# KELLY K MCCANN, MD

INTERNAL MEDICINE  INTEGRATIVE MEDICINE  PEDIATRICS

## GENERAL INFORMATION

Name: *First:* *Middle:* *Last:*

Preferred Name:

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Date of Birth:

Age:

SS#:

Gender: ○ Male ○ Female

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Genetic Background: ☐ African ☐ European ☐ Native American ☐ Mediterranean

*(Check all that apply)* ☐ Asian ☐ Ashkenazi ☐ Middle Eastern ☐

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Highest Education Level: ○ High School ○ Some College ○ Graduate ○ Post-Graduate

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Job Title:

Nature of Business:

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Primary Address: *Number, Street:* *Apt. No.:*

*City:* *State:* *Zip:*

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Primary Address: *Number, Street:* *Apt. No.:*

*City:* *State:* *Zip:*

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Home Phone 1:

Home Phone 2:

Work Phone:

Cell Phone:

Fax Phone:

E-Mail:

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Emergency Contact: *Name:* *Phone Number:*

*Address:* *Apt No:*

*City:* *State:* *Zip:*

Physician: *Name:* *Phone Number:*

*Fax:*

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Referred By: ○ Book ○ Website

○ Media ○ Friend or Family Member ○ Other:

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# Medical Questionnaire

## 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 current and ongoing problems in order of priority:

| | | | | | Success | | |
|---|---|---|---|---|---|---|---|
| Describe Problem | Mild | Moderate | Severe | Prior Treatment / Approach | Excellent | Good | Fair |
| *Example: Post Nasal Drip* | ○ | ◉ | ○ | *Elimination Diet* | ◉ | ○ | ○ |
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## MEDICAL HISTORY:

☑ = Past Condition ☑ = Ongoing Condition

**DISEASE / DIAGNOSIS / CONDITIONS** *Check appropriate box and provide date of onset*

### 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) _____
- ❑ ❑ Rheumatic Fever _____
- ❑ ❑ 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 _____

### GENITAL AND URINARY SYSTEMS

- ❑ ❑ Kidney Stones _____
- ❑ ❑ Gout _____
- ❑ ❑ Interstitial Cystitis _____
- ❑ ❑ Frequent Urinary Tract Infections _____
- ❑ ❑ Frequent Yeast Infections _____
- ❑ ❑ Erectile Dysfunction or Sexual Dysfunction _____
- ❑ ❑ Other _____

### MUSCULOSKELETAL / PAIN

- ❑ ❑ Osteoarthritis _____
- ❑ ❑ Fibromyalgia _____
- ❑ ❑ Chronic Pain _____
- ❑ ❑ Other _____

### INFLAMATORY / AUTOIMMUNE

- ❑ ❑ Chronic Fatigue Syndrome _____
- ❑ ❑ Autoimmune Disease _____
- ❑ ❑ Rheumatoid Arthritis _____
- ❑ ❑ Lupus SLE _____
- ❑ ❑ Immune Deficiency Disease _____
- ❑ ❑ Poor Immune Function (frequent infections) _____
- ❑ ❑ Food Allergies _____
- ❑ ❑ Environmental Allergies _____
- ❑ ❑ Multiple Chemical Sensitivities _____
- ❑ ❑ Latex Allergy _____
- ❑ ❑ Other _____

### RESPIRATORY DISEASES

- ❑ ❑ Asthma _____
- ❑ ❑ Chronic Sinusitis _____
- ❑ ❑ Bronchitis _____
- ❑ ❑ Emphysema _____
- ❑ ❑ Pneumonia _____
- ❑ ❑ Tuberculosis _____
- ❑ ❑ Sleep Apnea _____
- ❑ ❑ Other _____

### SKIN DISEASES _____

- ❑ ❑ Eczema _____
- ❑ ❑ Psoriasis _____
- ❑ ❑ Acne _____
- ❑ ❑ Melanoma _____
- ❑ ❑ Skin Cancer _____
- ❑ ❑ Other _____

