# Intake Form for Dr. Valerie LeComte

Main health problem: *

How did you hear about us? *

**Context of Care Review**

*Successful heath care and preventive medicine are only possible when the physician has a complete understanding if the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires. Your, time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.*

Please tell me the story of your health-when did you start noticing a decline? *

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

What do you hope to achieve by working with me? *

When was the last time you felt well? *

Did something trigger your change in health/symptoms?

What behaviors or lifestyle habits do you currently engage in regularly that you believe support health? *

What behaviors or lifestyle habits do you currently engage in regularly that you believe are making you feel worse or are self destructive? *

What do you love to do?

How often do you do these things?

**Current Living Situation**

Highest Education Level: *

Occupational status: *

Marital status: *

Name of spouse:

Years married:

Spouse's age:

Spouse's occupation:

Spouse's education level:

Spouse's present health:

Total number of children:

Names and ages of children:

Who currently lives in your home?

Prior marriage(s)? ☐ Yes ☐ No

If yes, provide date and length of marriage(s):

Are there currently any significant marital stressors? ☐ Yes ☐ No

If yes, briefly explain:

Have you served in the military? ☐ Yes ☐ No

If yes, specify what branch and when?

Have you ever been accused or convicted of any crime? ☐ Yes ☐ No

If yes, please explain in detail the nature of the crime or accusation:

**Childhood/Family History**

Where were you born? _____

Was your birth: ☐ Normal ☐ Premature ☐ Long Labor ☐ Complications ☐ Vaginal delivery ☐ C-section

Were you: ☐ breast fed ☐ bottle fed

When pregnant with you, did your mother: ☐ smoke tobacco ☐ use recreational drugs ☐ drink alcohol ☐ use other medications

Did you begin walking and talking: ☐ On time ☐ Early ☐ Late ☐ Do no know

List any traumatic event(s) or abusive situation(s) that occurred during your childhood:

List any significant accidents, illnesses, or injuries that occurred during your childhood:

Did you experience any of the following childhood illnesses (birth to 12)

☐ ADD (attention deficit disorder)
☐ Asthma
☐ Bronchitis
☐ Congenital Problems
☐ Ear infections
☐ Frequent colds or flu
☐ Frequent headaches
☐ Jaundice
☐ Mumps
☐ Pneumonia
☐ Seasonal allergies
☐ Skin disorders
☐ Strep infections
☐ Tonsillitis
☐ Upset stomach, digestive problems
☐ Measles

Were you exposed to second hand smoke as a child? ☐ Yes ☐ No

Did you have alcoholic parents ☐ Yes ☐ No

How would you characterize your family life growing up?

Were you adopted? ☐ Yes ☐ No

If yes, at what age? _____

*Father*

If living: age and health:

If deceased: age, year, and cause of death:

Occupation: _____

Relationship: ☐ Distant ☐ Conflicted ☐ Warm ☐ Very Close

*Mother*

If living: age and health:

If deceased: age, year, and cause of death:

Occupation: _____

Relationship: ☐ Distant ☐ Conflicted ☐ Warm ☐ Very Close

Parents' marital status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Names of brother(s)/sister(s), ages and relationship (None, Distant, Conflicted, Warm or Very Close):

What is your family heritage?

**Personal HIstory**

Please list your strengths:

Are you currently receiving healthcare? ☐ Yes ☐ No

If yes, where and from whom?

If no, when and where did you last receive healthcare?

Do you have any known contagious diseases at this time? ☐ Yes ☐ No

If yes, what?

What are your most important health problems? Including date of onset, severity/frequency, treatment approach, and success. List in order of importance:

Have you had to miss work in the past year because of health problems? If so, to what extent?

Was there any event or action that you or others think that might have contributed to your symptoms (be as detailed as possible)?

