



WESTERN WISCONSIN HEALTH

Thank you for choosing Western Wisconsin Health Roberts Clinic for your functional medicine needs.

Enclosed you will find the paperwork to fill out for your consult and a print out of your scheduled appointments. The provider would appreciate if this paperwork could be dropped off, mailed or faxed back to us prior to your visit so that it can be reviewed.

In order for the provider to give you the best plan of care, we request that you contact any healthcare organization, outside of Allina, to release your healthcare records to Western Wisconsin Health. The types of records that are helpful include recent lab results, imaging results with the reports, recent office visit notes and sleep study results.

Please request the records at least 3 weeks prior to your consult to allow time for processing.

If you have not given us your insurance card or a photo ID it would be appreciated if you could send us front and back copies of each to be scanned into your account. You can email this to patient.access@wwhealth.org.

We encourage you to check with your insurance provider to make sure that our clinic and practitioner are within your health network.

You will need to check in 30 minutes prior to your consult for rooming time with the assistant. If you arrive late or paperwork is not complete your time with the provider will be shorter.

If you have any questions or concerns please feel free to reach out to us.

Patient Access

Western Wisconsin Health Roberts Clinic

Phone: 715-760-3311 FAX: 715-760-3036

Male 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 Social media
 Other _____
 Referral from friend/family member _____

Current Health Concerns

Please rank current and ongoing health concerns in order of priority

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

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: _____

Do you have sleep apnea? Yes No

If yes, do you use your c-pap? Yes No

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 Soy Free Corn 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:

- | | |
|---|---|
| <input type="checkbox"/> Fast eater | <input type="checkbox"/> Significant other or family members have special dietary needs |
| <input type="checkbox"/> Eat too much | <input type="checkbox"/> Love to eat |
| <input type="checkbox"/> Late-night eating | <input type="checkbox"/> Eat because I have to |
| <input type="checkbox"/> Dislike healthy foods | <input type="checkbox"/> Have negative relationship to food |
| <input type="checkbox"/> Time constraints | <input type="checkbox"/> Struggle with eating issues |
| <input type="checkbox"/> Travel frequently | <input type="checkbox"/> Emotional eater (eat when sad, lonely, bored, etc.) |
| <input type="checkbox"/> Eat more than 50% of meals away from home | <input type="checkbox"/> Eat too much under stress |
| <input type="checkbox"/> Healthy foods not readily available | <input type="checkbox"/> Eat too little under stress |
| <input type="checkbox"/> Poor snack choices | <input type="checkbox"/> Don't care to cook |
| <input type="checkbox"/> Significant other or family members don't like healthy foods | <input type="checkbox"/> 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 day 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	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
At school	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
In your job	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
In your social life	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With close friends	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With sex	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your attitude	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your boyfriend/girlfriend	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your children	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your parents	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10
With your spouse	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10

History

Patient's Birth/Childhood History:

Preconception/Mother's General Health: Tobacco Use Alcohol Drugs DES

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

Secondhand Smoke Exposure? 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

Men's History

(Check box if applicable)

- Testicular mass Testicular pain Prostate enlargement Prostate infection
 Change in sex drive Impotence Premature ejaculation Difficulty obtaining an erection
 Difficulty maintaining an erection Loss of control of urine Urinary urgency/hesitancy/change in stream
 Vasectomy Nocturia (urination at night) # of times per night _____
 Sexually transmitted diseases (describe) _____

Men's History (cont.)

Screening/Procedures: (If applicable, provide date)

Last PSA test: _____ PSA Level: 0–2 2–4 4–10 >10

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures/epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genetic disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If cancer, type: _____

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

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

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		
Tonsillectomy		
Joint replacement		
Heart surgery		
Other:		
Hospitalizations	Date	Reason

