WESTERN WISCONSIN HEALTH

Enclosed you will find a questionnaire that is required for your upcoming appointment with Marrie Simpson or Dr. Nash at:
Western Wisconsin Health Roberts Clinic
(503 Cherry Lane, Roberts, WI 54023)

Please answer all the questions and bring this packet with you to your appointment.

If you have any questions or are unable to make your appointment, please call us at 715-760-3311 or 715-684-1652.

Appointment Date: _____

Time: _____

Please arrive 30 minutes early to get checked in and have your vitals taken. Have your insurance card and an updated photo id with you, in case we need to update our computer system. Also, please bring a list of any medications and or supplements (vitamins) you may be taking, showing the strength and dosage amounts.

Thank you.

Female Intake Questionnaire

General Information

Name_____ Age_____ Today's Date _____

Date of Birth _____ Email _____

Address _____ City_____ State ____ Zip_____

Phone (Home)_____ (Cell)_____ (Work) _____

Genetic Background: ☐ African American ☐ Hispanic ☐ Mediterranean ☐ Asian
☐ Native American ☐ Caucasian ☐ Northern European
☐ Other _____

When, where and from whom did you last receive medical or health care? _____

_____

Emergency Contact: _____ Relationship _____

Phone (Home)_____ (Cell)_____ (Work) _____

How did you hear about our practice?

☐ Clinic website ☐ IFM website ☐ Referral from doctor ☐ Referral from friend/family member
☐ Social media ☐ Other_____

Current Health Concerns

Please rank current and ongoing health concerns in order of priority

Describe Problem / Severity	Mild	Moderate	Severe	Prior Treatment/Approach / Success	Excellent	Good	Fair
Example: Post Nasal Drip	*X*			*Elimination Diet*	*X*		
1.							
2.							
3.							
4.							
5.							
7.							
8.							
9.							
9.							
10.							

Allergies

Name of Medication/Supplement/Food:	Reaction:
1.	
2.	
3.	
4.	
5.	

Lifestyle Review

Sleep

How many hours of sleep do you get each night on average?_____

Do you have problems falling asleep? ☐ Yes ☐ No Staying asleep? ☐ Yes ☐ No

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

Do you feel rested upon awakening? ☐ Yes ☐ No

Do you use sleeping aids? ☐ Yes ☐ No

If yes, explain:_____

Exercise

Current Exercise Program:

Activity	Type	# of Times Per Week	Time/Duration (Minutes)
Cardio/Aerobic			
Strength/Resistance			
Flexibility/Stretching			
Balance			
Sports/Leisure (e.g., golf)			
Other:			

Do you feel motivated to exercise? ☐ Yes ☐ A little ☐ No

Are there any problems that limit exercise? ☐ Yes ☐ No

If yes, explain:_____

Do you feel unusually fatigued or sore after exercise? ☐ Yes ☐ No

If yes, explain:_____

Nutrition

Do you currently follow any of the following special diets or nutritional programs? *(Check all that apply)*

☐ Vegetarian ☐ Vegan ☐ Allergy ☐ Elimination ☐ Low Fat ☐ Low Carb ☐ High Protein
☐ Blood Type ☐ Low sodium ☐ No Dairy ☐ No Wheat ☐ Gluten Free
☐ Other: _____

Do you have sensitivities to certain foods? ☐ Yes ☐ No
If yes, list food and symptoms: _____

Do you have an aversion to certain foods? ☐ Yes ☐ No
If yes, explain: _____

Do you adversely react to: *(Check all that apply)*

☐ Monosodium glutamate (MSG) ☐ Artificial sweeteners ☐ Garlic/onion ☐ Cheese ☐ Citrus foods
☐ Chocolate ☐ Alcohol ☐ Red wine ☐ Sulfite–containing foods (wine, dried fruit, salad bars)
☐ Preservatives ☐ Food colorings ☐ Other food substances: _____

Are there any foods that you crave or binge on? ☐ Yes ☐ No
If yes, what foods? _____