## MEDICAL HISTORY (CONTINUED):

☑ = Past Condition ☑ = Ongoing Condition

## NEUROLOGIC / MOOD

- ❑ ❑ Depression _____
- ❑ ❑ Anxiety _____
- ❑ ❑ Bipolar Disorder _____
- ❑ ❑ Schizophrenia _____
- ❑ ❑ Headaches _____
- ❑ ❑ Migraines _____
- ❑ ❑ ADD / ADHD _____
- ❑ ❑ Other _____
- ❑ ❑ Autism _____
- ❑ ❑ Mild Cognitive Impairment _____
- ❑ ❑ Memory Problems _____
- ❑ ❑ Parkinson's Disease _____
- ❑ ❑ Multiple Sclerosis _____
- ❑ ❑ ALS _____
- ❑ ❑ Seizures _____
- ❑ ❑ Other _____

**PREVENTIVE TESTS AND DATE OF LAST TEST**

*Check box if yes and provide date*

- ❑ ❑ Full Physician Exam _____
- ❑ ❑ Bone Density _____
- ❑ ❑ Colonoscopy _____
- ❑ ❑ Cardiac Stress Test _____
- ❑ ❑ EBT Heart Scan _____
- ❑ ❑ EKG _____
- ❑ ❑ Hemoccult Test-stool test for blood _____
- ❑ ❑ MRI _____
- ❑ ❑ CT Scan _____
- ❑ ❑ Upper Endoscopy _____
- ❑ ❑ Upper GI Series_____
- ❑ ❑ 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 _____

INJURIES

*Check box if yes*

- ❑ Back Injury
- ❑ Neck Injury
- ❑ Other
- ❑ Head Injury
- ❑ Broken Bones

HOSPITALIZATIONS

| Date | Reason |
|---|---|
| | |
| | |
| | |
| | |

COMMENTS

_____

_____

_____

_____

_____

## GYNECOLOGIC HISTORY *(for women only)*

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

❑ Pregnancies _____ ❑ Caesarean _____ ❑ Vaginal Deliveries _____
❑ Miscarriages _____ ❑ Abortions _____ ❑ Living Children: _____
❑ Post Partum Depression _____ ❑ Toxemia _____ ❑ General 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
Has your period ever skipped? ❍ No ❍ Yes If yes, for How Long? _____
Last Menstrual Period: _____
Use of hormonal contraception such as: ❑ Birth Control Pills ❑ Patch ❑ Nuva Ring How Long? _____
Do you use contraception? ❍ No ❍ Yes ❑ Condom ❑ Diaphragm ❑ IUD ❑ Partner Vasectomy

**WOMEN'S DISORDERS / HORMONAL IMBALANCES**

❑ Fibrocystic Breasts ❑ Endometriosis ❑ Fibroids ❑ Infertility
❑ Painful Periods ❑ Heavy Periods ❑ PMS
Last Mammogram: _____ ❑ Breast Biopsy / Date: _____
Last PAP Test: _____ ❍ Normal ❍ Abnormal
Date of 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 ❑ Infertility
❑ Vaginal Dryness ❑ Decreased Libido ❑ Heavy Bleeding ❑ Joint Pains
❑ Headaches ❑ Weight Gain ❑ Loss of Control of Urine ❑ Palpitations
❑ Use of hormone replacement therapy: How long? _____

## MEN'S HISTORY *(for men only)*

Have you had a PSA done? ❍ Yes ❍ No
PSA Level: ❑ 0 - 2 ❑ 2 - 4 ❑ 4 - 10 ❑ Above 10

❑ Prostate Enlargement ❑ Prostate Infection ❑ Change in Libido ❑ Impotence
❑ Difficulty Obtaining an Erection ❑ Difficulty Maintaining an 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? ❍ No ❍ Yes Where? _____

Wilderness Camping ❍ No ❍ Yes Where? _____

Have you ever had severe? ❍ Gastroenteritis ❍ No ❍ Yes ❍ Diarrhea ❍ No ❍ Yes

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

Do you feel bloated after meals? ❍ No ❍ Yes

## PATIENT BIRTH HISTORY

❍ Term ❍ Premature

Pregnancy Complications: _____

Birth Complications: _____

❑ Breast Fed: ❍ No ❍ Yes If yes, how Long? _____

❑ Bottle Fed: ❍ No ❍ Yes

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

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

## DENTAL HISTORY

**DENTAL SURGERY**

❑ Silver Mercury Fillings? How many? _____

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

❑ Gingivitis ❑ Problems with Chewing

Do you floss regularly? ❍ No ❍ Yes

## MEDICATIONS

**CURRENT MEDICATIONS**

| Medication | Dose | Frequency | Start Date (month / year) | Reason for Use |
|---|---|---|---|---|
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**PREVIOUS MEDICATIONS:** ***Last 10 years***