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daytime sleepiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty falling asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Early waking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flushing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heat intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night waking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nightmares	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can't remember dreams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low body temperature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head, Eyes, and Ears			
Conjunctivitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted sense of smell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted taste	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear fullness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear ringing/buzzing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye crusting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyelid margin redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to loud noises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal			
Back muscle spasm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Calf cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest tightness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foot cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint deformity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle spasms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle twitches:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Around eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arms or legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Musculoskeletal (cont.)	Mild	Moderate	Severe
Neck muscle spasm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tendonitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tension headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TMJ problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood/Nerves			
Agoraphobia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Auditory hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blackouts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With judgment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness (spinning)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fearfulness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light-headedness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other phobias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paranoia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tremor/trembling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visual hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular			
Angina/chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breathlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irregular pulse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen ankles/feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Symptom Review *(cont.)*

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

Urinary	Mild	Moderate	Severe
Bed wetting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hesitancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leaking/incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain/burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate enlargement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urgency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Digestion			
Anal spasms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bad teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloating of:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whole abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloating after meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood in stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Canker sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cracking at corner of lips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dentures w/poor chewing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Farting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fissures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foods "repeat" (reflux)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intolerance to:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lactose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All dairy products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gluten (wheat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Corn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eggs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatty foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yeast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease/jaundice (yellow eyes or skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Symptom Review *(cont.)*

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

Nails	Mild	Moderate	Severe
Bitten	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brittle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Curve up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frayed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fungus – fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fungus – toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ragged cuticles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ridges	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thickening of:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Finger nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toenails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
White spots/lines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lymph Nodes			
Enlarged/neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tender/neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other enlarged/tender lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin, Dryness of			
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any cracking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any peeling?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
And unmanageable?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any cracking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any peeling?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mouth/throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scalp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any dandruff?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin in general	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Problems			
Acne on back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne on chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne on face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne on shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Athlete’s foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bumps on back of upper arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cellulite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dark circles under eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ears get red	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Skin Problems <i>(cont.)</i>	Mild	Moderate	Severe
Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Herpes – genital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jock itch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lackluster skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moles w color/size change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oily skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pale skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patchy dullness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Red face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to bites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to poison ivy/oak	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shingles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin darkening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strong body odor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thick calluses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vitiligo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching Skin			
Anus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear canals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nipples	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genitals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Roof of mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scalp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin in general	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Male Reproductive			
Discharge from penis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ejaculation problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genital pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impotence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lumps in testicles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor libido (low sex drive)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Allergies

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

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 | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Take several nutritional supplements each day | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Keep a record of everything you eat each day | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Modify your lifestyle (e.g., work demands, sleep habits) | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Practice a relaxation technique | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 1 |
| Engage in regular exercise | <input type="checkbox"/> 5 | <input type="checkbox"/> 4 | <input type="checkbox"/> 3 | <input type="checkbox"/> 2 | <input type="checkbox"/> 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

Have medications or supplements ever caused unusual side effects or problems? Yes No

If yes, describe: _____

Have you used any of these regularly or for a long time:

NSAIDs (Advil, Aleve, etc.), Motrin, Aspirin? Yes No Tylenol (acetaminophen)? Yes No
 Acid-blocking drugs (Zantac, Prilosec, Nexium, etc.)? Yes No

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? _____



Toxin Exposure Questionnaire

Patient Name _____ Date _____

Please check the best response for each of the following questions. Your provider will discuss your answers with you.