List any accidents, illnesses injuries, hospitalizations/surgeries or imaging (X-ray, CAT scan, MRI etc):

| | | | |
|---|---|---|---|
| Have you ever been diagnosed with any of these Gastrointestinal conditions | ☐ Irritable bowel syndrome | ☐ Inflammatory bowel disease | ☐ Crohns |
| | | | ☐ Ulcerative Colitis |
| | ☐ Gastritis or Peptic Ulcer Disease | ☐ GERD (reflux) | ☐ Celiac Disease |
| | | ☐ Gallstones | ☐ Hepatitis |
| | ☐ Fatty Liver | ☐ Pancreatitis | |
| Have you ever been diagnosed with any of these Cardiovascular conditions? | ☐ Heart attack | ☐ Other heart disease | ☐ Stroke |
| | ☐ High cholesterol | ☐ Arrhythmia (irregular heartbeat) | ☐ Hypertension |
| | | | ☐ Rheumatic Heart Disease |
| | ☐ Mitral Valve Prolapse | ☐ Congestive Heart Failure | |
| Have you ever been diagnosed with any of these Metabolic/Endocrine conditions? | ☐ Type 1 Diabetes | ☐ Type 2 Diabetes | ☐ Hypoglycemia |
| | ☐ Metabolic Syndrome | ☐ Insulin Resistance or pre-diabetes | ☐ Hypothyroidism (low thyroid) |
| | ☐ Hyperthyroidism (high thyroid) | ☐ Endocrine problems | ☐ PCOS polycystic ovarian syndrome |
| | ☐ Infertility | ☐ Weight gain | ☐ Weight loss |
| | ☐ Frequent weight fluctuations | ☐ Bulimia | ☐ Anorexia |
| | | ☐ Binge eating disorder | ☐ Any eating disorder |
| Have you ever been diagnosed with any of these Cancers? | ☐ Lung | ☐ Breast | ☐ Colon |
| | ☐ Ovarian | ☐ Prostate | ☐ Skin |
| | ☐ Thyroid | | |
| Have you ever been diagnosed with any of these Genitourinary conditions? | ☐ Kidney stones | ☐ Gout | ☐ Interstitial cystitis |
| | ☐ Frequent UTIs | ☐ Frequent yeast infections | ☐ Erectile or sexual dysfunction |
| | ☐ STDs | | |
| Have you ever been diagnosed with any of these Musculoskeletal conditions? | ☐ Ostoarthritis | ☐ Fibromyalgia | ☐ Chronic pain |
| Have you ever been diagnosed with any of these inflammatory/autoimmune disorders? | ☐ Chronic fatigue syndrome | ☐ Lupus | ☐ Rheumatoid arthritis |
| | ☐ Immune deficiency disease | ☐ Other autoimmune disorder | ☐ Herpes-genital |
| | | | ☐ Severe infectious disease |
| | ☐ Poor immune function (frequent infections) | ☐ Food allergies | ☐ Environmental allergies |
| | | ☐ Multiple Chemical sensitivities | ☐ Latex allergy |
| Have you ever been diagnosed with any of these respiratory conditions? | ☐ Asthma | ☐ Chronic Sinusitis | ☐ Bronchitis |
| | ☐ Emphysema | ☐ COPD | ☐ Pneumonia |
| | ☐ Tuberculosis | ☐ Sleep apnea | |
| Have you ever been diagnosed with any of these skin conditions? | ☐ Eczema | ☐ Psoriasis | ☐ Acne |
| | ☐ Melanoma | | |

Have you ever been diagnosed with any of these Neurological or Psychiatric conditions?

- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Schizophrenia
- ☐ Headaches
- ☐ Migraines
- ☐ ADD/ADHD
- ☐ Autism
- ☐ Mild Cognitive Impairment
- ☐ Memory problems
- ☐ Parkinson's disease
- ☐ Multiple sclerosis
- ☐ ALS
- ☐ Seizures
- ☐ Meningitis
- ☐ Alzheimers

Have you ever been diagnosed with any of these miscellaneous conditions?

- ☐ Anemia
- ☐ Chickenpox
- ☐ German measles
- ☐ Measles
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Whooping cough

**General**

Height: _____

Weight: _____

Weight one year ago: _____

Are you happy with your weight? And if no what would you change?