| Medication | Dose | Frequency | Start Date (month / year) | Reason for Use |
|---|---|---|---|---|
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**NUTRITIONAL SUPPLEMENTS (VITAMINS / MINERALS / HERBS / HOMEOPATHY)**

| Supplication and Brand | Dose | Frequency | Start Date (month / year) | Reason for Use |
|---|---|---|---|---|
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Have your medications or supplements ever caused you unusual side effects or problems? ❍ No ❍ Yes
If yes, describe: _____

_____

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin, Tylenol, Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.) ❍ No ❍ Yes If yes, list: _____

Frequent antibiotics: More than 3 times a year ❍ No ❍ Yes

Long term antibiotics: ❍ No ❍ Yes

Use of steroids (prednisone, nasal allergy inhalers) in the past: ❍ No ❍ Yes

Use of oral contraceptives: ❍ No ❍ Yes

## FAMILY HISTORY

*Check family members that apply*

| | Mother | Father | Brother(s) | Sister(s) | Children | Maternal Grandmother | Maternal Grandfather | Paternal Grandmother | Paternal Grandfather | Aunts | Uncles | Other |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Age (current or when deceased) | | | | | | | | | | | | |
| Cancers | | | | | | | | | | | | |
| Colon Cancer | | | | | | | | | | | | |
| Breast or Ovarian Cancer | | | | | | | | | | | | |
| Heart Disease | | | | | | | | | | | | |
| Hypertension | | | | | | | | | | | | |
| Obesity | | | | | | | | | | | | |
| Diabetes | | | | | | | | | | | | |
| Stroke | | | | | | | | | | | | |
| Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Sondylitis) | | | | | | | | | | | | |
| 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) | | | | | | | | | | | | |
| Psychiatric Disorders | | | | | | | | | | | | |
| Depression | | | | | | | | | | | | |
| Schizophrenia | | | | | | | | | | | | |
| ADHD | | | | | | | | | | | | |
| Autism | | | | | | | | | | | | |
| Bipolar Disease | | | | | | | | | | | | |

## SOCIAL HISTORY

**NUTRITIION HISTORY**

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

Have you made any changes in your eating habits because of your health? ❍ No ❍ Yes If yes, describe: _____

_____

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

***Check all that apply:***

❑ Low Fat ❑ Low Carbohydrate ❑ High Protein ❑ Low Sodium Pain ❑ Diabetic

❑ No Wheat ❑ Gluten Restricted ❑ Vegetarian ❑ Vegan ❑ Ultrametabolism

❑ Specific Program for Weight Loss / Maintenance Type: _____ Other: _____

| | |
|---|---|
| Height (feet / inches): _____ | Current Weight: _____ |
| Usual Weight Range + / - 5 lbs: _____ | Desired Weight Range + / - 5 lbs: _____ |
| Highest adult weight: _____ | Lowest adult weight: _____ |
| Weight Fluctuations (greater than 10 lbs.): ❍ No ❍ Yes | Body Fat %: _____ |

How often do you weight yourself? ❍ Daily ❍ Weekly ❍ Monthly ❍ Rarely ❍ Never

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

Do you avoid any particular foods? ❍ No ❍ Yes If yes, types and reason: _____

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

_____

Do you grocery shop? ❍ No ❍ Yes If no, who does the shopping? _____

Do you read food labels? ❍ No ❍ Yes _____

Do you cook? ❍ No ❍ Yes If no, who does the cooking? _____

How many meals do you eat out per week? ❍ 0 - 1 ❍ 1 - 3 ❍ 3 - 5 ❍ More than 5 meals per week

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

❑ Fast Eater
❑ Eat too much
❑ Late night eating
❑ Dislike healthy food
❑ Time constraints
❑ Eat more than 50% of 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
❑ 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
❑ Erratic eating pattern
❑ Significant other or family members have special dietary needs or food preferences

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

_____

_____

**SMOKING**

Do you currently smoke? ❍ No ❍ Yes If yes, for how many years? _____ Packs per day: _____

