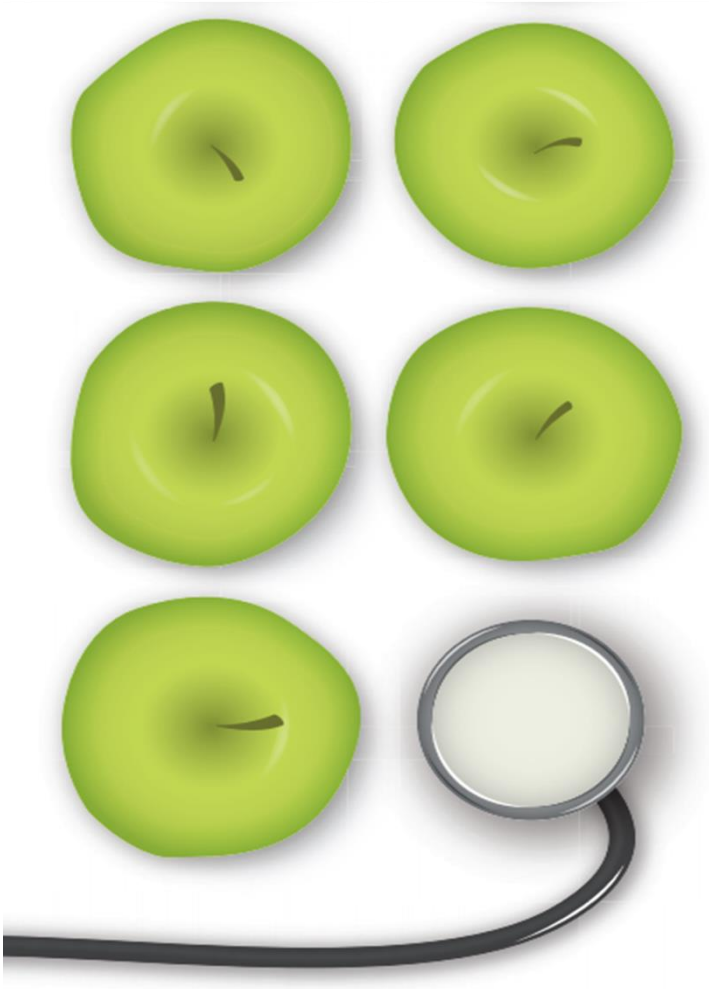
A Functional Approach, PA

Genetic. Environment. Lifestyle.



Integrative, Science-Based Healthcare Approach.

Introductory Patient Information

817 Douglas Ave., Ste. 179
Altamonte Springs, FL 32714

407.331.5050
Fax 407.331.5189

www.AFunctionalApproach.com

TABLE OF CONTENTS

PATIENT CHECKLIST

DID YOU REMEMBER TO?

- ☐ Read all the practice documents.
- ☐ Obtain any medical records and/or test results that you would like sent at least 7 days prior to your appointment date.

FILL OUT AND/OR SIGN THE FOLLOWING FORMS

- ☐ Important Patient Information
- ☐ General Information
- ☐ Notice of Medicare Denial
- ☐ Functional Medicine Laboratory Testing
- ☐ Selling Nutritional and Herbal Supplements
- ☐ Authorization for Release of Medical Information
- ☐ Medical Questionnaire
- ☐ 3-Day Diary

Dear Patient,
Welcome to A Functional Approach, PA. We look forward to meeting you.

PRACTICE POLICIES FOR PATIENTS

Our goal 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/fax all attached forms to our office at least **3 days** after scheduling your appointment. This will allow us to help solve your problems more efficiently and enhance the quality of your care. **If your patient packet is late, your appointment will be canceled and will be rescheduled once the paperwork is turned in.**

WEBSITE
Information and all relevant patient forms are available through our website, www.AFunctionalApproach.com.

MEDICAL RECORDS
Medical records can only be released with your authorization. A medical records release form is enclosed for your use. You are responsible for obtaining any previous medical records from other physicians or health care providers. Please contact your providers to obtain these records. Your records should be express mailed to 817 Douglas Ave., Ste 179, Altamonte Springs, Fl 32714.

CONSULTATIONS/ FEES
The cost of the visits will be based on time and is $100 per half hour. An initial visit as typically 1 to 1 ½ hours. Laboratory/diagnostic testing and Autonomic Response Testing (ART) 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 select and the highest quality of supplements. Some follow-up visits may be long distance per phone or Skype, but initial visits must be completed in office.

- Initial consultation (50 minute- 80 minute): $200- $300
- Typical Follow-up (25 minute- 50 minute): $100-$200

CANCELLATION OF APPOINTMENTS
Your appointment must be cancelled at least 48 hours before your scheduled visit or you will be charged 50% of the charges. You may cancel your appointment by calling the office. If calling after hours, please leave a message.