When during the day is your energy the best? _____

Worst?

Main interests and hobbies:

Watch T.V.? ☐ Yes ☐ No

If yes, how many hours?

Read? ☐ Yes ☐ No

If yes, what and how often?

Do you use any illegal drugs including marijuana? ☐ Yes ☐ No

If yes, what and how often?

Have you ever been in treatment for alcohol or drug use? ☐ Yes ☐ No

If yes, please explain:

Do you use tobacco? ☐ Yes ☐ No

If yes, how much?

Do you drink alcohol? ☐ Yes ☐ No

If yes, please specify: ☐ Rarely ☐ Occasionally ☐ Daily ☐ Past

How many drinks do you usually have? _____

Which types of exercise do you participate in weekly? Include type, number of sessions per week, and duration.

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

List problems that limit physical activity.

Do you feel unusually fatigued after activity? ☐ Yes ☐ No

**Current Medications and Supplements**

*Are you hypersensitive or allergic to:*

Any drugs/medications?

Any foods:

Any environmental chemicals?

List all medications (from drugstore or prescription) you are taking and dosages if known:

List all supplements are taking and dosages if known:

**Nutrition**

*Please list what you eat during a typical day and at what time:*

Breakfast:

Lunch:

Dinner:

Snacks:

Drinks:

Do you use caffeine products (soda, coffee, tea, etc)? ☐ Yes ☐ No

If yes, how much? _____

What foods/drinks do you regularly crave?

Do you cook for yourself/your family? ☐ Yes ☐ No

How many meals per day do you usually eat? _____

Do you avoid any certain types of foods? ☐ Yes ☐ No

Explain if answer is yes.

Do you grocery shop? ☐ Yes ☐ No

Do you read food labels? ☐ Yes ☐ No

How many meals do you eat out per week? _____

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

| | | |
|---|---|---|
| ☐ Erratic eating pattern | ☐ Fast eater | ☐ Late night eating |
| ☐ Dislike healthy food | ☐ Significant other/family dislikes healthy foods | ☐ Eat more than 50% of meals out |
| ☐ Travel frequently | ☐ Non-availability of healthy foods | ☐ Do not plan meals or menus |
| ☐ Reliance on convenience | ☐ Poor snack choices | ☐ Time constraints |
| ☐ Love to eat | ☐ Eat because I have to | ☐ Have a negative relationship with food |
| ☐ Don't care to cook | ☐ Emotional eater | ☐ Confused about nutrition advice |

The most important thing you think you should change about your diet to improve your health is

Do you currently follow a special diet or nutritional program? ☐ Yes ☐ No

Tell me more if you follow a certain diet or if there is anything else I should know

Does skipping meals greatly affect your symptoms? ☐ Yes ☐ No

Has there ever been a food that you have craved or binged on over a period of time? ☐ Yes ☐ No

If yes then what foods? _____

**Adult Mental Health**

Have you received previous counseling? ☐ Yes ☐ No

Please specify: ☐ Psychiatrist ☐ Psychologist ☐ School Counselor ☐ Clergy

If yes, when and why?

Was it helpful?

*If yes:*

Have you ever been admitted to a psychiatric hospital? ☐ Yes ☐ No

If yes, when and where?

Have you ever had thoughts of, planned, or attempted suicide? ☐ Yes ☐ No

If yes, please explain:

Are you currently having any thoughts of harming yourself? ☐ Yes ☐ No

Are you currently having any thoughts of harming someone else? ☐ Yes ☐ No

Have you ever taken psychiatric medications? ☐ Yes ☐ No

If yes, please list (include problem, medication, dose, start/stop date, side effects and response):

**Spiritual Orientation**

Please list your spiritual orientation or religion:

How active are these beliefs in your life? ☐ Very active ☐ Somewhat active ☐ Not very active

If you like, share some of your thoughts on your spiritual practice/religion:

How much do your beliefs help you when times are difficult?