Do you eat 3 meals a day? ☐ Yes ☐ No If no, how many _____

Does skipping a meal greatly affect you? ☐ Yes ☐ No

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

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

☐ Fast eater
☐ Eat too much
☐ Late-night eating
☐ Dislike healthy foods
☐ Time constraints
☐ Travel frequently
☐ Eat more than 50% of meals away from home
☐ Healthy foods not readily available
☐ Poor snack choices
☐ Significant other or family members don't like healthy foods
☐ Significant other or family members have special dietary needs
☐ Love to eat
☐ Eat because I have to
☐ Have negative relationship to food
☐ Struggle with eating issues
☐ Emotional eater (eat when sad, lonely, bored, etc.)
☐ Eat too much under stress
☐ Eat too little under stress
☐ Don't care to cook
☐ Confused about nutrition advice

Diet

Please record what you eat in a typical day:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Fluids _____

How many servings do you eat in a typical week of these foods:

Fruits (not juice)_____ Vegetables (not including white potatoes) _____

Legumes (beans, peas, etc) _____ Red meat _____ Fish _____

Dairy/Alternatives _____ Nuts & Seeds _____ Fats & Oils _____

Cans of soda (regular or diet) _____ Sweets (candy, cookies, cake, ice cream, etc.) _____

Do you drink caffeinated beverages? ☐ Yes ☐ No If yes, check amounts:

Coffee (cups per day) ☐ 1 ☐ 2-4 ☐ >4 Tea (cups per day) ☐ 1 ☐ 2-4 ☐ >4

Caffeinated sodas—regular or diet (cans per day) ☐ 1 ☐ 2-4 ☐ >4

Do you have adverse reactions to caffeine? ☐ Yes ☐ No

If yes, explain: _____

When you drink caffeine do you feel: ☐ Irritable or wired ☐ Aches or pains

Smoking

Do you smoke currently? ☐ Yes ☐ No Packs per day: _____ Number of years _____

What type? ☐ Cigarettes ☐ Smokeless ☐ Pipe ☐ Cigar ☐ E-Cig

Have you attempted to quit? ☐ Yes ☐ No

If yes, using what methods: _____

If you smoked previously: Packs per day: _____ Number of years _____

Are you regularly exposed to second-hand smoke? ☐ Yes ☐ No

Alcohol

How many alcoholic beverages do you drink in a week? *(1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits)*

☐ 1–3 ☐ 4–6 ☐ 7–10 ☐ >10 ☐ None

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

Have you ever had a problem with alcohol? ☐ Yes ☐ No

If yes, when? _____

Explain the problem: _____

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

Other Substances

Are you currently using any recreational drugs? ☐ Yes ☐ No

If yes, type: _____

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

Stress

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

How much stress do each of the following cause on a daily basis *(Rate on scale of 1-10, 10 being highest)*

Work ____ Family ____ Social ____ Finances ____ Health ____ Other____

Do you use relaxation techniques? ☐ Yes ☐ No

If yes, how often? _____

Which techniques do you use? *(Check all that apply)*

☐ Meditation ☐ Breathing ☐ Tai Chi ☐ Yoga ☐ Prayer ☐ Other: _____

Have you ever sought counseling? ☐ Yes ☐ No

Are you currently in therapy? ☐ Yes ☐ No

If yes, describe: _____

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

What are your hobbies or leisure activities?_____

Relationships

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Gay/Lesbian ☐ Long-Term Partner ☐ Widow/er

With whom do you live? (Include children, parents, relatives, friends, pets) _____

_____

Current occupation: _____

Previous occupations:_____

Do you have resources for emotional support? ☐ Yes ☐ No *(Check all that apply)*

☐ Spouse/Partner ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other:_____

Do you have a religious or spiritual practice? ☐ Yes ☐ No

If yes, what kind? _____

How well have things been going for you? *(Mark on scale of 1–10, or N/A if not applicable)*