FOOD & WATER	YES	SOMETIMES	IN THE PAST	NO
1. Do you consume conventionally-farmed (non-organic) or genetically-modified fruits and vegetables?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you consume conventionally-raised (non-organic) animal products (i.e., meat, poultry, dairy, eggs)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you consume canned or farmed fish and seafood?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you consume processed foods (i.e., foods with added artificial colors, flavors, preservatives, or sweeteners), deep-fried, or fast foods?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you drink water from a well, spring, or cistern, or from plumbing pipes or fixtures installed before 1986?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you drink sodas, juices, or other beverages with natural or refined sweeteners (i.e., high-fructose corn syrup, cane sugar, agave nectar, Stevia, undiluted fruit juice, etc.) or artificial sweeteners (i.e., NutraSweet/Equal/aspartame, Sweet 'N Low/saccharine, Splenda/sucralose, Sunett/Sweet One/acesulfame K, neotame)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HOME & WORK ENVIRONMENT	YES	SOMETIMES	IN THE PAST	NO
1. Do you live in an apartment or home built before 1978, or in a mobile home, boat, or RV?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your home or workplace contain new construction materials or furniture (i.e., paint, laminate flooring, particle board, new carpeting, bedding, furniture, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Does your home or workplace show signs of mold or water damage (i.e., cracking paint, ceiling leaks, decaying insulation or foam, visible mold, or damp windows, basement, or crawlspaces, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you exposed to toxic substances (i.e., treated lumber, lead paint, paint chips or dust, broken mercury thermometers or fluorescent bulbs, etc.) at home or work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you exposed to conventional cleaning chemicals, disinfectants, hand sanitizers, air fresheners, scented candles, or other scented products at home or work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you live or work near an industrial pollution source (i.e., highway, factory, incinerator, gas station, power plant, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you live or work near a source of electromagnetic radiation (i.e., cell phone tower, high-voltage power lines, or other known source)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you live or work in an agricultural area or another type of area where you are exposed to herbicides, pesticides, or fungicides?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have wood-burning, propane, or gas stoves or appliances at home or work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you live or work in a sealed building with recirculated air?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TRAVEL & RECREATION	YES	SOMETIMES	IN THE PAST	NO
1. Do you frequent parks, golf courses, or other outdoor or recreational areas treated with herbicides, pesticides, or fungicides?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you travel by air?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you run or bike to work along busy streets?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you get sick while camping, hiking, or traveling (foreign or domestic)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you exposed to toxic chemicals as a result of a hobby (i.e., paints, photo-developing chemicals, epoxy adhesives, glues, varnishes, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL & PERSONAL CARE	YES	SOMETIMES	IN THE PAST	NO
1. Are you sensitive to personal care products like lotions, moisturizers, toners, shampoos, conditioners, shaving creams, and soaps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you sensitive to smoke, perfumes, fragrances, cleaning products, gasoline, or other fumes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you smoke, or are you often exposed to second-hand smoke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have a history of heavy use of alcohol, or recreational or prescription drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any unusual reactions to anesthesia or to prescription or over-the-counter medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have root canals, extracted teeth, "silver" fillings, crowns, dental sealants, dentures, retainers, aligning trays, braces, mouth guards, dental implants, etc.?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have food reactions, sensitivities, or intolerances? Do you have environmental allergies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have any artificial materials in your body (implants, pins, joints, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you lead a high-stress lifestyle, or have you experienced a stressful or traumatic event?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Note: For more information on the questions included here, please see the [Toxin Exposure Questionnaire—Bibliography](#) in IFM's Clinical Practice Toolkit.

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** ...
Swear at you, insult you, put you down, or humiliate you?
or
Act in a way that made you afraid that you might be physically hurt?
Yes No If yes enter 1 _____
2. Did a parent or other adult in the household **often** ...
Push, grab, slap, or throw something at you?
or
Ever hit you so hard that you had marks or were injured?
Yes No If yes enter 1 _____
3. Did an adult or person at least 5 years older than you **ever**...
Touch or fondle you or have you touch their body in a sexual way?
or
Try to or actually have oral, anal, or vaginal sex with you?
Yes No If yes enter 1 _____
4. Did you **often** feel that ...
No one in your family loved you or thought you were important or special?
or
Your family didn't look out for each other, feel close to each other, or support each other?
Yes No If yes enter 1 _____
5. Did you **often** feel that ...
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
or
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
Yes No If yes enter 1 _____
6. Were your parents **ever** separated or divorced?
Yes No If yes enter 1 _____
7. Was your mother or stepmother:
Often pushed, grabbed, slapped, or had something thrown at her?
or
Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
or
Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
Yes No If yes enter 1 _____
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
Yes No If yes enter 1 _____
9. Was a household member depressed or mentally ill or did a household member attempt suicide?
Yes No If yes enter 1 _____
10. Did a household member go to prison?
Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