**Environmental Exposures**

Have you ever lived near a refinery, polluted area or in a home with leaded paint? ☐ Yes ☐ No

If yes, what sort of pollution where you exposed to?

Have you ever lived in a house that had new carpeting, paint, cabinets, or any other refurbishing that seemed to affect your health?

Do you seem particularly sensitive to ro perfumes, gasoline or other vapors?

Do you spray pesticides, herbicides or other chemicals around your home? ☐ Yes ☐ No

What year was your home/apartment built? _____

Water: ☐ City ☐ Well

H20 Purification System: ☐ Yes ☐ No

Air Purifiers: ☐ Yes ☐ No

Type of Heat: ☐ Gas ☐ Electric

If other, please describe:

Do you live near any bodies of water? ☐ Swamp ☐ River ☐ Ocean ☐ None

If other, please describe:

Do you live near any of the following: ☐ High Voltage Power Lines ☐ Refinery ☐ Woods ☐ Industrial area

Describe your bedroom (curtains, blinds, carpet, feather pillows, etc)

Flooring in other rooms you spend time in:

**Other**

Please list any other concerns or comments:

## Health History

*For the following section, please read the question and select from the following responses: Yes, No, or In Past. If No, move on to the next question. If Yes or In past, please specify the severity in the "Others" box, choosing from the following: Mild, Moderate, or Severe.*

**Endocrine**

| | | | |
|---|---|---|---|
| Do you sleep well? | ☐ Yes | ☐ No | ☐ In Past |
| Average 6-8 hours? | ☐ Yes | ☐ No | ☐ In Past |
| Awake rested? | ☐ Yes | ☐ No | ☐ In Past |
| Cannot stay asleep? | ☐ Yes | ☐ No | ☐ In Past |
| Cannot fall asleep? | ☐ Yes | ☐ No | ☐ In Past |
| Insomnia? | ☐ Yes | ☐ No | ☐ In Past |
| Afternoon Fatigue? | ☐ Yes | ☐ No | ☐ In Past |
| Wake up tired even after 6 or more hours of sleep? | ☐ Yes | ☐ No | ☐ In Past |

| | | | |
|---|---|---|---|
| Tired or sluggish? | ☐ Yes | ☐ No | ☐ In Past |
| Dizziness when standing up quickly? | ☐ Yes | ☐ No | ☐ In Past |
| Hyperthyroid/Hypothyroid? | ☐ Yes | ☐ No | ☐ In Past |
| Hypoglycemia? | ☐ Yes | ☐ No | ☐ In Past |
| Difficulty losing weight? | ☐ Yes | ☐ No | ☐ In Past |
| Gain weight easily? | ☐ Yes | ☐ No | ☐ In Past |
| Feel cold - hands, feet, all over? | ☐ Yes | ☐ No | ☐ In Past |
| Thinning of hair on scalp, face, or genitals or excessive falling hair? | ☐ Yes | ☐ No | ☐ In Past |
| Under high amounts of stress? | ☐ Yes | ☐ No | ☐ In Past |

**Neurologic**

| | | | |
|---|---|---|---|
| Seizures? | ☐ Yes | ☐ No | ☐ In Past |
| Muscle weakness? | ☐ Yes | ☐ No | ☐ In Past |
| Loss of memory | ☐ Yes | ☐ No | ☐ In Past |
| Vertigo or dizziness? | ☐ Yes | ☐ No | ☐ In Past |
| Paralysis? | ☐ Yes | ☐ No | ☐ In Past |
| Numbness or Tingling? | ☐ Yes | ☐ No | ☐ In Past |
| Easily Stressed? | ☐ Yes | ☐ No | ☐ In Past |
| Loss of balance? | ☐ Yes | ☐ No | ☐ In Past |