PAYMENT OPTIONS
Our office accepts cash, checks, or credit cards (MasterCard, Visa, Discover) for services rendered. When you schedule the initial visit, we request a credit card on file to hold the appointment for you. No charges will be

applied to your credit card unless you miss or cancel an appointment without proper notice. On the day of your scheduled appointment, all charges for consultations as well as laboratory testing will be itemized and reviewed with you. Payment is due at time of service.

If additional lab tests kits are required and payment is not made directly to the lab, but rather due to our office, the appropriate fees will be charged to your credit card on file unless you provide other payment information and instructions prior to your appointment. Any fees for phone consultations will be handled like this as well.

INSURANCE INFORMATION

We do not accept insurance and we cannot assist you with claim resolution. In addition, we are not Medicare providers. You will be provided with a billing receipt that you can submit to your insurance carrier.

PHONE CALLS, MESSAGES & FAXES

1. Our office is open Monday- Friday 6:30 AM- 12 N, and Monday, Tuesday, and Thursday from 2:00 PM-5:00 PM.
2. The office phone number is 407-331-5050
3. The fax number is 407-331-5189
4. If you call after hours, our office staff will return your call on the next business day.
5. If you have an emergency, call 911 or go directly to the emergency room.
6. When leaving a message, please be brief and include the following information:
    a. Full name, spell your last name, and date of birth.
    b. Reason for call
    c. Best time to call back
    d. Phone number(s)

PRESCRIPTION REFILL REQUESTS

It may take up to 72 business hours to process a prescription refill. Please plan ahead to avoid any interruptions in your medications.

FREQUENTLY ASKED QUESTIONS

Do you think you can help me with my health problem?

We use an innovative systems approach to assessing and treating your healthcare concerns. Perhaps you have experienced being examined by your doctor, having blood test done, x-rays or other diagnostic tests taken, only for your doctor to report back that "all your tests are normal". Yet, both you and your doctor know that you are sick. Unfortunately, this experience is all too common.

Most practitioners are trying to look only in specific places for the answers, using the same familiar labs or diagnostic test. Yet, many causes of illness cannot be found in these places. We are highly skilled at evaluation, assessment, and intervention of chronic problems such as fibromyalgia, fatigue syndromes, autoimmune diseases, inflammatory disorders, mood and behavior disorders, memory problems, and other chronic, complex conditions. We also give focus on the prevention and intervention needed for heart disease, diabetes, dementia, hormonal imbalances and digestive disorders.

What is Autonomic Response Testing (ART)?

Autonomic Response Testing (ART) is a highly sensitive and accurate form of bio-feedback testing developed by Dietrich Klinghardt, M.D. Ph.D, and Louisa Williams, DC ND. It looks for the stressed condition of the Autonomic Nervous System (ANS) called 'blocked regulation'. Blocked regulation refers to the inability of the ANS to self-regulate and is commonly caused by 7 factors. These include: undiagnosed food allergies, heavy metal toxicity, chemical toxicity, chronic unresolved infections, scars, temporo-mandibular joint (TMJ) dysfunction, unresolved psycho-emotional stress, and electromagnetic stress. ART marries together techniques from many disciplines including Applied Kinesiology and biophoton physics and is carried out by noting changes in muscle strength while an organ, gland, substance, or function is being tested.

Are my tests done at A Functional Approach, PA?

Some testing can be done through conventional laboratories and others are only available through specialty laboratories. During your consultation we will determine which tests are needed. Most of the time, the initial bloodwork will be drawn on the first visit to be sent to the appropriate specialty laboratory. This requires a 10 hour fast. Some additional testing can be performed at home with test kits to collect urine, saliva, or stool. Some follow-up or non-specialty tests may require you to go to a local laboratory to have blood drawn. We will review testing recommendations, instructions (for example fasting or nonfasting, etc.) and costs. In all cases, we will assist you in coordinating initial and follow-up testing. Occasionally we may recommend certain tests that are not performed at our facility (sleep studies, etc.). In those instances, we can provide you with an order that you can take to a facility near your home or we can schedule an appointment to have them done near our office.

Will I see other practitioners at A Functional Approach, PA?

We offer an integrated office housing a sports chiropractic physician and also offer services, such as acupuncture and massage. These may be incorporated as part of your complete wellness program. All appointments for Functional Medicine will be with Kelley Teixeira, NP-C, Adult Nurse Practitioner.

Do you take insurance?

We do not accept insurance or Medicare; we do not file insurance claims on your behalf; nor do we assist with claim resolution. However, we will provide a detailed receipt of services performed for you to submit to your insurance carriers. We expect payment in full by check, cash, or credit card due at the time services are provided. Most lab tests are covered by insurance/ Medicare.

What credit cards do you accept?

We accept the following credit cards MasterCard, Visa, and Discover. It is important to maintain an active credit card on file at the office for billing follow-up consultations, laboratory testing, and other services.

Is Kelley Teixeira, ARNP a primary care provider?