Biotoxin Illness Symptom Cluster Score Sheet

Fatigue

Concentration problems

Memory

Problem finding words

Unusual skin sensations, tingling

Weakness

Achiness

Headaches

Difficult new knowledge assimilation

Light sensitivity

Shortness of breath

Sinus congestion

Nasal drainage

Joint pain

Morning stiffness

Muscle cramps

Cough

Increased thirst

Confusion

Appetite swings

Body temperature dysregulation

Urinary frequency / urgency

Red eyes

Blurred vision

Excessive sweating or nights sweats

Mood swings

Unusual pain - especially sharp
stabbing "icepick" pain

Abdominal tenderness or pain

Diarrhea / loose stools

Numbness

Eyes tearing up

Disorientation

Metallic taste in mouth

Vertigo

Static electric shocks

One point per big box

Total Score

Candida Screening Questionnaire

Answering these questions and adding up the scores will help you and your clinician decide if yeast may be contributing to your health problems.

For each section read the directions and score as indicated. Total your score and record it at the end of the section. Add the totals for each section to get your Grand Total Score.

Section A: History

For each “yes” answer, circle the point score for that question. Add up the total score and record it at the end of this section.

SECTION A: HISTORY		Point Score
1	Have you taken tetracyclines (Sumycin, Panmycino, Vibramycin, Minocin, etc.) or other antibiotics for acne for one month (or longer)?	35
2	Have you, at any time in your life, taken other “broad spectrum” antibiotics* for respiratory, urinary, or other infections (for two months or longer, or in shorter courses four or more times in a one-year period)?	35
3	Have you taken a broad spectrum antibiotic drug*, even a single course?	6
4	Have you, at any time in your life, been bothered by persistent prostatitis, vaginitis, or other problems affecting your reproductive organs?	25
5	Have you been pregnant?	3
	<i>One time?</i>	3
6	Have you taken birth control pills?	5
	<i>Two or more times?</i>	5
7	Have you taken birth control pills?	8
	<i>For six months to two years?</i>	8
8	Have you taken prednisone, decadron or other cortisone-type drugs?	15
	<i>For more than two years?</i>	15
9	Have you taken prednisone, decadron or other cortisone-type drugs?	6
	<i>For two weeks or less?</i>	6
10	Does exposure to perfumes, insecticides, fabric shop odors, and other chemicals provoke symptoms?	15
	<i>For more than two weeks?</i>	15
11	Does exposure to perfumes, insecticides, fabric shop odors, and other chemicals provoke symptoms?	5
	<i>Mild symptoms?</i>	5
12	Are your symptoms worse on damp, muggy days or in moldy places?	20
	<i>Moderate to severe symptoms?</i>	20
13	Have you had athlete’s foot, ringworm, “jock itch,” or other chronic fungus infections of the skin or nails?	10
	<i>Mild to moderate?</i>	10
14	Do you crave sugar?	20
	<i>Severe or persistent?</i>	20
15	Do you crave breads?	10
16	Do you crave alcoholic beverages?	10
17	Does tobacco smoke really bother you?	10
Section A Total		_____

*Including Keflex, ampicillin, amoxicillin, Ceclor, Bactrim, and Septra. Such antibiotics kill off “good germs” while they’re killing off those which cause infection.

Section B: Major Symptoms

For each of your symptoms, circle the appropriate figure in the point score column. Add up the total score and record it at the end of this section.

SECTION B: MAJOR SYMPTOMS	Point Score		
	<i>Occasional and/or Mild</i>	<i>Frequent and/ or Moderately Severe</i>	<i>Very Frequent and/or Very Severe or Disabling</i>
1 Fatigue or lethargy	3	6	9
2 Feeling of being “drained”	3	6	9
3 Poor memory	3	6	9
4 Depression	3	6	9
5 Feeling “spacey” or “unreal”	3	6	9
6 Inability to make decisions	3	6	9
7 Numbness, burning, or tingling	3	6	9
8 Muscle aches or weakness	3	6	9
9 Pain and/or swelling in joints	3	6	9
10 Abdominal pain	3	6	9
11 Constipation	3	6	9
12 Diarrhea	3	6	9
13 Bloating, belching, or intestinal gas	3	6	9
14 Troublesome vaginal burning, itching, or discharge	3	6	9
15 Persistent vaginal burning or itching	3	6	9
16 Prostatitis	3	6	9
17 Impotence	3	6	9
18 Loss of sexual desire or feeling	3	6	9
19 Endometriosis or infertility	3	6	9
20 Cramps and/or other menstrual irregularities	3	6	9
21 Premenstrual tension	3	6	9
22 Attacks of anxiety or crying	3	6	9
23 Cold hands or feet and/or chilliness	3	6	9
24 Shaking or irritable when hungry	3	6	9
		Section B Total	_____