**Neck**

| | | | |
|---|---|---|---|
| Pain or stiffness in neck? | ☐ Yes | ☐ No | ☐ In Past |
| Difficulty swallowing? | ☐ Yes | ☐ No | ☐ In Past |
| Lumps in neck? | ☐ Yes | ☐ No | ☐ In Past |

| | | | |
|---|---|---|---|
| Goiter? | ☐ Yes | ☐ No | ☐ In Past |

**Immune**

| | | | |
|---|---|---|---|
| Reactions to immunizations? | ☐ Yes | ☐ No | ☐ In Past |
| Chronically swollen glands? | ☐ Yes | ☐ No | ☐ In Past |
| Slow would healing? | ☐ Yes | ☐ No | ☐ In Past |
| Chronic fatigue syndrome? | ☐ Yes | ☐ No | ☐ In Past |
| Chronic infections? | ☐ Yes | ☐ No | ☐ In Past |
| Night sweats? | ☐ Yes | ☐ No | ☐ In Past |

**Ears**

| | | | |
|---|---|---|---|
| Ringing in ears? | ☐ Yes | ☐ No | ☐ In Past |
| Ear aches? | ☐ Yes | ☐ No | ☐ In Past |
| Impaired hearing? | ☐ Yes | ☐ No | ☐ In Past |

**Eyes**

| | | | |
|---|---|---|---|
| Impaired vision? | ☐ Yes | ☐ No | ☐ In Past |
| Cataracts? | ☐ Yes | ☐ No | ☐ In Past |
| Glaucoma? | ☐ Yes | ☐ No | ☐ In Past |
| Tearing or dryness? | ☐ Yes | ☐ No | ☐ In Past |
| Spots in vision? | ☐ Yes | ☐ No | ☐ In Past |
| Color blindness? | ☐ Yes | ☐ No | ☐ In Past |
| Eye pain or strain? | ☐ Yes | ☐ No | ☐ In Past |

**Head?**

| | | | |
|---|---|---|---|
| Headaches? | ☐ Yes | ☐ No | ☐ In Past |
| Migraines? | ☐ Yes | ☐ No | ☐ In Past |
| Head injury? | ☐ Yes | ☐ No | ☐ In Past |
| Jaw or TMJ problems? | ☐ Yes | ☐ No | ☐ In Past |

**Nose and Sinus**

| | | | |
|---|---|---|---|
| Stuffiness? | ☐ Yes | ☐ No | ☐ In Past |
| Sinus problems? | ☐ Yes | ☐ No | ☐ In Past |
| Nose bleeds? | ☐ Yes | ☐ No | ☐ In Past |
| Nasal polyps? | ☐ Yes | ☐ No | ☐ In Past |
| Hay fever? | ☐ Yes | ☐ No | ☐ In Past |
| Loss of smell? | ☐ Yes | ☐ No | ☐ In Past |

**Mouth and Throat**

| | | | |
|---|---|---|---|
| Teeth grinding? | ☐ Yes | ☐ No | ☐ In Past |
| Gum problems? | ☐ Yes | ☐ No | ☐ In Past |
| Jaw clicks? | ☐ Yes | ☐ No | ☐ In Past |
| Frequent sore throat? | ☐ Yes | ☐ No | ☐ In Past |
| Copious saliva? | ☐ Yes | ☐ No | ☐ In Past |
| Sore tongue or lips? | ☐ Yes | ☐ No | ☐ In Past |
| Hoarseness? | ☐ Yes | ☐ No | ☐ In Past |

**Skin**

| | | | |
|---|---|---|---|
| Eczema or hives? | ☐ Yes | ☐ No | ☐ In Past |
| Dryness of skin or scalp? | ☐ Yes | ☐ No | ☐ In Past |
| Dry or flaky skin and/or scalp? | ☐ Yes | ☐ No | ☐ In Past |
| Itching? | ☐ Yes | ☐ No | ☐ In Past |
| Rashes? | ☐ Yes | ☐ No | ☐ In Past |
| Acne/boils? | ☐ Yes | ☐ No | ☐ In Past |
| Change in skin color? | ☐ Yes | ☐ No | ☐ In Past |
| Lumps or bumps on skin? | ☐ Yes | ☐ No | ☐ In Past |
| Perpetual hair loss? | ☐ Yes | ☐ No | ☐ In Past |
| Weak nails? | ☐ Yes | ☐ No | ☐ In Past |