Even though she is trained as a primary care provider, she does not provide acute care services. We will work with you closely as consultants and coaches in preventative, nutritional, and functional medicine to help you address the roots of chronic health problems.

Do I have to see the provider in person for my new consultation?

Yes, medical licenses require an in person meeting with a patient in order to provide an initial medical consultation. Follow-up appointments can be arranged by phone or in the office. It is recommended that an in person consultation be made whenever possible for a more detailed evaluation.

Consent Forms

817 Douglas Ave., Ste. 179
Altamonte Springs, FL 32714

407.331.5050
Fax 407.331.5189

www.AFunctionalApproach.com

GENERAL INFORMATION

APPOINTMENTS

- There is a 48-hour cancellation policy (please see cancellation policy in Practice Policies for Patients)
- As a courtesy, we will call to confirm the appointment prior to your scheduled time; ultimately it is your responsibility to keep the scheduled appointment or reschedule.
- The visits will be based on time and is $100 per half hour. An initial visit as typically 1 to 1 ½ hours.
    - Initial consultation (50 minute- 80 minute): $200- $300
    - Typical Follow-up (25 minute- 50 minute): $100-$200

LABS/ TESTS

- After your initial and follow-up consultations, lab tests and/or diagnostic tests may be ordered.
- Testing recommendations and cost(s) per test will be reviewed.
- Lab tests performed "fasting", which means nothing except water 10 hours before the test.
- For Autonomic Response Testing (ART), it is best to hold supplements for at least 2 days prior to test.
- Some lab tests take up to 5 weeks to be finalized. If your follow-up appointment was not booked at the time of your initial visit, then you should contact the office to schedule a follow-up appointment.
- Lab test results will only be reviewed at a follow-up visit. **No lab copies will be sent ahead of the follow-up or in lieu of the follow up.** All lab testing should be reviewed from a Functional Medicine standpoint as pieces of one complete health puzzle and ideal, not "normal" lab values are sought.

BILLING/ INSURANCE

- Payment for the office visit, phone consultation or lab tests is expected at time of service. We accept cash, check, or credit cards. All credit card payments will be processed the same day of the visit or phone call.
- If test kits are sent to you, you will be charged the day the kit is mailed. Some labs require payments made directly to the lab, especially when the test is covered under insurance. In this case, we will review with you how this payment is made. A small ($10) handling fee is charged by our office for each test kit.
- We do not accept insurance and we cannot assist you with a claim resolution. We will provide you with a billing summary which you can submit to your insurance carrier.

PRIMARY CARE PHYSICIAN

Please note that Kelley Teixeira, NP-C is not your primary care provider. We recommend that you have a primary care provider. We will work with you as consultants and coaches in preventative, nutritional, and functional medicine to help you address the root cause of your health problems.

_____ _____

Patient Signature *Date*

ALL MEDICARE PATIENTS MUST SIGN THIS FORM

NOTICE OF POSSIBLE MEDICARE DENIAL

Medicare will only pay for services determined to be reasonable and necessary under Section 1862 (a) (1) of Medicare Law. If a particular service is considered not acceptable and unnecessary under Medicare standards, Medicare will deny payment for those excluded services.

MEDICARE NOTICE

Kelley Teixeira, NP-C is not a Medicare provider; therefore, your payment is due at the time services are provided. Any claims submitted will have to be sent to Medicare by the patient; payment reimbursement is not guaranteed and is subject to Medicare eligibility/reimbursement rules and regulations.

PATIENT ACKNOWLEDGEMENT

My provider and/or staff have informed me, that he or she believes services provided will likely be denied by Medicare for reasons listed above.

Signature: _____

Print Name: _____

Date: _____

FUNCTIONAL MEDICINE LABORATORY TESTING

The purpose of functional medicine laboratory testing in our office is to evaluate nutritional, biochemical, or physiological imbalance and to determine any need for medical referral. These lab tests in our office are not intended to diagnose disease. This office utilizes conventional lab tests as well as Autonomic Response Testing (ART) as a comprehensive functional medicine assessment. Autonomic Response Testing (ART) is a highly sensitive and accurate form of bio-feedback testing developed by Dietrich Klinghardt, M.D. Ph.D, and Louisa Williams, DC ND. It looks for the stressed condition of the Autonomic Nervous System (ANS) called 'blocked regulation'. Blocked regulation refers to the inability of the ANS to self-regulate and is commonly caused by 7 factors. These include: undiagnosed food allergies, heavy metal toxicity, chemical toxicity, chronic unresolved infections, scars, temporo-mandibular joint (TMJ) dysfunction, unresolved psycho-emotional stress, and electromagnetic stress. ART marries together techniques from many disciplines including Applied Kinesiology and biophoton physics and is carried out by noting changes in muscle strength while an organ, gland, substance, or function is being tested.