Section C: Other Symptoms*

For each of your symptoms, circle the appropriate figure in the point score column. Add up the total score and record it at the end of this section.

SECTION C: OTHER SYMPTOMS	Point Score		
	<i>Occasional and/or Mild</i>	<i>Frequent and/ or Moderately Severe</i>	<i>Very Frequent and/or Very Severe or Disabling</i>
1 Drowsiness	1	2	3
2 Irritability or jitteriness	1	2	3
3 Uncoordination	1	2	3
4 Inability to concentrate	1	2	3
5 Frequent mood swings	1	2	3
6 Headache	1	2	3
7 Dizziness/loss of balance	1	2	3
8 Pressure above ears, feeling of head swelling	1	2	3
9 Tendency to bruise easily	1	2	3
10 Chronic rashes or itching	1	2	3
13 Numbness, tingling	1	2	3
13 Indigestion or heartburn	1	2	3
14 Food sensitivity or intolerance	1	2	3
14 Mucus in stools	1	2	3
15 Rectal itching	1	2	3
16 Dry mouth or throat	1	2	3
17 Rash or blisters in mouth	1	2	3
18 Bad breath	1	2	3
19 Foot, body, or hair odor not relieved by washing	1	2	3
20 Nasal congestion or postnasal drip	1	2	3
21 Nasal itching	1	2	3
22 Sore throat	1	2	3
23 Laryngitis, loss of voice	1	2	3
24 Cough or recurrent bronchitis	1	2	3
25 Pain or tightness in chest	1	2	3

*While the symptoms in this section commonly occur in people with yeast-connected illness, they are also found in other individuals

SECTION C: OTHER SYMPTOMS	Point Score		
	<i>Occasional and/or Mild</i>	<i>Frequent and/ or Moderately Severe</i>	<i>Very Frequent and/or Very Severe or Disabling</i>
26 Wheezing or shortness of breath	1	2	3
27 Urgency or urinary frequency	1	2	3
28 Burning on urination	1	2	3
29 Spots in front of eyes or erratic vision	1	2	3
30 Burning or tearing of eyes	1	2	3
31 Recurrent infections or fluid in ears	1	2	3
32 Ear pain or deafness	1	2	3
	Section C Total		_____

Section A Total Score _____

Section B Total Score _____

Section C Total Score _____

Grand Total Score _____

The Grand Total Score will help you and your clinician decide if your health problems are yeast connected. Scores in women will run higher as seven items in the questionnaire apply exclusively to women, while only two apply exclusively to men.

Men	Women	Interpretation
40 or below	60 or below	Yeast is less apt to cause health problems
41-90	61-121	Yeast-connected health problems are possibly present
91-140	121-180	Yeast-connected health problems are probably present
141 or higher	181 or higher	Yeast-connected health problems are almost certainly present