**Respiratory/Cardiac**

| | | | |
|---|---|---|---|
| Shortness of breath? | ☐ Yes | ☐ No | ☐ In Past |
| Pain in breathing? | ☐ Yes | ☐ No | ☐ In Past |
| Cough? | ☐ Yes | ☐ No | ☐ In Past |
| Coughing up blood? | ☐ Yes | ☐ No | ☐ In Past |
| Asthma? | ☐ Yes | ☐ No | ☐ In Past |
| Wheezing? | ☐ Yes | ☐ No | ☐ In Past |
| Bronchitis? | ☐ Yes | ☐ No | ☐ In Past |
| Emphysema? | ☐ Yes | ☐ No | ☐ In Past |
| Shortness of breath when lying down? | ☐ Yes | ☐ No | ☐ In Past |
| Hearth palpitations? | ☐ Yes | ☐ No | ☐ In Past |
| Inward trembling? | ☐ Yes | ☐ No | ☐ In Past |

**Musculoskeletal**

| | | | |
|---|---|---|---|
| Muscle spasms or cramps? | ☐ Yes | ☐ No | ☐ In Past |
| Joint pain or stiffness? | ☐ Yes | ☐ No | ☐ In Past |
| Arthritis? | ☐ Yes | ☐ No | ☐ In Past |
| Sciatica? | ☐ Yes | ☐ No | ☐ In Past |
| Weakness? | ☐ Yes | ☐ No | ☐ In Past |
| Broken bones? | ☐ Yes | ☐ No | ☐ In Past |

**Blood**

| | | | |
|---|---|---|---|
| Varicose veins? | ☐ Yes | ☐ No | ☐ In Past |
| Anemia? | ☐ Yes | ☐ No | ☐ In Past |
| Easy bleeding or bruising? | ☐ Yes | ☐ No | ☐ In Past |
| Cold hands/feet? | ☐ Yes | ☐ No | ☐ In Past |

**Gastrointestinal**

| | | | |
|---|---|---|---|
| Crave sweets during the day? | ☐ Yes | ☐ No | ☐ In Past |

| | | | |
|---|---|---|---|
| Irritable if meals are missed? | ☐ Yes | ☐ No | ☐ In Past |
| Depend on coffee to keep yourself going or started? | ☐ Yes | ☐ No | ☐ In Past |
| Get lightheaded if meals are missed? | ☐ Yes | ☐ No | ☐ In Past |
| Eating relieves fatigue? | ☐ Yes | ☐ No | ☐ In Past |
| Change in thirst? | ☐ Yes | ☐ No | ☐ In Past |
| Change in appetitive? | ☐ Yes | ☐ No | ☐ In Past |
| Greasy or high fat foods cause distress? | ☐ Yes | ☐ No | ☐ In Past |
| Indigestion and fullness lasts 2-4 hours after eating? | ☐ Yes | ☐ No | ☐ In Past |
| Heartburn? | ☐ Yes | ☐ No | ☐ In Past |
| Abdominal pain or cramps? | ☐ Yes | ☐ No | ☐ In Past |
| Excessive belching, burping, or bloating? | ☐ Yes | ☐ No | ☐ In Past |
| Gas immediately following meals? | ☐ Yes | ☐ No | ☐ In Past |
| Use antacids? | ☐ Yes | ☐ No | ☐ In Past |
| Offensive breath? | ☐ Yes | ☐ No | ☐ In Past |
| Nausea/vomiting? | ☐ Yes | ☐ No | ☐ In Past |
| Ulcer? | ☐ Yes | ☐ No | ☐ In Past |
| Gallbladder disease? | ☐ Yes | ☐ No | ☐ In Past |
| History of gallbladder attacks or stones? | ☐ Yes | ☐ No | ☐ In Past |
| Have you ever had your gallbladder removed? | ☐ Yes ☐ No | | |
| Liver disease? | ☐ Yes | ☐ No | ☐ In Past |
| Hemorrhoids? | ☐ Yes | ☐ No | ☐ In Past |