Attempts to quit: ❍ 1 - 3 ❍ 4 - 6 ❍ 7 - 10 ❍ More than 10 ❍ More than 15 ❍ More than 20

Previous Smoking: ❍ No ❍ Yes If yes, for how many years?_____ Packs per day: _____

2nd Hand smoke exposure: ❍ No ❍ Yes If yes, explain: _____

**ALCOHOL INTAKE**

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 ❍ More than 10

Previous alcohol intake: ❑ None ❑ Yes (❍ Mild ❍ Moderate ❍ High)

Have you ever been told you should cut down your alcohol intake? ❍ No ❍ Yes

Do you get annoyed when people ask you about your drinking? ❍ No ❍ Yes

Do you ever feel guilty about your alcohol consumption? ❍ No ❍ Yes

Do you ever take an eye-opener? ❍ No ❍ Yes

Do you notice a tolerance to alcohol (can you "hold" more than others)? ❍ No ❍ Yes

Have you ever been unable to remember what you did during a drinking episode? ❍ No ❍ Yes

Do you get into arguments or physical fights when you have been drinking? ❍ No ❍ Yes

Have you ever been arrested or hospitalized because of drinking? ❍ No ❍ Yes

Have you ever thought about getting help to control or stop your drinking? ❍ No ❍ Yes

**OTHER SUBSTANCES**

Caffeine intake: ❍ No ❍ Yes If yes, cups / day: ____ ❑ Coffee ❑ Tea ❍ 1 ❍ 2 - 4 ❍ More than 4 a day

Caffeinated Sodas or Diet Sodas intake: ❍ No ❍ Yes

12-ounce can / bottle / day ❍ 1 ❍ 2 - 4 ❍ More than 4 a day

List favorite type: *Example: Diet Coke, Pepsi, etc.*: _____

Are you currently using any recreational drugs? ❍ No ❍ Yes If yes, type(s): _____

Have you ever used IV or inhaled recreational drugs? ❍ No ❍ Yes If yes, type(s): _____

**EXERCISE**

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

| **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? ❍ No ❍ Yes If yes, please describe: _____

_____

_____

Do you usually sweat when exercising? ❍ No ❍ Yes

**PSYCHOSOCIAL**

Do you feel significantly less vital than 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 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 sought counseling? ❍ No ❍ Yes
Are you currently in therapy? ❍ No ❍ Yes If yes, describe:_____

_____

Do you feel you have an excessive amount of stress in your life? ❍ No ❍ Yes
Do you feel you can easily handle the stress in your life? ❍ No ❍ Yes

Daily Stressors: Rate on a scale of 1 – 10 (1 being the least stress and 10 being the most stress)
Work _____ Family _____ Social _____ Finances _____ Health _____ Other _____

Do you practice meditation or relaxation techniques? ❍ No ❍ Yes If yes, how often? _____
Check all that apply: ❑ Yoga ❑ Meditation ❑ Imagery ❑ Breathing ❑ Tai Chi ❑ Prayer ❑ Other:_____

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

**SLEEP / REST**

Average number of hours you sleep per night: _____
Do you have trouble falling asleep? ❍ No ❍ Yes
Do you feel rested upon awakening? ❍ No ❍ Yes
Do you have problems with insomnia? ❍ No ❍ Yes
Do you snore? ❍ No ❍ Yes ❍ Sometimes
Do you use sleeping aids? ❍ No ❍ Yes If yes, explain: _____

**ROLES / RELATIONSHIPS**

Marital Status: ❍ Single ❍ Married ❍ Divorced ❍ Gay / Lesbian ❍ Long Term Partnership
*List Children:*

| Child's Name | Age | Gender |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Who is living in Household? Number: _____ Names: _____
Their Employment / Occupation: _____

Resources for emotional support: _____
*Check all that apply:* ❑ Spouse ❑ Family ❑ Friends ❑ Religious / Spiritual ❑ Pets ❑ Other: _____

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

| How well have things been going for you? | Very Well | Fine | Poorly | Does Not Apply |
|---|---|---|---|---|
| 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? ❍ No ❍ Yes If yes, describe symptoms: _____

_____

Do you have an adverse reaction to caffeine? ❍ No ❍ Yes

When you drink caffeine do you feel: ❑ Irritable or Wired ❑ Aches & 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 (*Example: 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)? ❍ No ❍ Yes