	N/A	Poorly				Fine					Very Well
Overall	☐	1	2	3	4	5	6	7	8	9	10
At school	☐	1	2	3	4	5	6	7	8	9	10
In your job	☐	1	2	3	4	5	6	7	8	9	10
In your social life	☐	1	2	3	4	5	6	7	8	9	10
With close friends	☐	1	2	3	4	5	6	7	8	9	10
With sex	☐	1	2	3	4	5	6	7	8	9	10
With your attitude	☐	1	2	3	4	5	6	7	8	9	10
With your boyfriend/girlfriend	☐	1	2	3	4	5	6	7	8	9	10
With your children	☐	1	2	3	4	5	6	7	8	9	10
With your parents	☐	1	2	3	4	5	6	7	8	9	10
With your spouse	☐	1	2	3	4	5	6	7	8	9	10

History

Patient's Birth/Childhood History:

You were born: ☐ Term ☐ Premature ☐ Don't know

Were there any pregnancy or birth complications? ☐ Yes ☐ No

If yes, explain:_____

You were: ☐ Breast-fed/How long? _____ ☐ Bottle-fed/Type of formula:_____ ☐ Don't know

Age of introduction of: Solid food:_____ Wheat _____ Dairy _____

As a child, were there any foods that were avoided because they gave you symptoms? ☐ Yes ☐ No

If yes, what foods and what symptoms? (Example: milk—gas and diarrhea)

_____

_____

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

Dental History:

Check if you have any of the following, and provide number if applicable:

☐ Silver mercury fillings ____ ☐ Gold fillings ____ ☐ Root canals ____ ☐ Implants ____

☐ Caps/Crowns ____ ☐ Tooth pain____ ☐ Bleeding gums____ ☐ Gingivitis _____

☐ Problems with chewing____ ☐ Other dental concerns (explain):_____

Have you had any mercury fillings removed? ☐ Yes ☐ No If yes, when:_____

How many fillings did you have as a kid? _____

Do you brush regularly? ☐ Yes ☐ No Do you floss regularly? ☐ Yes ☐ No

Environmental/Detoxification History

Do any of these significantly affect you?

☐ Cigarette smoke ☐ Perfume/colognes ☐ Auto exhaust fumes ☐ Other: _____

In your work or home environment are you regularly exposed to: *(Check all that apply)*

☐ Mold ☐ Water leaks ☐ Renovations ☐ Chemicals ☐ Electromagnetic radiation

☐ Damp environments ☐ Carpets or rugs ☐ Old paint ☐ Stagnant or stuffy air ☐ Smokers

☐ Pesticides ☐ Herbicides ☐ Harsh chemicals (solvents, glues, gas, acids, etc) ☐ Cleaning chemicals

☐ Heavy metals (lead, mercury, etc.) ☐ Paints ☐ Airplane travel ☐ Other _____

Have you had a significant exposure to any harmful chemicals? ☐ Yes ☐ No

If yes: Chemical name, length of exposure, date:_____

Do you have any pets or farm animals? ☐ Yes ☐ No

If yes, do they live: ☐ Inside ☐ Outside ☐ Both inside and outside

Symptom Review

Please check if these symptoms occur presently or have occurred in the last 6 months

General	Mild	Moderate	Severe
Cold hands and feet	☐	☐	☐
Cold intolerance	☐	☐	☐
Daytime sleepiness	☐	☐	☐
Difficulty falling asleep	☐	☐	☐
Early waking	☐	☐	☐
Fatigue	☐	☐	☐
Fever	☐	☐	☐
Flushing	☐	☐	☐
Heat intolerance	☐	☐	☐
Night waking	☐	☐	☐
Nightmares	☐	☐	☐
Can't remember dreams	☐	☐	☐
Low body temperature	☐	☐	☐
Head, Eyes, and Ears			
Conjunctivitis	☐	☐	☐
Distorted sense of smell	☐	☐	☐
Distorted taste	☐	☐	☐
Ear fullness	☐	☐	☐
Ear ringing/buzzing	☐	☐	☐
Eye crusting	☐	☐	☐
Eye pain	☐	☐	☐
Eyelid margin redness	☐	☐	☐
Headache	☐	☐	☐
Hearing loss	☐	☐	☐
Hearing problems	☐	☐	☐
Migraine	☐	☐	☐
Sensitivity to loud noises	☐	☐	☐
Vision problems	☐	☐	☐
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	☐	☐	☐