| | | | |
|---|---|---|---|
| Pancreatitis? | ☐ Yes | ☐ No | ☐ In Past |
| Difficulty digesting fruits and vegetables; undigested foods found in stools? | ☐ Yes | ☐ No | ☐ In Past |
| Feeling that bowels do not empty completely? | ☐ Yes | ☐ No | ☐ In Past |
| Diarrhea? | ☐ Yes | ☐ No | ☐ In Past |
| Constipation? | ☐ Yes | ☐ No | ☐ In Past |
| Alternating diarrhea and constipation? | ☐ Yes | ☐ No | ☐ In Past |
| Hard, dry, or small stool? | ☐ Yes | ☐ No | ☐ In Past |
| Black stools? | ☐ Yes | ☐ No | ☐ In Past |
| Blood in stools? | ☐ Yes | ☐ No | ☐ In Past |
| Use laxatives frequently? | ☐ Yes | ☐ No | ☐ In Past |
| Bowel movements: How often? | _____ | | |
| Is this a change? | ☐ Yes ☐ No | | |

**Mental/Emotional**

| | | | |
|---|---|---|---|
| Treated for memory problems? | ☐ Yes | ☐ No | ☐ In Past |
| History of abuse? | ☐ Yes | ☐ No | ☐ In Past |
| Tension? | ☐ Yes | ☐ No | ☐ In Past |
| Depression? | ☐ Yes | ☐ No | ☐ In Past |
| Anxiety or nervousness? | ☐ Yes | ☐ No | ☐ In Past |
| Poor concentration? | ☐ Yes | ☐ No | ☐ In Past |
| Mood swings? | ☐ Yes | ☐ No | ☐ In Past |
| Considered suicided? | ☐ Yes | ☐ No | ☐ In Past |
| Attempted suicide? | ☐ Yes | ☐ No | ☐ In Past |

| | | | |
|---|---|---|---|
| Treated for drug dependence? | ☐ Yes | ☐ No | ☐ In Past |
| Behavioral issues? | ☐ Yes | ☐ No | ☐ In Past |
| Sexuality issues? | ☐ Yes | ☐ No | ☐ In Past |
| Self esteem/ growth issues? | ☐ Yes | ☐ No | ☐ In Past |
| Mental sluggishness? | ☐ Yes | ☐ No | ☐ In Past |

**Urinary**

| | | | |
|---|---|---|---|
| Increased frequency of urination? | ☐ Yes | ☐ No | ☐ In Past |
| Inability to hold urine? | ☐ Yes | ☐ No | ☐ In Past |
| Pain in urination? | ☐ Yes | ☐ No | ☐ In Past |
| Frequency at night? | ☐ Yes | ☐ No | ☐ In Past |
| Frequent UTI's? | ☐ Yes | ☐ No | ☐ In Past |
| Kidney stones? | ☐ Yes | ☐ No | ☐ In Past |

**Female Reproductive**

Age of first menses? _____

Age of last menses? (if menopausal) _____

Length of cycle (in days) _____

Duration of menses (in days) _____

| | | | |
|---|---|---|---|
| Are your cycles regular? | ☐ Yes | ☐ No | ☐ In Past |
| Bleeding between cycles? | ☐ Yes | ☐ No | ☐ In Past |
| Clotting? | ☐ Yes | ☐ No | ☐ In Past |
| Scanty blood flow? | ☐ Yes | ☐ No | ☐ In Past |
| Heavy blood flow? | ☐ Yes | ☐ No | ☐ In Past |
| Pain and cramping during periods? | ☐ Yes | ☐ No | ☐ In Past |
| Pelvic pain during menses? | ☐ Yes | ☐ No | ☐ In Past |