Functional medicine assessment is designed to find the underlying causes of your condition. Functional medicine has evolved through the efforts of scientists and clinicians from the fields of clinical nutrition, molecular biology, biochemistry, physiology, conventional medicine, and a wide array of scientific disciplines. Functional medicine evaluates the body as a whole, with special attention to the relationship of one body system to another and the nutrient imbalances and toxic overload that may adversely affect these relationships.

Your medical provider may or may not agree with the necessity for—or our interpretation of—these tests. If you have any questions or concerns, please discuss them with us.

I have read and understand the above:

_____ _____

Signature Date

_____ _____

Witness Date

SELLING NUTRITIONAL AND HERBAL SUPPLEMENTS

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201(g)(1), the term drug is defined as an "article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease." Technically, vitamins, minerals, trace elements, amino acids, herbs, or homeopathic remedies are not classified as drugs. However, these substances can have significant effects on physiology and must be used rationally. In this office, we provide nutritional counseling and make individualized recommendations regarding use of these substances in order to upgrade the quality of foods in a patient's diet and to supply nutrition to support the physiological and biomechanical processes of the human body. Although these products may also be suggested with a specific therapeutic purpose in mind, their use is chiefly designed to support given aspects of metabolic function. Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking.

Sale of Nutritional Supplements at A Functional Approach, PA

You are under no obligation to purchase nutritional supplements at our clinic.

As a service to you, we make nutritional supplements available in our office. We purchase these products only from manufacturers who have gained our confidence through considerable research and experience. We determine quality by considering: (1) the quality of science behind the product; (2) the quality of the ingredients themselves; (3) the quality of the manufacturing process; and (4) the synergism among product components. The brands of supplements that we carry in our facility are those that meet our high standards and tend to produce predictable results.

While some of these supplements may come at a higher financial cost than those found on the shelves of pharmacies or health food stores, the value must also include assurance of their purity, quality, bioavailability (ability to be properly absorbed and utilized by the body), and effectiveness. The chief reason we make these products available is to ensure quality. You are not guaranteed the same level of quality when you purchase your supplements from the general marketplace. We are not suggesting that such products have no value; however, given the lack of stringent testing requirements for dietary supplements, product quality varies widely.

If you have concerns about this issue, please discuss them with our staff.

I, _____,

have read and understand the above statement on _____ (date),

witnessed by _____, _____ (date).

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Name of Facility or Person: _____

Address: _____

Telephone Number: _____ Fax Number: _____

THE PURPOSE FOR THIS RELEASE:
You are hereby authorized to furnish and release to A Functional Approach, PA all information from my medical, psychological, and other healthcare records, with no limitation placed on history of illness or diagnostic or therapeutic information, including the furnishing of photocopies of all written documents pertinent thereto.

In addition to the above general authorization to release of protected health information, I further authorize release of the following information if it is contained in those records:

Alcohol or Drug Abuse: ❑ Yes ❑ No

Communicable disease related information, including AIDS or ARC diagnosis and/or HIV or HTLA-III test results or treatment: ❑ Yes ❑ No

Genetic testing: ❑ Yes ❑ No

Note: With respect to drug and alcohol abuse treatment information, or records regarding communicable disease related information, the information is from confidential records which are protected by state and federal laws that prohibit further disclosure with specific written consent of the person to whom they pertain, or otherwise permitted by law. A general authorization for release of protected health information is not sufficient for this purpose.

This authorization can be revoked in writing at anytime except to the extent the disclosure made in good faith has already occurred in reliance on this authorization.

I hereby release A Functional Approach, PA, its employees, agents, managing members, and the attending provider(s) from legal responsibility or liability for the release of the above information to the extent authorized. A copy of this authorization shall be valid as the original.

I understand there may be a fee for the service depending on the number of pages photocopied.

Name: _____ DOB: _____
Please Print

Signature: _____ Date: _____

PLEASE INCLUDE A COPY OF YOUR DRIVER'S LICENSE ALONG WITH THE COMPLETED AND SIGNED FORM.

Information Released: _____ Date: _____

Signature: _____

Health Questionnaires

817 Douglas Ave., Ste. 179
Altamonte Springs, FL 32714

407.331.5050
Fax 407.331.5189

www.AFunctionalApproach.com

A Functional Approach, PA

GENERAL INFORMATION

First *Middle* *Last*

Name _____

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 _____

Number, Street *Apt. No.*

Home Primary Address _____

City *State* *Zip*

Number, Street *Apt. No.*

Alternate Address _____

City *State* *Zip*

Home Phone _____ Cell Phone _____

Work Phone _____ E-mail _____

Name *Relationship*

Emergency Contact _____

Address *City*

_____

Phone *Alternate Phone*

Name *Phone Number*

Physician _____

Fax

Referred By ❑Website ❑Media ❑Friend/ Family Member Name_____
❑Other _____

PHARMACY INFORMATION

Primary Pharmacy

Name *Phone Number*

_____

Address

_____

City *State* *Zip*

_____

E-mail *Fax**

_____

It is extremely important that you list the pharmacy's fax number.