Musculoskeletal *(cont.)*	Mild	Moderate	Severe
Neck muscle spasm	☐	☐	☐
Tendonitis	☐	☐	☐
Tension headache	☐	☐	☐
TMJ problems	☐	☐	☐
Mood/Nerves			
Agoraphobia	☐	☐	☐
Anxiety	☐	☐	☐
Auditory hallucinations	☐	☐	☐
Blackouts	☐	☐	☐
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	☐	☐	☐
Cardiovascular			
Angina/chest pain	☐	☐	☐
Breathlessness	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
High blood pressure	☐	☐	☐
Irregular pulse	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Palpitations	☐	☐	☐
Phlebitis	☐	☐	☐
Swollen ankles/feet	☐	☐	☐
Varicose veins	☐	☐	☐

Symptom Review *(cont.)*

Please check if these symptoms occur presently or have occurred in the last 6 months

Urinary	Mild	Moderate	Severe
Bed wetting	☐	☐	☐
Hesitancy	☐	☐	☐
Infection	☐	☐	☐
Kidney disease	☐	☐	☐
Kidney stone	☐	☐	☐
Leaking/incontinence	☐	☐	☐
Pain/burning	☐	☐	☐
Urgency	☐	☐	☐
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	☐	☐	☐
Dentures w/poor chewing	☐	☐	☐
Diarrhea	☐	☐	☐
Difficulty swallowing	☐	☐	☐
Dry mouth	☐	☐	☐
Farting	☐	☐	☐
Fissures	☐	☐	☐
Foods "repeat" (reflux)	☐	☐	☐
Heartburn	☐	☐	☐
Hemorrhoids	☐	☐	☐
Intolerance to:	☐	☐	☐
Lactose	☐	☐	☐
All dairy products	☐	☐	☐
Gluten (wheat)	☐	☐	☐
Corn	☐	☐	☐
Eggs	☐	☐	☐
Fatty foods	☐	☐	☐
Yeast	☐	☐	☐
Liver disease/jaundice (yellow eyes or skin)	☐	☐	☐
Lower abdominal pain	☐	☐	☐
Mucus in stools	☐	☐	☐

Digestion *(cont.)*	Mild	Moderate	Severe
Nausea	☐	☐	☐
Periodontal disease	☐	☐	☐
Sore tongue	☐	☐	☐
Strong stool odor	☐	☐	☐
Undigested food in stools	☐	☐	☐
Upper abdominal pain	☐	☐	☐
Vomiting	☐	☐	☐
Eating			
Binge eating	☐	☐	☐
Bulimia	☐	☐	☐
Can't gain weight	☐	☐	☐
Can't lose weight	☐	☐	☐
Carbohydrate craving	☐	☐	☐
Carbohydrate intolerance	☐	☐	☐
Poor appetite	☐	☐	☐
Salt cravings	☐	☐	☐
Frequent dieting	☐	☐	☐
Sweet cravings	☐	☐	☐
Caffeine dependency	☐	☐	☐
Respiratory			
Bad breath	☐	☐	☐
Bad odor in nose	☐	☐	☐
Cough – dry	☐	☐	☐
Cough – productive	☐	☐	☐
Hayfever:	☐	☐	☐
Spring	☐	☐	☐
Summer	☐	☐	☐
Fall	☐	☐	☐
Change of season	☐	☐	☐
Hoarseness	☐	☐	☐
Nasal stuffiness	☐	☐	☐
Nose bleeds	☐	☐	☐
Post nasal drip	☐	☐	☐
Sinus fullness	☐	☐	☐
Sinus infection	☐	☐	☐
Snoring	☐	☐	☐
Sore throat	☐	☐	☐
Wheezing	☐	☐	☐
Winter stuffiness	☐	☐	☐

Symptom Review *(cont.)*

Please check if these symptoms occur presently or have occurred in the last 6 months