| | | | |
|---|---|---|---|
| Irritable and depressed during menses? | ☐ Yes | ☐ No | ☐ In Past |
| Acne breakouts? | ☐ Yes | ☐ No | ☐ In Past |
| Facial hair growth? | ☐ Yes | ☐ No | ☐ In Past |
| Hair loss/ thinning? | ☐ Yes | ☐ No | ☐ In Past |
| Endometriosis? | ☐ Yes | ☐ No | ☐ In Past |
| Ovarian cysts? | ☐ Yes | ☐ No | ☐ In Past |
| Vaginal odor? | ☐ Yes | ☐ No | ☐ In Past |
| Vaginal discharge? | ☐ Yes | ☐ No | ☐ In Past |
| Date of last PAP? | _____ | | |
| Abnormal PAP? | ☐ Yes | ☐ No | ☐ In Past |
| Are you sexually active? | ☐ Yes | ☐ No | ☐ In Past |
| Sexual orientation? | _____ | | |
| Increased sex drive? | ☐ Yes | ☐ No | ☐ In Past |
| Diminished sex drive? | ☐ Yes | ☐ No | ☐ In Past |
| Birth control? (if yes or in past, please specify in "other") | ☐ Yes | ☐ No | ☐ In Past |
| Gonorrhea/Chlamydia? | ☐ Yes | ☐ No | ☐ In Past |
| Herpes? | ☐ Yes | ☐ No | ☐ In Past |
| Genital Warts? | ☐ Yes | ☐ No | ☐ In Past |
| Syphilis? | ☐ Yes | ☐ No | ☐ In Past |
| Difficulty conceiving? | ☐ Yes | ☐ No | ☐ In Past |
| Number of pregnancies? | _____ | | |
| Number of live births? | _____ | | |
| Number of miscarriages? | _____ | | |
| Number of abortions? | _____ | | |

| | | | |
|---|---|---|---|
| Do you do self breast exams? | ☐ Yes | ☐ No | ☐ In Past |
| Breast pain/tenderness? | ☐ Yes | ☐ No | ☐ In Past |
| Breast lumps? | ☐ Yes | ☐ No | ☐ In Past |
| Nipple discharge? | ☐ Yes | ☐ No | ☐ In Past |
| Menopausal symptoms? | ☐ Yes | ☐ No | ☐ In Past |

Other symptoms?

**Male Reproductive**

| | | | |
|---|---|---|---|
| Are you sexually active? | ☐ Yes | ☐ No | ☐ In Past |

Sexual orientation?

| | | | |
|---|---|---|---|
| Increased sex drive? | ☐ Yes | ☐ No | ☐ In Past |
| Diminished sex drive? | ☐ Yes | ☐ No | ☐ In Past |
| Decrease in libido? | ☐ Yes | ☐ No | ☐ In Past |
| Decrease in spontaneous morning erections? | ☐ Yes | ☐ No | ☐ In Past |
| Decrease in fullness of erections? | ☐ Yes | ☐ No | ☐ In Past |
| Premature ejaculation? | ☐ Yes | ☐ No | ☐ In Past |
| Genital Warts? | ☐ Yes | ☐ No | ☐ In Past |
| Chlamydia/Gonorrhea? | ☐ Yes | ☐ No | ☐ In Past |
| Herpes? | ☐ Yes | ☐ No | ☐ In Past |
| Impotence? | ☐ Yes | ☐ No | ☐ In Past |
| Discharge or sores? | ☐ Yes | ☐ No | ☐ In Past |
| Testicular masses? | ☐ Yes | ☐ No | ☐ In Past |
| Testicular pain? | ☐ Yes | ☐ No | ☐ In Past |
| Prostate disease? | ☐ Yes | ☐ No | ☐ In Past |
| Hernias? | ☐ Yes | ☐ No | ☐ In Past |

Readiness Assessment

| In order to improve you health, score how willing you are to make the following changes on a scale of 1 (unwilling) to 5 (very willing) | |
|---|---|
| Modify your diet | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| Take nutritional supplements if needed | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| Modify your lifestyle | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| Practice relaxation techniques | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| Engage in regular exercise | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| Have periodic lab tests to assess progress | ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 |
| How much ongoing support and contact would be helpful to you as you implement your personal health program? | |
| Anything else you want me to know? | |