Compounding/ Supplement Pharmacy

Name *Phone Number*

_____

Address

_____

City *State* *Zip*

_____

E-mail *Fax**

_____

It is extremely important that you list the pharmacy's fax number.

CREDIT CARD INFORMATION

Patient _____ Date _____

DOB _____

Preferred Method of Payment (please circle one): Cash / Check / Credit Card

If paying by credit card, we accept VISA, MasterCard, and Discover.

Name on Card _____

Card Type ❑Visa ❑MasterCard ❑Discover

Account Number _____Expiration Date (mm/yy) _____ CVV# _____

I am placing this card on file and understand that my credit card will be charged per General Information Consent and office policy.

_____ _____

Signed *Date*

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:

Describe Problem	Mild	Moderate	Severe	Prior Treatment/ Approach	Mild	Moderate	Severe
Example: Post Nasal Drip	*X*			*Elimination Diet*			

MEDICAL HISTORY

DISEASES/DIAGNOSIS/CONDITIONS

❑ *P=Past Condition* ❑ *O=Ongoing Condition* *Check Appropriate box and provide date of onset.*

P	O	GASTROINTESTINAL	DATE
❑	❑	Irritable Bowel Syndrome	
❑	❑	Inflammatory Bowel Disease	
❑	❑	Crohn's	
❑	❑	Ulcerative Colitis	
❑	❑	Gastritis or Peptic Ulcer Disease	
❑	❑	GERD (reflux)	
❑	❑	Celiac Disease	

P	O	CARDIOVASCULAR	DATE
❑	❑	Heart Attack	
❑	❑	Other Heart Disease	
❑	❑	Stroke	
❑	❑	Elevated Cholesterol	
❑	❑	Arrhythmia (irregular heart beat)	
❑	❑	Hypertension (high blood pressure)	
❑	❑	Rheumatic Fever	
❑	❑	Mitral Valve Prolapse	
❑	❑	Other	

P	O	METABOLIC/ENDOCRINE	DATE
❑	❑	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	
❑	❑	Infertility	
❑	❑	Weight Gain	
❑	❑	Weight Loss	
❑	❑	Frequent Weight Fluctuations	
❑	❑	Bulimia	
❑	❑	Anorexia	
❑	❑	Night Eating Syndrome	
❑	❑	Eating Disorder (non-specific)	
❑	❑	Other_____	

P	O	CANCER	DATE
❑	❑	Lung Cancer	
❑	❑	Breast Cancer	
❑	❑	Colon Cancer	
❑	❑	Ovarian Cancer	
❑	❑	Prostate Cancer	
❑	❑	Other _____	

P	O	GENITAL & URINARY SYSTEMS	DATE
❑	❑	Kidney Stones	
❑	❑	Gout	
❑	❑	Interstitial Cystitis	
❑	❑	Frequent Urinary Tract Infections	
❑	❑	Frequent Yeast Infections	
❑	❑	Erectile or Sexual Dysfunction	
❑	❑	Other_____	

P	O	MUSCLOSKELETAL/ PAIN	DATE
❑	❑	Osteoarthritis	
❑	❑	Fibromyalgia	
❑	❑	Chronic Pain	
❑	❑	Other _____	

P	O	INFLAMMATORY/AUTOIMMUNE	DATE
❑	❑	Chronic Fatigue Syndrome	
❑	❑	Autoimmune Disease	
❑	❑	Rheumatoid Arthritis	
❑	❑	Lupus SLE	
❑	❑	Immune Deficiency Disease	
❑	❑	Herpes-Genital	
❑	❑	Severe Infectious Disease	
❑	❑	Poor Immune Function (frequent infections)	
❑	❑	Food Allergies	
❑	❑	Environmental Allergies	
❑	❑	Multiple Chemical Sensitivities	
❑	❑	Latex Allergy	
❑	❑	Other_____	

P	O	RESPIRATORY DISEASES	DATE
❑	❑	Asthma	
❑	❑	Chronic Sinusitis	
❑	❑	Bronchitis	
❑	❑	Emphysema	
❑	❑	Pneumonia	
❑	❑	Tuberculosis	
❑	❑	Sleep Apnea	

P	O	SKIN DISEASES	DATE
❑	❑	Eczema	
❑	❑	Psoriasis	
❑	❑	Acne	
❑	❑	Melanoma	
❑	❑	Skin Cancer	
❑	❑	Other _____	

MEDICAL HISTORY (CONTINUED)

P	O	NEUROLOGIC/MOOD	DATE
❑	❑	Depression	
❑	❑	Anxiety	
❑	❑	Bipolar Disorder	
❑	❑	Schizophrenia	
❑	❑	Headaches	
❑	❑	Migraines	
❑	❑	ADD/ADHD	
❑	❑	Autism	
❑	❑	Mild Cognitive Impairment	
❑	❑	Memory Problems	
❑	❑	Parkinson's Disease	
❑	❑	Multiple Sclerosis	
❑	❑	ALS	
❑	❑	Seizures	
❑	❑	Other_____	

PREVENTATIVE TESTS/SURGERIES

Check box if yes and provide date.