Nails	Mild	Moderate	Severe
Bitten	☐	☐	☐
Brittle	☐	☐	☐
Curve up	☐	☐	☐
Frayed	☐	☐	☐
Fungus – fingers	☐	☐	☐
Fungus – toes	☐	☐	☐
Pitting	☐	☐	☐
Ragged cuticles	☐	☐	☐
Ridges	☐	☐	☐
Soft	☐	☐	☐
Thickening of:	☐	☐	☐
Finger nails	☐	☐	☐
Toenails	☐	☐	☐
White spots/lines	☐	☐	☐
Lymph Nodes			
Enlarged/neck	☐	☐	☐
Tender/neck	☐	☐	☐
Other enlarged/tender lymph nodes	☐	☐	☐
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	☐	☐	☐
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	☐	☐	☐

Skin Problems *(cont.)*	Mild	Moderate	Severe
Ears get red	☐	☐	☐
Easy bruising	☐	☐	☐
Eczema	☐	☐	☐
Herpes – genital	☐	☐	☐
Hives	☐	☐	☐
Jock itch	☐	☐	☐
Lackluster skin	☐	☐	☐
Moles w color/size change	☐	☐	☐
Oily skin	☐	☐	☐
Pale skin	☐	☐	☐
Patchy dullness	☐	☐	☐
Psoriasis	☐	☐	☐
Rash	☐	☐	☐
Red face	☐	☐	☐
Sensitive to bites	☐	☐	☐
Sensitive to poison ivy/oak	☐	☐	☐
Shingles	☐	☐	☐
Skin cancer	☐	☐	☐
Skin darkening	☐	☐	☐
Strong body odor	☐	☐	☐
Thick calluses	☐	☐	☐
Vitiligo	☐	☐	☐
Itching Skin			
Anus	☐	☐	☐
Arms	☐	☐	☐
Ear canals	☐	☐	☐
Eyes	☐	☐	☐
Feet	☐	☐	☐
Hands	☐	☐	☐
Legs	☐	☐	☐
Nipples	☐	☐	☐
Nose	☐	☐	☐
Genitals	☐	☐	☐
Roof of mouth	☐	☐	☐
Scalp	☐	☐	☐
Skin in general	☐	☐	☐
Throat	☐	☐	☐

Symptom Review *(cont.)*

Please check if these symptoms occur presently or have occurred in the last 6 months

Female Reproductive	Mild	Moderate	Severe
Breast cysts	☐	☐	☐
Breast lumps	☐	☐	☐
Breast tenderness	☐	☐	☐
Ovarian cyst	☐	☐	☐
Poor libido (sex drive)	☐	☐	☐
Endometriosis	☐	☐	☐
Fibroids	☐	☐	☐
Infertility	☐	☐	☐
Vaginal discharge	☐	☐	☐
Vaginal odor	☐	☐	☐
Vaginal itch	☐	☐	☐
Vaginal pain	☐	☐	☐
Premenstrual:	☐	☐	☐
Bloating	☐	☐	☐
Breast tenderness	☐	☐	☐
Carbohydrate craving	☐	☐	☐
Chocolate craving	☐	☐	☐
Constipation	☐	☐	☐
Decreased sleep	☐	☐	☐
Diarrhea	☐	☐	☐
Fatigue	☐	☐	☐
Increased sleep	☐	☐	☐
Irritability	☐	☐	☐
Menstrual:	☐	☐	☐
Cramps	☐	☐	☐
Heavy periods	☐	☐	☐
Irregular periods	☐	☐	☐
No periods	☐	☐	☐
Scanty periods	☐	☐	☐
Spotting between	☐	☐	☐

Readiness Assessment and Health Goals

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

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 follow through? _____

_____

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

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

How much ongoing support (e.g., telephone consults, email correspondence) from our professional staff would be helpful to you as you implement your personal health program? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Comments _____

_____

How many times have you taken antibiotics?

	< 5	> 5	Reason for Use
Infancy/Childhood			
Teen			
Adulthood			

Have you ever taken long term antibiotics? ☐ Yes ☐ No

If yes, explain: _____

How often have you taken oral steroids (e.g., cortisone, prednisone, etc.)?