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

Explain: _____

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

❑ Herbicides ❑ Insecticides (frequent visits of exterminator) ❑ Pesticides ❑ Organic Solvents

❑ Heavy Metals ❑ Other: _____

Chemical Name, Date, Length of Exposure: _____

Do you dry clean your clothes frequently? ❍ No ❍ Yes

Do you or have you lived or worked in a damp or moldy environment or had other mold exposures? ❍ No ❍ Yes

Do you have any pets or farm animals? ❍ No ❍ Yes If yes, explain: _____

## SYMPTOM REVIEW

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

### GENERAL
- ❑ Cold Hands & Feet
- ❑ Cold Intolerance
- ❑ Low Body Temperature
- ❑ Low Blood Pressure
- ❑ Daytime Sleepiness
- ❑ Difficulty Falling Asleep
- ❑ Early Waking
- ❑ Fatigue
- ❑ Fever
- ❑ Flushing
- ❑ Heat Intolerance
- ❑ Night Waking
- ❑ Nightmares
- ❑ No Dream Recall

### HEAD, EYES & EARS
- ❑ Conjunctivitis
- ❑ Distorted Sense Of Smell
- ❑ Distorted Taste
- ❑ Ear Fullness
- ❑ Ear Pain
- ❑ Ear Ringing / Buzzing
- ❑ Lid Margin Redness
- ❑ Eye Crusting
- ❑ Eye Pain
- ❑ Hearing Loss
- ❑ Hearing Problems
- ❑ Headache
- ❑ Migraine
- ❑ Sensitivity To Loud Noises
- ❑ Vision Problems (Other Than Glasses)
- ❑ Macular Degeneration
- ❑ Vitreous Detachment
- ❑ Retinal Detachment

### MUSCULOSKELETAL
- ❑ Back Muscle Spasm
- ❑ Calf Cramps
- ❑ Chest Tightness
- ❑ Foot Cramps
- ❑ Joint Deformity
- ❑ Joint Pain
- ❑ Joint Redness
- ❑ Joint Stiffness
- ❑ Muscle Pain
- ❑ Muscle Spasms
- ❑ Muscle Stiffness

Muscle Twitches:
- ❑ Around Eyes
- ❑ Arms Or Legs

- ❑ Muscle Weakness
- ❑ Neck Muscle Spasm
- ❑ Tendonitis
- ❑ Tension Headaches
- ❑ TMJ Problems

### MOOD / NERVES
- ❑ Agoraphobia
- ❑ Anxiety
- ❑ Auditory Hallucinations
- ❑ Black-Out
- ❑ Depression

Difficulty:
- ❑ Concentrating
- ❑ With Balance
- ❑ With Thinking
- ❑ With Judgment
- ❑ With Speech
- ❑ With Memory

- ❑ Dizziness (Spinning)
- ❑ Fainting
- ❑ Fearfulness
- ❑ Irritability
- ❑ Light-Headedness
- ❑ Numbness
- ❑ Other Phobias
- ❑ Panic Attacks
- ❑ Paranoia
- ❑ Seizures
- ❑ Suicidal Thoughts
- ❑ Tingling
- ❑ Tremor / Trembling
- ❑ Visual Hallucinations

### EATING
- ❑ Binge Eating
- ❑ Bulimia
- ❑ Can't Gain Weight
- ❑ Can't Lose Weight
- ❑ Can't Maintain Healthy Weight
- ❑ Frequent Dieting
- ❑ Poor Appetite
- ❑ Salt Cravings
- ❑ Carbohydrate Craving (Breads, Pastas)
- ❑ Sweet Cravings (Candy, Cookies, Cakes)
- ❑ Chocolate Cravings
- ❑ Caffeine Dependent

### DIGESTION
- ❑ Anal Spasms
- ❑ Bad Teeth
- ❑ Bleeding Gums

Bloating Of:
- ❑ Lower Abdomen
- ❑ Whole Abdomen
- ❑ Bloating After Meals

- ❑ Blood In Stools
- ❑ Burping
- ❑ Canker Sores
- ❑ Cold Sores
- ❑ Constipation
- ❑ Cracking At Corner Of Lips
- ❑ Cramps
- ❑ Dentures w/Poor Chewing
- ❑ Diarrhea
- ❑ Alternating Diarrhea And Constipation
- ❑ Difficulty Swallowing
- ❑ Dry Mouth
- ❑ Excess Flatulence / Gas
- ❑ Fissures
- ❑ Foods "Repeat" (Reflux)
- ❑ 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 Or Skin)
- ❑ Lower Abdominal Pain
- ❑ Mucus In Stools
- ❑ Periodontal Disease
- ❑ Sore Tongue
- ❑ Strong Stool Odor
- ❑ Undigested Food In Stools