Y	PREVENTATIVE TESTS	DATE
❑	Full Physical Exam	
❑	Bone Density	
❑	Colonoscopy	
❑	Cardiac Stress Test	
❑	EBT Heart Scan	
❑	EKG	
❑	Hemoccult Test- blood in stool	
❑	MRI	
❑	CT Scan	
❑	Upper Endoscopy	
❑	Upper GI Series	
❑	Ultrasound	

Y	SURGERIES	DATE
❑	Appendectomy	
❑	Hysterectomy +/ - Ovaries	
❑	Gall Bladder	
❑	Hernia	
❑	Tonsillectomy	
❑	Dental Surgery	
❑	Joint Replacement- Knee/Hip	
❑	Heart Surgery-Bypass Valve	
❑	Angioplasty or Stent	
❑	Pacemaker	
❑	Other _____	
❑	Other _____	

Y	INJURIES	DATE
❑	Back/ Neck Injury	
❑	Head Injury	
❑	Broken Bones	
❑	Scars *Where?* _____	
❑	Other _____	

BLOOD TYPE

❑A ❑B ❑AB ❑O

❑Rh + ❑unknown

HOSPITALIZATIONS ❑None

Date	Reason

COMMENTS/ ELOBORATE ON ANY TRAUMA (PHYSICAL OR EMOTIONAL IN YOUR LIFE)

_____

_____

_____

GYNECOLOGIC HISTORY (FOR WOMEN ONLY)

OBSTETRIC HISTORY *If yes, check box and provide number.*

❑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

Has your period ever skipped? _____ For how long?_____

Last Menstrual Period:_____

Do/Have you used hormonal contraception: ❑Birth Control Pills ❑Patch ❑Nova Ring ❑IUD How long?_____

Do you currently use contraception? ❑Yes ❑No ❑Condom ❑Diaphragm ❑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

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?_____

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 ❑ 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? ❑ 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

Pregnancy Complications: _____

Birth Complications:_____

❑ Breast Fed. How long?_____ ❑ Bottle-fed

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

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

VACCINATIONS

Did you receive typical childhood vaccinations? ❑ Yes ❑ No
Did you ever have any reactions to vaccinations? ❑ Yes ❑ No Describe _____
Did you serve in the military and receive vaccinations? ❑ Yes ❑ No
Did you receive any additional vaccinations? ❑ Yes ❑ No Describe _____

DENTAL HISTORY

DENTAL SURGERY

❑ Silver Mercury Fillings How many? _____ When? _____ ❑ Gold Fillings ❑ Implants

❑ Root Canals How many? _____ When? _____ ❑ Wisdom Teeth Removal When? _____

❑ TMJ/ Joint Pain ❑ Grinding at night ❑ Tooth Pain ❑ Bleeding Gums ❑ Gingivitis

❑ Problems with Chewing

Do you floss regularly? ❑ Yes ❑ No

MEDICATIONS

CURRENT MEDICATIONS

Medication	Dose	Frequency	Start Date (month/yr)	Reason for Use

PREVIOUS MEDICATIONS *(LAST 10 YEARS)*

Medication	Dose	Frequency	Start Date (month/yr)	Reason for Use

NUTRITIONAL SUPPLEMENTS *(VITAMINS/MINERALS/HERBS/HOMEOPATHY)*

Supplement and Brand	Dose	Frequency	Start Date (month/yr)	Reason for Use

Have your medications or supplements ever caused you unusual side effects or problems? ❑ Yes ❑ No
Describe: _____
Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ❑ Yes ❑ No
Have you had prolonged or regular use of Tylenol? ❑ Yes ❑ No
Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.) ❑ Yes ❑ No
Frequent antibiotics > 3 times/year ❑ Yes ❑ No
Long term antibiotics ❑Yes ❑ No
Use of steroids (prednisone, nasal allergy inhalers) in the past ❑ Yes ❑ No
Use of oral contraceptives ❑ Yes ❑ No

FAMILY HISTORY

Add ages in appropriate column. Check if disorder applies.	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Others
Age(s) (if still alive)												
Age(s) at death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (Psoriatic, Rheumatoid, Ankylosing Sondylitis)												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema/Psoriasis												
Food Allergies, Sensitivities												
Environmental Sensitivities												
Dementia												
Parkinson’s												
ALS or Motor Neuron Disease												
Genetic Disorders												
Substance Abuse (alcoholism, etc)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												

SOCIAL HISTORY

NUTRITION HISTORY

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

Have you made any changes in your eating habits because of your health? ❑ Yes ❑ No Describe:_____

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 ❑Other _____

❑ Specific Program for Weight Loss/Maintenance Type: _____

Height (feet/inches)_____ Current Weight _____ Body Fat % _____

Usual Weight Range +/- 5 lbs _____ Desired Weight Range +/- 5 lbs _____

Highest adult weight _____ Lowest adult weight _____ Weight Fluctuations (> 10 lbs.) ☐ Yes ☐ No