	< 5	> 5	Reason for Use
Infancy/Childhood			
Teen			
Adulthood			

Health Goals

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

_____

_____

When was the last time you felt well? _____

_____

_____

Did something trigger your change in health? _____

_____

_____

What makes you feel better? _____

_____

_____

What makes you feel worse? _____

_____

_____

How does your condition affect you? _____

_____

_____

What do you think is happening and why? _____

_____

_____

What do you feel needs to happen for you to get better? _____

_____

_____

THE INSTITUTE FOR FUNCTIONAL MEDICINE®

Medical Symptoms Questionnaire (MSQ)

Patient Name_____ Date_____

Rate each of the following symptoms based upon your typical health profile for the past 14 days.

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

HEAD

_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia

Total _____

EYES

_____ Watery 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 _____

EARS

_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss

Total _____

NOSE

_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation

Total _____

MOUTH/THROAT

_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, lips
_____ Canker sores

Total _____

SKIN

_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating

Total _____

HEART

_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain

Total _____

MEDICAL SYMPTOMS QUESTIONNAIRE (MSQ)

LUNGS

_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing **Total** _____

DIGESTIVE TRACT

_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain **Total** _____

JOINTS/MUSCLE

_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness **Total** _____

WEIGHT

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

ENERGY/ACTIVITY

_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness **Total** _____

MIND

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

EMOTIONS

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

OTHER

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

Grand Total _____

Medical History: Illnesses/Conditions

Check YES = a condition you currently have, **Check PAST** = a condition you've had in the past.

Gastrointestinal	Yes	Past
Irritable bowel syndrome	☐	☐
GERD (reflux)	☐	☐
Crohn's disease/ulcerative colitis	☐	☐
Peptic ulcer disease	☐	☐
Celiac disease	☐	☐
Gallstones	☐	☐
Other:	☐	☐
Respiratory		
Bronchitis	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Pneumonia	☐	☐
Sinusitis	☐	☐
Sleep apnea	☐	☐
Other:	☐	☐
Urinary/Genital		
Kidney stones	☐	☐
Gout	☐	☐
Interstitial cystitis	☐	☐
Frequent yeast infections	☐	☐
Frequent urinary tract infections	☐	☐
Sexual dysfunction	☐	☐
Sexually transmitted diseases	☐	☐
Other:	☐	☐
Endocrine/Metabolic		
Diabetes	☐	☐
Hypothyroidism (low thyroid)	☐	☐
Hyperthyroidism (overactive thyroid)	☐	☐
Polycystic Ovarian Syndrome	☐	☐
Infertility	☐	☐
Metabolic syndrome/insulin resistance	☐	☐
Eating disorder	☐	☐
Hypoglycemia	☐	☐
Other:	☐	☐
Inflammatory/Immune		
Rheumatoid arthritis	☐	☐
Chronic fatigue syndrome	☐	☐
Food allergies	☐	☐
Environmental allergies	☐	☐
Multiple chemical sensitivities	☐	☐
Autoimmune disease	☐	☐
Immune deficiency	☐	☐
Mononucleosis	☐	☐
Hepatitis	☐	☐
Other:	☐	☐

Musculoskeletal	Yes	Past
Fibromyalgia	☐	☐
Osteoarthritis	☐	☐
Chronic pain	☐	☐
Other:	☐	☐
Skin		
Eczema	☐	☐
Psoriasis	☐	☐
Acne	☐	☐
Skin cancer	☐	☐
Other:	☐	☐
Cardiovascular		
Angina	☐	☐
Heart attack	☐	☐
Heart failure	☐	☐
Hypertension (high blood pressure)	☐	☐
Stroke	☐	☐
High blood fats (cholesterol, triglycerides)	☐	☐
Rheumatic fever	☐	☐
Arrythmia (irregular heart rate)	☐	☐
Murmur	☐	☐
Mitral valve prolapse	☐	☐
Other:	☐	☐
Neurologic/Emotional		
Epilepsy/Seizures	☐	☐
ADD/ADHD	☐	☐
Headaches	☐	☐
Migraines	☐	☐
Depression	☐	☐
Anxiety	☐	☐
Autism	☐	☐
Multiple sclerosis	☐	☐
Parkinson's disease	☐	☐
Dementia	☐	☐
Other:	☐	☐
Cancer		
Lung	☐	☐
Breast	☐	☐
Colon	☐	☐
Ovarian	☐	☐
Skin	☐	☐
Other:	☐	☐