**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
- ❑ Ears Get Red
- ❑ Easy Bruising
- ❑ Lack Of Sweating
- ❑ Eczema
- ❑ Herpes – Genital
- ❑ Hives
- ❑ Jock Itch
- ❑ Lackluster Skin
- ❑ Moles W/Color And / Or Size Change
- ❑ Oily Skin
- ❑ Pale Skin
- ❑ Patchy Dullness
- ❑ Rash
- ❑ Red Face
- ❑ Sensitive To Bites
- ❑ Sensitive To Poison Ivy / Oak
- ❑ Shingles
- ❑ Skin Darkening
- ❑ Strong Body Odor
- ❑ Hair Loss
- ❑ Vitiligo

**ITCHING SKIN**

- ❑ Skin In General
- ❑ Anus
- ❑ Arms
- ❑ Ear Canals
- ❑ Eyes
- ❑ Feet
- ❑ Hands
- ❑ Legs
- ❑ Nipples
- ❑ Nose
- ❑ Penis
- ❑ Roof Of Mouth
- ❑ Scalp
- ❑ Throat

**SKIN, DRYNESS OF**

- ❑ Eyes
- ❑ Feet
  - ❑ Any Cracking?
  - ❑ Any Peeling?
- ❑ Hair
- ❑ And Unmanageable?
- ❑ Hands
  - ❑ Any Cracking?
  - ❑ Any Peeling?
- ❑ Mouth / Throat
- ❑ Scalp
  - ❑ Any Dandruff?
- ❑ Skin In General

**LYMPH NODES**

- ❑ Enlarged / Neck
- ❑ Tender / Neck
- ❑ Other Enlarged / Tender
- ❑ Lymph Nodes

**NAILS**

- ❑ Bitten
- ❑ Brittle
- ❑ Curve Up
- ❑ Frayed
- ❑ Fungus – Fingers
- ❑ Fungus – Toes
- ❑ Pitting
- ❑ Ragged Cuticles
- ❑ Ridges
- ❑ Soft

Thickening Of:

- ❑ Finger Nails
- ❑ Toenails

- ❑ White Spots / Lines

**RESPIRATORY**

- ❑ Bad Breath
- ❑ Bad Odor In Nose
- ❑ Cough – Dry
- ❑ Couth – Productive
- ❑ Hoarseness
- ❑ Sore Throat

Hay Fever:

- ❑ Spring
- ❑ Summer
- ❑ Fall
- ❑ Change Of Seasons

- ❑ Nasal Stuffiness
- ❑ Nose Bleeds
- ❑ Post Nasal Drip
- ❑ Sinus Fullness
- ❑ Sinus Infection
- ❑ Snoring
- ❑ Wheezing
- ❑ Winter Stuffiness
- ❑

**Cardiovascular**

- ❑ Angina / Chest Pain
- ❑ Breathlessness
- ❑ Heart Murmur
- ❑ Irregular Pulse
- ❑ Palpitations
- ❑ Phlebitis
- ❑ Swollen Ankles / Feet
- ❑ Varicose Veins

**URINARY**

- ❑ Bed Wetting
- ❑ Hesitancy (Trouble Getting Started)
- ❑ Infection
- ❑ Kidney Disease
- ❑ Leaking / Incontinence
- ❑ Pain / Burning
- ❑ Prostate Infection
- ❑ Urgency

**MALE REPRODUCTIVE**

- ❑ Discharge From Penis
- ❑ Ejaculation Problem
- ❑ Genital Pain
- ❑ Impotence
- ❑ Prostate Or Urinary Infection
- ❑ Lumps In Testicles
- ❑ Poor Libido (Sex Drive)