Crista Mold Questionnaire

Date
Taken

CHECK **ALL SYMPTOMS** EXPERIENCED IN THE **PAST 3-6 MONTHS**

CATEGORY 1

- | | | |
|--|---|--|
| <input type="checkbox"/> Brain fog | <input type="checkbox"/> Feeling overwhelmed | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Feel tired all the time | <input type="checkbox"/> Episodic/chronic dry cough | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Frequent runny nose | <input type="checkbox"/> Irritated lungs | <input type="checkbox"/> Delayed recovery from colds |
| <input type="checkbox"/> Blow your nose often | <input type="checkbox"/> Blood-streaked mucous | <input type="checkbox"/> Exhausted from exercise |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> Nasal polyps | <input type="checkbox"/> Frequent static shocks |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Coated tongue | <input type="checkbox"/> Increased thirst |
| <input type="checkbox"/> Post-nasal drip | <input type="checkbox"/> Sores in the mouth | <input type="checkbox"/> Trouble sleeping |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Bumps on back of throat | <input type="checkbox"/> Feeling of internal vibration |
| <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Thrush | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Sore or itchy ear canals | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Frequent yawning or sighing | <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Drunken feeling |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Bothered by loud noises | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Skin rash | <input type="checkbox"/> Yeast infection |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Burning or itchy skin | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Eye irritation | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Intestinal gas |
| <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Spider veins | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Frequent change in vision | <input type="checkbox"/> Bothered by tags and seams on clothing | <input type="checkbox"/> Feeling bloated |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Anemia | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Dark circles under eyes | <input type="checkbox"/> Protruding veins on limbs | <input type="checkbox"/> Crave sweets |
| <input type="checkbox"/> Sensitivity to sunlight | <input type="checkbox"/> Lower extremity edema | <input type="checkbox"/> Crave alcohol |
| <input type="checkbox"/> Nervousness/can't settle | <input type="checkbox"/> Clear your throat often | |
| <input type="checkbox"/> Low mood or depressed | | |

TOTAL **CATEGORY 1** BOXES MARKED: _____

- 0-4 boxes marked = Score 0
- 5-9 boxes marked = Score 1
- 10-15 boxes marked = Score 2
- 16+ boxes marked = Score 3

CATEGORY 1 SCORE _____

CATEGORY 2

- | | | |
|---|---|--|
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Food sensitivities | <input type="checkbox"/> Non-obstructive sleep apnea |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Chemical sensitivities | <input type="checkbox"/> Difficulty thinking clearly |
| <input type="checkbox"/> Burning lungs | <input type="checkbox"/> Abnormal reaction to antibiotics | <input type="checkbox"/> Disorientation |
| <input type="checkbox"/> Recurrent respiratory infections | <input type="checkbox"/> Epstein-Barr virus | <input type="checkbox"/> Balance Issues |
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Recurrent yeast infections | <input type="checkbox"/> Slow reflexes |
| <input type="checkbox"/> Allergies aren't well controlled by medication | <input type="checkbox"/> Bacterial vaginosis | <input type="checkbox"/> Incoordination |
| <input type="checkbox"/> Voice sounds nasally | <input type="checkbox"/> Recurrent athlete's foot, jock itch, or toenail fungus | <input type="checkbox"/> Numbness or tingling |
| <input type="checkbox"/> Plugged or clogged ears | <input type="checkbox"/> Peeling/sloughing skin | <input type="checkbox"/> Nerve pains |
| <input type="checkbox"/> Chronic sinusitis | <input type="checkbox"/> Episodes of fast heart rate | <input type="checkbox"/> Unexplained menstrual changes |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Overactive bladder |
| <input type="checkbox"/> Alternating constipation/diarrhea | <input type="checkbox"/> Raynaud's syndrome | <input type="checkbox"/> Bladder infection |
| <input type="checkbox"/> Diarrhea | | <input type="checkbox"/> React to musty spaces |
| <input type="checkbox"/> Irritable bowel | | |

TOTAL **CATEGORY 2** BOXES MARKED: _____

- 0-2 boxes marked = Score 0
- 3-5 boxes marked = Score 1
- 6-9 boxes marked = Score 2
- 10+ boxes marked = Score 3