Medical History *(cont.)*

Diagnostic Studies	Date	Comments
Bone density		
CT scan		
Colonoscopy		
Cardiac stress test		
EKG		
MRI		
Upper endoscopy		
Upper GI series		
Chest X-ray		
Other X-rays		
Barium enema		
Other:		
Injuries		
Broken bone(s)		
Back injury		
Neck injury		
Head injury		
Other:		
Surgeries		
Appendectomy		
Dental		
Gallbladder		
Hernia		
Hysterectomy		
Tonsillectomy		
Joint replacement		
Heart surgery		
Other:		
Hospitalizations	**Date**	**Reason**

Women's History

Obstetric History: *(Check box and provide number if applicable)*

☐ Pregnancies _____ ☐ Miscarriages _____ ☐ Abortions _____ ☐ Living children _____
☐ Vaginal deliveries_____ ☐ Cesarean _____ ☐ Term births _____ ☐ Premature birth_____

Birth weight of largest baby_____ Birth weight of smallest baby _____

Did you develop any problems in or after pregnancy, for example, toxemia (high blood pressure), diabetes, post-partum depression, issues with breast feeding, etc.? ☐ Yes ☐ No
If yes, please explain _____

Menstrual History:

Age at first period _____ Date of last menstrual period _____
Length of cycle _____ Time between cycles _____
Cramping? ☐ Yes ☐ No Pain? ☐ Yes ☐ No

Have you ever had premenstrual problems (bloating, breast tenderness, irritability, etc.)? ☐ Yes ☐ No
If yes, please describe:_____

Do you have other problems with your periods (heavy, irregular, spotting, skipping, etc.)? ☐ Yes ☐ No
If yes, please describe:_____

Use of hormonal birth control: ☐ Birth control pills ☐ Patch ☐ Nuva ring
☐ Other_____ How Long _____

Any problems with hormonal birth control? ☐ Yes ☐ No
If yes, explain _____

Use of other contraception? ☐ Yes ☐ No ☐ Condoms ☐ Diaphragm ☐ IUD ☐ Partner vasectomy

Are you in menopause? ☐ Yes ☐ No If yes, age at last period:_____

Was it surgical menopause? ☐ Yes ☐ No If yes, explain surgery:_____

_____

Do you currently have symptomatic problems with menopause? *(Check all that apply)*

☐ Hot flashes ☐ Mood swings ☐ Concentration/memory problems ☐ Headaches ☐ Joint pain
☐ Vaginal dryness ☐ Weight gain ☐ Decreased libido ☐ Loss of control of urine ☐ Palpitations

Are you on hormone replacement therapy? ☐ Yes ☐ No
If yes, for how long and for what reason (hot flashes, osteoporosis prevention, etc.)?_____

_____

Other Gynecological Symptoms: *(Check if applicable)*

☐ Endometriosis ☐ Infertility ☐ Fibrocystic breasts ☐ Vaginal infection ☐ Fibroids
☐ Ovarian cysts ☐ Pelvic inflammatory disease ☐ Reproductive cancer
☐ Sexually transmitted disease (describe) _____

_____

Gynecological Screening/Procedures: *(If applicable, provide date)*

Last Pap test: _____ ☐ Normal ☐ Abnormal
Last mammogram: _____ ☐ Normal ☐ Abnormal
Last bone density: _____ Results: ☐ High ☐ Low ☐ Within Normal Range
Other tests/procedures (list type and dates) _____

_____

Family History:

Check family members that have/had any of the following

	Mother	Father	Brother (s)	Sister (s)	Child	Child	Child	Child	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other
Age (if still alive)													
Age at death (if deceased)													
Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Autoimmune disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Seizures/epilepsy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
ADHD	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Autism	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Irritable Bowel Syndrome	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Substance abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Genetic disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Medications/Supplements

Current medications (include prescription and over-the-counter)

Medication	Dosage	Start Date (mo/yr)	Reason for Use

Nutritional supplements (vitamins/minerals/herbs etc.)

Name and Brand	Dosage	Start Date (mo/yr)	Reason for Use