**FEMALE REPRODUCTIVE**

- ❑ Breast Cysts
- ❑ Breast Lumps
- ❑ Breast Tenderness
- ❑ Ovarian Cyst
- ❑ Poor Libido (Sex Drive)
- ❑ Vaginal Discharge
- ❑ Vaginal Odor
- ❑ Vaginal Itch
- ❑ Vaginal Pain With Sex

Premenstrual:

- ❑ Bloating Breast Tenderness
- ❑ Carbohydrate Cravings
- ❑ Chocolate Craving
- ❑ Constipation
- ❑ Decreased Sleep
- ❑ Diarrhea
- ❑ Fatigue
- ❑ Increased Sleep
- ❑ Irritability

Menstrual:

- ❑ Cramps
- ❑ Heavy Periods
- ❑ Irregular Periods
- ❑ No Periods
- ❑ Scanty Periods
- ❑ Spotting Between

## 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: _____

_____

_____

## MSQ – MEDICAL SYMPTOM / TOXICITY QUESTIONNAIRE

**NAME:** _____ **DATE:** _____

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying cause of illness, and helps you track your progress over time. Rate each of the following symptoms base upon your health profile for the past 30 days. If you are taking after the first time, record your symptoms for the last 48 hours ONLY.

**POINT SCALE**

0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

**DIGESTIVE TRACT**

___ Nausea or vomiting
___ Diarrhea
___ Constipation
___ Bloated Feeling
___ Belching, or passing gas
___ Heartburn
___ Intestinal / Stomach pain
*Total*_____

**EARS**
___ Itchy ears
___ Earaches, ear infections
___ Drainage from ear
___ Ringing in ears, hearing loss
*Total*_____

**EMOTIONS**
___ Mood swings
___ Anxiety, fear or nervousness
___ Anger, irritability, or aggressiveness
___ Depression
*Total*_____

**ENERGY / ACTIVITY**
___ Fatigue, sluggishness
___ Apathy, lethargy
___ Hyperactivity
___ Restlessness
*Total*_____

**EYES**
___ Watery or 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*_____

**HEAD**

___ Headaches
___ Faintness
___ Dizziness
___ Insomnia
*Total*_____

**HEART**
___ Irregular or skipped heartbeat
___ Rapid or pounding heartbeat
___ Chest pain
*Total*_____

**JOINTS / MUSCLES**
___ Pain or aches in joints
___ Arthritis
___ Stiffness
___ Pain or aches in muscles
___ Feeling of weakness or tiredness
*Total*_____

**LUNGS**
___ Chest congestion
___ Asthma, bronchitis
___ Shortness of breath
___ Difficult breathing
*Total*_____

**MIND**
___ Poor memory
___ Confusion, poor comprehension
___ Poor concentration
___ Poor physical coordination
___ Difficulty in making decisions
___ Stuttering or stammering
___ Slurred speech
___ Learning disabilities
*Total*_____

**MOUTH / THROAT**

___ Chronic coughing
___ Gagging, frequent need to clear throat
___ Sore throat, hoarseness, loss of voice
___ Swollen/discolored tongue, gum, lips
___ Canker sores
*Total*_____

**NOSE**
___ Stuffy nose
___ Sinus problems
___ Hay fever
___ Sneezing attacks
___ Excessive mucus formation
*Total*_____

**SKIN**
___ Acne
___ Hives, rashes, or dry skin
___ Hair loss
___ Flushing or hot flashes
___ Excessive sweating
*Total*_____

**WEIGHT**
___ Binge eating / drinking
___ Craving certain foods
___ Excessive weight
___ Compulsive eating
___ Water retention
___ Underweight
*Total*_____

**OTHER**
___ Frequent illness
___ Frequent or urgent urination
___ Genital itch or discharge
*Total*_____

**GRAND TOTAL** _____

**KEY TO QUESTIONNAIRE**
Add individual scores and total each group. Add each group scores and give a grand total.

- Optimal is less than 10
- Mild Toxicity: 10 – 50
- Moderate Toxicity: 50 – 100
- Severe Toxicity: Over 100

## SF-36 (QUALITY OF LIFE ASSESSMENT)

INSTRUCTIONS: This set of questions asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Answer every question by marking the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

In general, would you say your health is: *(Please select one)*

- ❍ Excellent
- ❍ Very Good
- ❍ Good
- ❍ Fair
- ❍ Poor

Compared to one year ago, how would you rate your health in general now? *(Please select one)*

