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Chicago, IL 60611
312/266-8565 voice
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Name_____ Sex: _____ Age: _____ Today's Date_____
Marital Status: ☐ Single ☐ Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widow Children: _____
Occupation: _____ DOB:_____/_____/_____ Height:_____
Your Weight Today _____ Do you consider yourself: ☐ underweight ☐ overweight ☐ just right
Unintentional weight loss or gain of 10 pounds or more in the last three months? ☐ Yes ☐ No
Body composition % or muscle % _____
Symptoms: _____
Aggravating Factors: _____

Are you recovering from a cold or flu? _____ Are you pregnant? _____
Reason for office visit:
_____
_____
Date of last physical exam: _____ Practitioner name and phone number:_____
Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):
_____
Outcome_____
What types of therapy have you tried for this problem(s):
☐ diet modification ☐ fasting ☐ vitamins/minerals ☐ herbs ☐ homeopathy ☐ chiropractic ☐ acupuncture ☐ conventional drugs ☐ other_____
List current health problems for which you are being treated:
_____
Current medications: (prescription or over-the-counter):_____
_____
Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10
Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems):
_____
Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, farmer, miner)?
_____
_____
Do you use: ☐ corrective lenses ☐ hearing aid ☐ medical devices/prosthetics/implants, describe:

Recent changes in your ability to: ☐ see ☐ hear ☐ taste ☐ smell ☐ feel hot/cold sensations
☐ Move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)
Strong like for any of the following flavors: ☐ sour ☐ bitter ☐ sweet ☐ rich/fatty ☐ spicy/pungent ☐ salty
Strong dislike for any of the following flavors: ☐ sour ☐ bitter ☐ sweet ☐ rich/fatty ☐ spicy/pungent ☐ salty
Do you prefer: ☐ warmth (i.e., food, drinks, weather, etc.) ☐ cold (i.e., food, drinks, weather, etc.) ☐ No preference

Is your sleep disturbed at the same time each night? _____ If yes, what time? _____

Time of day you: Feel the most energy or the least symptoms:

☐ 7 a.m.- 9 a.m. ☐ 9 a.m.- 11 a.m. ☐ 11 a.m.- 1 p.m.
☐ 1 p.m.- 3 p.m. ☐ 3 p.m.- 5 p.m. ☐ 5 p.m.- 7 p.m.
☐ 7 p.m.- 9 p.m. ☐ 9 p.m.- 11 p.m. ☐ 11 p.m.- 1 p.m.
☐ 1 a.m.- 3 a.m. ☐ 3 a.m.- 5 a.m. ☐ 5 a.m.- 7 a.m.

Feel the worst or symptoms are aggravated:

☐ 7 a.m.- 9 a.m. ☐ 9 a.m.- 11 a.m. ☐ 11 a.m.- 1 p.m.
☐ 1 p.m.- 3 p.m. ☐ 3 p.m.- 5 p.m. ☐ 5 p.m.- 7 p.m.
☐ 7 p.m.- 9 p.m. ☐ 9 p.m.- 11 p.m. ☐ 11 p.m.- 1 a.m.
☐ 1 a.m.- 3 a.m. ☐ 3 a.m.- 5 a.m. ☐ 5 a.m.- 7 p.m.

Do you experience any of these general symptoms EVERY DAY?

☐ Debilitating fatigue ☐ Shortness of breath ☐ Insomnia ☐ Constipation ☐ Chronic pain/inflammation
☐ Depression ☐ Panic attacks ☐ Nausea ☐ Fecal incontinence ☐ Bleeding
☐ Disinterest in sex ☐ Headaches ☐ Vomiting ☐ Urinary incontinence ☐ Discharge
☐ Disinterest in eating ☐ Dizziness ☐ Diarrhea ☐ Low grade fever ☐ Itching/rash

Of the following statements check which apply:

☐ Over 40 years old
☐ Occasionally or frequently skip meals
☐ Suffer from fatigue
☐ Currently overweight
☐ Have been/am on a low-fat, high-carbohydrate diet
☐ Have fasted
☐ Have been/am on a low calorie diet
☐ Have decreased strength or muscle mass
☐ Underweight with decreased muscle mass
☐ Regular use of over the counter drugs
☐ Perimenopausal or menopausal
☐ Crave sweets or carbohydrates
☐ Crave stimulants such as caffeine or soft drinks
☐ Currently taking prescription drugs
☐ Suffer from a low libido
☐ Suffer from premenstrual syndrome (PMS)
☐ Have triglyceride levels above 150
☐ Suffer from chronic pain
☐ Suffer from headaches
☐ Suffer from joint aches or pains
☐ Suffer from intestinal disturbances
☐ Have cholesterol abnormalities
☐ Have excess body fat
☐ Suffer from infertility
☐ Suffer from chronic asthma
☐ Suffer from allergies
☐ Suffer from high blood pressure
☐ Suffer from osteoarthritis
☐ Suffer from osteoporosis
☐ Suffer from Type II diabetes
☐ Suffer from coronary artery disease
☐ Suffered from a stroke

Balanced Eating Habits – Check Which Apply

☐ Mixed food diet (animal and vegetable sources)
☐ Vegetarian
☐ Vegan
☐ Salt Restriction
☐ Fat Restriction
☐ Starch/carbohydrate restriction
☐ The Zone Diet (40/30/30)
☐ Total calorie restriction

Specific food restriction:

☐ Dairy ☐ Wheat ☐ Eggs ☐ Soy ☐ Corn
☐ All Gluten ☐ Other _____

Servings per day:

Fruits (citrus, melons, etc.)_____
Dark green or deep yellow/orange vegetables_____
Grains (unprocessed)_____
Beans, peas, legumes_____
Dairy, eggs_____
Meat, poultry, fish_____

Frequency of Eating Habits–Check Which Apply

☐ Skip breakfast or other meals_____
☐ Three meals/day
☐ Two meals/day
☐ One meal/day
☐ Graze-small frequent meals (how many/day)_____
☐ Generally eat on the run

Exercise Habits–Check Which Apply

- ☐ 5-7 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 45 min or more duration per workout
- ☐ 30-45 min or more duration per workout
- ☐ Less than 30 min
- ☐ Use of personal trainer
- ☐ Member of fitness club
- ☐ Own exercise equipment
- ☐ Walk: days/week_____
- ☐ Run, jog, jump rope, other aerobics: days/week_____
- ☐ Weight lift: days/week_____
- ☐ Stretch: days/week_____
- ☐ Yoga: days/week _____
- ☐ Other_____ days/week_____

Stimulant Use Habits-Check Which Apply

- ☐ Tobacco:
  - Cigarettes: #/day_____
  - Cigars: #/day_____
  - Pipe: #/day _____
- ☐ Alcohol:
  - Wine: # glasses/day or week_____
  - Liquor: # ounces/day or week_____
  - Beer: # glasses/day or week_____
- ☐ Caffeine:
  - Coffee: # of 6 oz cups/day_____
  - Tea: # of 6 oz cups/day_____
  - Soda w/caffeine: # of cans/day_____
  - Soda w/o caffeine: # of cans/day____
  - Other sources (Red Bull, etc.):_____
- ☐ Water: # glasses/day_____

Supplement Use Habits-Check Which Apply

- ☐ Multivitamin/mineral
- ☐ Vitamin C
- ☐ Vitamin E
- ☐ EPA/DHA
- ☐ GLA (evening primrose)
- ☐ Calcium, source _____
- ☐ Magnesium
- ☐ Zinc
- ☐ Friendly flora (acidophilus)
- ☐ Digestive enzymes
- ☐ Amino Acids
- ☐ CoQ10
- ☐ Antioxidants (lutein, resveritol, etc.)
- ☐ Herbs-teas
- ☐ Herbs-extracts
- ☐ Chinese herbs
- ☐ Ayurvedic herbs
- ☐ Homeopathy
- ☐ Bach flowers
- ☐ Superfoods (bee pollen, phytonutrient blends)
- ☐ Liquid meals (Ensure/Slim Fast)

Other _____

Stress Habits-Check Which Apply

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest):

1 2 3 4 5 6 7 8 9 0

Is your job associated with potentially harmful chemicals, pesticides, radioactivity or solvents? ☐ Y ☐ N

Do you suffer from insomnia/sleep disorders? ☐ Y ☐ N

Do you often abruptly awake from sleep? ☐ Y ☐ N

Do you suffer from depression/mood swings? ☐ Y ☐ N

Medical (Men)

- ☐ Benign Prostate hyperplasia (BPH)
- ☐ Prostate Cancer
- ☐ Decreased Sex Drive
- ☐ Infertility
- ☐ Sexually Transmitted Disease
- ☐ Other_____

_____

_____

Medical (Women)

- ☐ Menstrual Irregularities
- ☐ Endometriosis
- ☐ Infertility
- ☐ Fibrocystic Breasts
- ☐ Fibroids/Ovarian Cysts
- ☐ Premenstrual Syndrome (PMS)
- ☐ Vaginal Infections
- ☐ Decreased Sex Drive
- ☐ Sexually Transmitted Disease
- ☐ Other _____

_____

Age of First Period: _____
Date of Last Gynecological Exam: _____
Mammogram ☐ + ☐ -
Pap ☐ + ☐ -
Form of Birth Control _____
# of Children _____
# of Pregnancies _____

- ☐ C-section
- ☐ Surgical Menopause
- ☐ Menopause

Date of last menstrual cycle _____
Length of cycle _____ days
Interval of time between cycles _____ days
Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty)

_____

Family Health History (Parents/Siblings)

- ☐ Arthritis
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Heart disease
- ☐ Infertility
- ☐ Learning disabilities
- ☐ Mental illness
- ☐ Migraine headaches
- ☐ Neurological disorders (Parkinson's, paralysis)
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Suicide

Other _____

Medical History

- ☐ Arthritis
- ☐ Allergies/hay fever
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Autoimmune disease
- ☐ Blood pressure problems
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chronic fatigue syndrome
- ☐ Carpal tunnel syndrome
- ☐ Cholesterol, elevated
- ☐ Circulatory problems
- ☐ Colitis
- ☐ Dental problems
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticular disease
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Eyes, ears, nose, throat problems
- ☐ Environmental sensitivities
- ☐ Fibromyalgia
- ☐ Food intolerance
- ☐ Gastroesophageal reflux disease
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart disease
- ☐ Infection, chronic
- ☐ Inflammatory bowel disease
- ☐ Irritable bowel disease
- ☐ Kidney or bladder disease
- ☐ Learning disabilities
- ☐ Liver or gall bladder disease (stones)
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological problems (Parkinson's, paralysis)
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Sexually transmitted disease
- ☐ Seasonal affective disorder
- ☐ Skin Problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary tract infections
- ☐ Varicose veins

Other_____

_____