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

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 ❑ 3-5 ❑ >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 change about my diet to improve my health is:

_____

SMOKING

Currently Smoking? ❑Yes ❑No How many years? _____ Packs per day: _____

Attempts to quit: _____

Previous Smoking: How many years? _____ Packs per day? _____

Second Hand Smoke Exposure? _____

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 ❑ > 10 If "None," skip to Other Substances

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

Have you ever been told you should cut down 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 been arrested or hospitalized because of 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 | Tea cups/day: ❑ 1 ❑ 2-4 ❑ > 4

Caffeinated Sodas or Diet Sodas Intake: ❑ Yes ❑ No

12-ounce can/bottle ❑ 1 ❑ 2-4 ❑> 4 per day

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

Are you currently using any recreational drugs? ❑ Yes ❑ No 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, pliates, qi gong, etc.)			
Sports/Leisure(golf, tennis, 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? ❑Yes ❑ No

If yes, please describe:_____

_____

Do you usually sweat when exercising? ❑Yes ❑ No

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 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 sought 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 ❑ Meditation ❑ Imagery ❑Breathing ❑ Tai Chi ❑ Prayer ❑ Other: _____

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

SLEEP/REST

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

Do you have trouble falling asleep? ❑ Yes ❑ No Do you feel rested upon awakening? ❑ Yes ❑ No

Do you have problems with insomnia? ❑Yes ❑ No Do you snore? ❑ Yes ❑ No

Do you use sleeping aids? ❑ Yes ❑ No Explain:_____

ROLES/RELATIONSHIPS

Marital status ❑ Single ❑ Married ❑ Divorced ❑ Gay/Lesbian ❑Long Term Partnership ❑ Widow

List Children:

Child's Name	**Age**	**Gender**

Who is living in household? Number:_____ Names:_____

Their Employment/Occupations:_ _____

Resources for emotional support?

Check all that apply: ❑ Spouse ❑ Family ❑ Friends ❑ Religious/Spiritual ❑Pets ❑Other: _____

What is your Religious/Spiritual background? _____

Are you actively involved in Religious/Spiritual events? ❑ Yes ❑ No _____

_____

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 spouse				
With your children				
With your parents				

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:_____ ❑ No

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

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 (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 of exterminator) ❑ Pesticides ❑Organic Solvents

❑ Heavy Metals ❑ Other_____

Chemical Name, Date, Length of Exposure:_____

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

Do/ Did you live or work in a damp or moldy environment or had other mold exposures? ❑ Yes ❑ No

Do/Did you have any pets or farm animals? ❑ Yes ❑ No

SYMPTOM REVIEW

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

GENERAL
- ☐ cold hands and feet
- ☐ cold intolerance
- ☐ low body temperature
- ☐ low blood pressure
- ☐ daytime sleepiness
- ☐ difficulty falling asleep
- ☐ early waking
- ☐ fatigue
- ☐ fever
- ☐ flushing
- ☐ heat intolerance
- ☐ night walking
- ☐ nightmares
- ☐ no dream recall

DRYNESS OF:
- ☐ skin in general
- ☐ eyes
- ☐ feet cracking or peeling
- ☐ hair/ unmanageable hair
- ☐ hands w/ cracking / peeling
- ☐ mouth or throat
- ☐ scalp/ dandruff

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 (except 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
- ☐ muscle twitches- arms or legs
- ☐ muscle weakness
- ☐ neck muscle spasm
- ☐ tendonitis
- ☐ TMJ problems

MOOD/PSYCHOLOGICAL
- ☐ agoraphobia
- ☐ anxiety
- ☐ auditory hallucinations
- ☐ black-out, depression
- ☐ difficulty with concentrating
- ☐ difficulty with balance
- ☐ difficulty with thinking
- ☐ difficulty with judgment
- ☐ difficulty with speech
- ☐ difficulty 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
- ☐ difficulty gaining weight
- ☐ difficulty losing weight
- ☐ difficulty keeping healthy weight
- ☐ frequent dieting
- ☐ poor appetite
- ☐ salt cravings
- ☐ carbohydrate cravings (breads/pastas)
- ☐ sweet cravings (candy, cookies, cakes)
- ☐ chocolate cravings
- ☐ caffeine dependency