- ❍ Much better than one year ago
- ❍ Somewhat better now than one year ago
- ❍ About the same as one year ago
- ❍ Somewhat worse now than one year ago
- ❍ Much worse now than one year ago

The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? *(Please select one number on each line.)*

| **Activities** | **Yes, Limited a Lot** | **Yes, Limited a Little** | **Not Limited At All** |
|---|---|---|---|
| Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports | ❍ | ❍ | ❍ |
| Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf | ❍ | ❍ | ❍ |
| Lifting or carrying groceries | ❍ | ❍ | ❍ |
| Climbing several flights of stairs | ❍ | ❍ | ❍ |
| Climbing one flight of stairs | ❍ | ❍ | ❍ |
| Bending, kneeling, or stooping | ❍ | ❍ | ❍ |
| Walking more than a mile | ❍ | ❍ | ❍ |
| Walking several blocks | ❍ | ❍ | ❍ |
| Walking one block | ❍ | ❍ | ❍ |
| Bathing or dressing yourself | ❍ | ❍ | ❍ |

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

| *(Please select one number on each line)* | **Yes** | **No** |
|---|---|---|
| Cut down on the amount of time you spent on work or other activities | ❍ | ❍ |
| Accomplished less than you would like | ❍ | ❍ |
| Were limited in the kind of work or other activities | ❍ | ❍ |
| Had difficulty performing the work or other activities (for example, it took extra effort) | ❍ | ❍ |

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (e.g., feeling depressed or anxious)?

| *(Please circle one number on each line)* | **Yes** | **No** |
|---|---|---|
| Cut down on the amount of time you spent on work or other activities | ❍ | ❍ |
| Accomplished less than you would like | ❍ | ❍ |
| Didn't do work or other activities as carefully as usual | ❍ | ❍ |

During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? *(Please select one)*

- ❍ Not at all
- ❍ Slightly
- ❍ Moderately
- ❍ Quite a bit
- ❍ Extremely

How much physical pain have you had during the past 4 weeks? *(Please select one)*

- ❍ Excellent
- ❍ Very Good
- ❍ Good
- ❍ Fair
- ❍ Poor

During the past 4 weeks, how much did pain interfere with your normal work? *(Please select one)*

- ❍ Not at all
- ❍ A little bit
- ❍ Moderately
- ❍ Quite a bit
- ❍ Extremely

These questions are about how you feel and how things have been with you during the past 4 weeks. Please give the one answer that is closest to the way you have been feeling for each item.

| *(Please circle one number on each line)* | All of the Time | Most of the Time | Good Bit of the Time | Some of the Time | A Little of the Time | None of the Time |
|---|---|---|---|---|---|---|
| Did you feel full of life? | ❍ | ❍ | ❍ | ❍ | ❍ | ❍ |
| Have you been a very nervous person? | ❍ | ❍ | ❍ | ❍ | ❍ | ❍ |
| Have you felt calm and peaceful? | ❍ | ❍ | ❍ | ❍ | ❍ | ❍ |
| Did you have a lot of energy? | ❍ | ❍ | ❍ | ❍ | ❍ | ❍ |
| Have you felt downhearted and blue? | ❍ | ❍ | ❍ | ❍ | ❍ | ❍ |
| Did you feel worn out? | ❍ | ❍ | ❍ | ❍ | ❍ | ❍ |
| Have you been a happy person? | ❍ | ❍ | ❍ | ❍ | ❍ | ❍ |
| Did you feel tired? | ❍ | ❍ | ❍ | ❍ | ❍ | ❍ |

During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

*(Please check one box)*

- ❑ All of the time
- ❑ Most of the time
- ❑ Some of the time
- ❑ A little of the time
- ❑ None of the time

How TRUE or FALSE is each of the following statements for you?

| *(Please circle one number on each line)* | Definitely True | Mostly True | Don't Know | Mostly False | Definitely False |
|---|---|---|---|---|---|
| I seem to get a sick a little easier than other people | ❍ | ❍ | ❍ | ❍ | ❍ |
| I am as healthy as anybody I know | ❍ | ❍ | ❍ | ❍ | ❍ |
| I expect my health to get worse | ❍ | ❍ | ❍ | ❍ | ❍ |
| My health is excellent | ❍ | ❍ | ❍ | ❍ | ❍ |

*Thank You!*