form (ex. craving sweets, skipped meal and why, when the meal was at a restaurant, etc.).

- Please note all bowel movements and their consistency (regular, loose, firm, etc.)

Diet Dairy-Day 1

Name: ______________________________ Date: ______________

Daily Exercise (Type of Activity/ Time of Day/ Duration): ______________________

____

Daily Bowel Movements: ______________________________

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Diet Dairy-Day 2

Name: ______________________________ Date: ______________

Daily Exercise (Type of Activity/ Time of Day/ Duration): ______________________________

____

Daily Bowel Movements: ______________________________

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Diet Dairy-Day 3

Name: ______________________________ Date: ______________

Daily Exercise (Type of Activity/ Time of Day/ Duration): ______________________________

____

Daily Bowel Movements: ______________________________

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

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OTHER COMMENTS / QUESTIONS / CONCERNS: ______________________________

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Medical Symptoms Questionnaire

Name________________________________ **Date**__________________________

Rate each of the following symptoms based upon your typical 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 it, effect is *severe*
	3 - *Frequently* have it, effect is *not severe*
	4 - *Frequently* have it, effect is *severe*

HEAD	________	Headaches	
	________	Faintness	
	________	Dizziness	
	________	Insomnia	Total ________
EYES	________	Watery of 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 ________
EARS	________	Itchy ears	
	________	Earaches, ear infections	
	________	Drainage from ear	
	________	Ringing in ears, hearing loss	Total ________
NOSE	________	Stuffy nose	
	________	Sinus problems	
	________	Hay fever	
	________	Sneezing attacks	
	________	Excessive mucus formation	Total ________
MOUTH/ THROAT	________	Chronic coughing	
	________	Gagging, frequent need to clear throat	
	________	Sore throat, hoarseness, loss of voice	
	________	Swollen or discolored tongue, gums, lips	
	________	Canker sores	Total ________

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SKIN	________	Acne	
	________	Hives, rashes, dry skin	
	________	Hair loss	
	________	Flushing, hot flashes	
	________	Excessive sweating	Total ________
HEART	________	Irregular or skipped heartbeat	
	________	Rapid or pounding heartbeat	
	________	Chest pain	Total ________
LUNGS	________	Chest congestion	
	________	Asthma, bronchitis	
	________	Shortness of breath	
	________	Difficulty breathing	Total ________
DIGESTIVE TRACT	________	Nausea, vomiting	
	________	Diarrhea	
	________	Constipation	
	________	Bloated feeling	
	________	Belching, passing gas	
	________	Heartburn	
	________	Intestinal/stomach pain	Total ________
JOINTS/ MUSCLE	________	Pain or aches in joints	
	________	Arthritis	
	________	Stiffness or limitation of movement	
	________	Pain or aches in muscles	
	________	Feeling of weakness or tiredness	Total ________
WEIGHT	________	Binge eating/drinking	
	________	Craving certain foods	
	________	Excessive weight	
	________	Compulsive eating	
	________	Water retention	
	________	Underweight	Total ________

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ENERGY/ ACTIVITY	________	Fatigue, sluggishness	
	________	Apathy, lethargy	
	________	Hyperactivity	
	________	Restlessness	Total _________
MIND	________	Poor memory	
	________	Confusion, poor comprehension	
	________	Poor concentration	
	________	Poor physical coordination	
	________	Difficulty in making decisions	
	________	Stuttering or stammering	
	________	Slurred speech	
	________	Learning disabilities	Total _________
EMOTIONS	________	Mood swings	
	________	Anxiety, fear, nervousness	
	________	Anger, irritability, aggressiveness	
	________	Depression	Total _________
OTHER	________	Frequent illness	
	________	Frequent or urgent urination	
	________	Genital itch or discharge	Total _________
GRAND TOTAL			***TOTAL*** _____________

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Supplements Log

SUPPLEMENT	Supplement Directions	Before Breakfast	With Breakfast	Mid Morning	With Lunch	Mid Afternoon	With Dinner	Before Bedtime

Special Instructions:

Patient Name: ______________________________ Date: ______________________________

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