DIGESTION/ GI
- ☐ anal spasms
- ☐ bad teeth
- ☐ bleeding gums
- ☐ bloating of lower abdomen
- ☐ bloating of whole abdomen
- ☐ bloating after meals
- ☐ blood in stools
- ☐ burping
- ☐ cancer sores
- ☐ cold sores
- ☐ constipation
- ☐ cracking at corner of lips
- ☐ cramps
- ☐ dentures w/poor chewing
- ☐ diarrhea
- ☐ alternating diarrhea /constipation
- ☐ difficulty swallowing
- ☐ dry mouth
- ☐ excess flatulence/ gas
- ☐ fissures
- ☐ reflux
- ☐ gas
- ☐ heartburn
- ☐ hemorrhoids
- ☐ indigestion
- ☐ nausea
- ☐ upper abdominal pain
- ☐ vomiting
- ☐ intolerance to lactose
- ☐ intolerance to all dairy products
- ☐ intolerance to wheat
- ☐ intolerance to gluten(wheat/barley)
- ☐ intolerance to corn
- ☐ intolerance to eggs
- ☐ intolerance to fatty foods
- ☐ intolerance to yeast
- ☐ liver disease/jaundice
- ☐ abnormal liver function tests
- ☐ lower abdominal pain
- ☐ mucus in stools
- ☐ periodontal disease
- ☐ sore tongue
- ☐ strong stool/ flatulence 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
- ☐ hives
- ☐ jock itch
- ☐ lackluster skin
- ☐ moles with color or size change
- ☐ oily skin
- ☐ pale skin
- ☐ patchy dullness
- ☐ rash
- ☐ red face
- ☐ sensitivity to bites
- ☐ shingles
- ☐ skin darkening
- ☐ dark patches on face
- ☐ strong body odor
- ☐ hair loss
- ☐ vitiligo/ white patches

ITCHING
- ☐ skin in general
- ☐ anus
- ☐ arms
- ☐ ear canals
- ☐ eyes
- ☐ feet
- ☐ hands
- ☐ legs
- ☐ nipples
- ☐ nose
- ☐ penis
- ☐ roof of mouth
- ☐ scalp
- ☐ throat

LYMPH NODES
- ☐ enlarged nodes to neck
- ☐ tender nodes to neck
- ☐ other enlarged/ tender nodes _____

NAILS
- ☐ Bitten
- ☐ Brittle
- ☐ curve up
- ☐ frayed
- ☐ fungus-fingers
- ☐ fungus- toes
- ☐ pitting
- ☐ ridges
- ☐ soft
- ☐ white spots
- ☐ lines
- ☐ brown lines
- ☐ thickening of fingernails
- ☐ thickening of toenails
- ☐ ragged cuticles

RESPIRATORY
- ☐ bad breath
- ☐ bad odor in nose
- ☐ dry cough
- ☐ productive cough
- ☐ hoarseness
- ☐ sore throat
- ☐ hay fever-
  - ☐ spring
  - ☐ summer
  - ☐ fall
  - ☐ change of season
- ☐ nasal stuffiness
- ☐ post nasal drip
- ☐ sinus fullness
- ☐ sinus infection
- ☐ snoring
- ☐ wheezing
- ☐ winter stuffiness

CARDIOVASCULAR
- ☐ angina/ chest pain every _____
- ☐ breathlessness
- ☐ heart murmur
- ☐ irregular pulse
- ☐ palpations
- ☐ phlebitis
- ☐ swollen ankles/ feet
- ☐ varicose veins

URINARY
- ☐ bed wetting
- ☐ hesitancy
- ☐ infection
- ☐ kidney disease
- ☐ leaking/ incontinence
- ☐ pain/burning
- ☐ prostate infection
- ☐ urgency

MALE REPRODUCTIVE
- ☐ discharge from penis
- ☐ ejaculation problem
- ☐ genital pain
- ☐ impotence
- ☐ prostate or urinary infection
- ☐ lump in testicles
- ☐ poor libido

FEMALE REPRODUCTIVE
- ☐ breast cysts
- ☐ breast lumps
- ☐ breast tenderness
- ☐ ovarian cysts
- ☐ poor libido
- ☐ vaginal discharge
- ☐ vaginal odor
- ☐ vaginal itch
- ☐ vaginal pain with sex
- ☐ easily gets yeast infections

Premenstrual symptoms:
- ☐ bloating
- ☐ breast tenderness
- ☐ carbohydrate cravings
- ☐ constipation
- ☐ decreased sleep
- ☐ diarrhea
- ☐ fatigue
- ☐ increased sleep
- ☐ irritability

Menstrual symptoms:
- ☐ cramps
- ☐ heavy periods
- ☐ irregular periods
- ☐ no periods
- ☐ scanty periods
- ☐ spotting between periods

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 DIET DIARY 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.

- Do not change your eating behavior at this time, as the purpose of this food record is to analyze your present eating habits.
- Record information as soon as possible after the food has been consumed
- 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 w/ sugar and ½ & 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 1 teaspoon 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 sweet, 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 DIARY

Name:_____ Date: _____

DAY 1

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Bowel Movements (#, form, color)_____

Stress/Mood/Emotions _____

Other Comments_____

DAY 2

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Bowel Movements (#, form, color)_____

Stress/Mood/Emotions _____

Other Comments_____

DAY 3

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Bowel Movements (#, form, color)_____

Stress/Mood/Emotions _____

Other Comments_____