CATEGORY 2 SCORE _____

Continue to Category 3

Crista Mold Questionnaire continued

CHECK **ALL SYMPTOMS** EXPERIENCED IN THE **PAST 3-6 MONTHS**

CATEGORY 3

- | | | |
|--|---|---|
| <input type="checkbox"/> Daily use of sinus spray, sinus prescription, or Neti pot | <input type="checkbox"/> Asthma that's difficult to control with medication | <input type="checkbox"/> Liver pain or swelling |
| <input type="checkbox"/> Sinus surgery at any time in your life | <input type="checkbox"/> Idiopathic pneumonitis | <input type="checkbox"/> Fatty liver |
| <input type="checkbox"/> Chronic inflammatory response syndrome (CIRS) | <input type="checkbox"/> Lung scarring or nodules | <input type="checkbox"/> Non-alcoholic steatohepatitis (NASH) |
| <input type="checkbox"/> MARCoNS | <input type="checkbox"/> Respiratory distress | <input type="checkbox"/> Interstitial cystitis |
| <input type="checkbox"/> Peanut allergy | <input type="checkbox"/> Aspergillosis | <input type="checkbox"/> Kidney pain or swelling |
| <input type="checkbox"/> Chronic fatigue syndrome | <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Coagulation abnormalities | <input type="checkbox"/> Nephritis |
| <input type="checkbox"/> Dysautonomia | <input type="checkbox"/> Atriovenous abnormalities | <input type="checkbox"/> Chronic pelvic pain |
| <input type="checkbox"/> Postural Tachycardia Syndrome (PoTS) | <input type="checkbox"/> Churg Strauss Syndrome | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Histamine intolerance | <input type="checkbox"/> Hepatocellular carcinoma |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Erythema nodosum | <input type="checkbox"/> Previous or current cancer diagnosis |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Eosinophilic esophagitis | <input type="checkbox"/> Mast cell activation syndrome (MCAS) |
| <input type="checkbox"/> Memory loss | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Exposure to water-damaged building any time in your life |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Non-celiac intestinal disease | <input type="checkbox"/> Exposure to mold |
| <input type="checkbox"/> Sarcoidosis | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Positive Shoemaker tests |
| | <input type="checkbox"/> Cyclical vomiting syndrome | |

TOTAL **CATEGORY 3** BOXES MARKED: _____

Score 1 for each box marked
Boxes marked and score will be the same for this category

CATEGORY 3 SCORE _____

Continue to Results

TOTAL MOLD RISK RESULTS

Gather your Category scores from the 3 previous categories

CATEGORY 1 SCORE: _____ +

CATEGORY 2 SCORE: _____ +

CATEGORY 3 SCORE: _____ = **TOTAL MOLD RISK** _____

TOTAL MOLD RISK RESULTS

0-4 = Not Likely Mold Sickness

5-9 = Possible Mold Sickness

10+ = Probable Mold or Biotoxin Sickness

OTHER THINGS TO CONSIDER:

- LYME DISEASE, MSIDS, TICK-BORNE COINFECTIONS (USE HORROWITZ MSIDS-LYME QUESTIONNAIRE)
- OTHER ENVIRONMENTAL TOXINS (IE: MERCURY, LEAD, PM2.5, GLYPHOSATE, PESTICIDES, VOCs)
- INTESTINAL PARASITES, CHRONIC VIRAL SYNDROMES, OR OTHER STEALTH INFECTIONS
- FOOD SENSITIVITIES
- CVIDS OR IMMUNODEFICIENCY SYNDROMES

This tool is intended as a clinical information aid, and is not intended to diagnose or treat disease. Symptoms listed have been reported in mold illness patients. Not all symptoms have been proven in studies.

Horowitz/MSIDS 38 Point Symptom Checklist

Print your name: _____

Date: _____

Male: _____

Female: _____

Age: _____

This is a questionnaire to determine the probability of your having Lyme disease and other tick borne disorders.

Think about how you have been feeling over the previous month and how often you have been bothered by the following:

Section 1

	Frequency			
	never	sometimes	most of the time	all of the time
Unexplained fevers, sweats, chills, or flushing	0	1	2	3
Unexplained weight change...loss or gain	0	1	2	3
Fatigue, tiredness	0	1	2	3
Unexplained hair loss	0	1	2	3
Swollen glands	0	1	2	3
Sore throat	0	1	2	3
Testicular pain/pelvic pain	0	1	2	3
Unexplained menstrual irregularity	0	1	2	3
Unexplained breast milk production, breast pain	0	1	2	3
Irritable bladder or bladder dysfunction	0	1	2	3
Sexual dysfunction/loss of libido	0	1	2	3
Upset stomach	0	1	2	3
Change in bowel function (constipation or diarrhea)	0	1	2	3
Chest pain or rib soreness	0	1	2	3
Shortness of breath/cough	0	1	2	3
Heart palpitations, pulse skips, heart block	0	1	2	3
History of heart murmur or valve prolapse	0	1	2	3
Joint pain or swelling	0	1	2	3
Stiffness of the neck or back	0	1	2	3
Muscle pain or cramps	0	1	2	3
Twitching of the face or other muscles	0	1	2	3
Headaches	0	1	2	3
Neck cracks or neck stiffness	0	1	2	3
Tingling, numbness, burning or stabbing sensations	0	1	2	3
Facial paralysis (bells palsy)	0	1	2	3
Eyes/vision – double, blurry	0	1	2	3
Ears/hearing – buzzing, ringing, ear pain	0	1	2	3
Increased motion sickness, vertigo	0	1	2	3
Lightheadedness, poor balance, difficulty walking	0	1	2	3
Tremors	0	1	2	3
Confusion, difficulty thinking	0	1	2	3
Difficulty with concentration or reading	0	1	2	3
Forgetfulness, poor short term memory	0	1	2	3

Disorientation; getting lost, going to wrong places	0	1	2	3
Difficulty with speech or writing	0	1	2	3
Mood swings, irritability, depression	0	1	2	3
Disturbed sleep – too much, too little, early awake	0	1	2	3
Exaggerated symptoms or worse hangover from alcohol	0	1	2	3

Please add up your totals from each column, then add up the 4 column totals: _____ This is your first score.

Score from Section 1: _____

Section 2

Now, please check off each incident you can answer yes to with the following questions:

- | | | |
|---|-------|----------|
| 1. You have had a tick bite with no rash or flu-like symptoms. | _____ | 3 points |
| 2. You have had a tick bite, an Erythema migrans or undefined rash, followed by flu-like symptoms. | _____ | 5 points |
| 3. You live in what is considered a Lyme endemic area. | _____ | 2 points |
| 4. You have a family member diagnosed with Lyme and/or tick borne infections. | _____ | 1 points |
| 5. You experience migratory muscle pain. | _____ | 4 points |
| 6. You experience migratory joint pain. | _____ | 4 points |
| 7. You experience tingling/burning/numbness that migrates and/or comes and goes. | _____ | 4 points |
| 8. You have received a prior diagnosis of Chronic Fatigue Syndrome or Fibromyalgia. | _____ | 3 points |
| 9. You have received a prior diagnosis of a non specific autoimmune disorder (Lupus, MS, Rheumatoid Arthritis). | _____ | 3 points |
| 10. You have had a positive Lyme test (ELISA, Western Blot, PCR). | _____ | 5 points |

Please add your points from Section 2 _____ + Score from Section 1 _____ = _____ (This is your Ongoing Score)

Section 3

- Thinking about your overall physical health, for how many days during the past 30 days was your physical health not good? _____ Days
- Thinking about your overall mental health, for how many days during the past 30 days was your mental health not good? _____ Days

0 – 5 days = 1 point | 6 – 12 days = 2 points | 13 – 20 days = 3 points | 21 – 30 days = 4 points

Please add your points from Section 3 _____ + Ongoing Score _____ = _____

Section 4

Lastly, if on the first Section you rated a '3' for ALL of the following:

Fatigue | Forgetfulness, poor short term memory | Joint pain or Swelling | Tingling, numbness, burning or stabbing sensations | Disturbed sleep – Too Much, Too Little, Early Awake

Please give yourself a 5 and add it to the final score after Section 3 = _____ (This is your **FINAL SCORE**)

ONLY GIVE YOURSELF THESE 5 POINTS IF YOU RATED "3" for ALL OF THESE SYMPTOMS.

FINAL SCORING:

Now please take your final score and compare it to the scale used by Dr. Horowitz

0 – 20 Tick Borne Illness not likely | **21-45** Tick Borne Illness possible | **46 and above** Tick Borne Illness highly likely