FUNCTIONAL MEDICINE ADULT NEW PATIENT INTAKE FORMS

ALL FORMS MUST BE SUBMITTED TO OUR OFFICE
AT LEAST 7 DAYS PRIOR TO YOUR FIRST APPOINTMENT

Please be aware that some patients or staff may be sensitive to scented body products such as perfumes, colognes, lotions, deodorants, soaps and shampoos. We ask that you refrain from wearing scented products to our office.

DID YOU REMEMBER TO?

- Read all the practice documents
- Obtain recent test results from previously seen physicians and have them sent to
  - PBPM (Sozo Group LLC)
    701 Northpoint Parkway, Suite 140
    West Palm Beach, FL 33407

FILL OUT AND/OR SIGN THE FOLLOWING FORMS

- Practice Policies for Patients
- Notice of Medicare Denial
- Informed Consent Regarding Email or Internet Use of Protected Health Information
- General Information
- Pharmacy Information
- Medical Questionnaire
- Medical History
- MSQ - Medical Symptom/Toxicity Questionnaire

PLEASE COME FASTING – WE WILL DRAW BLOOD AT YOUR VISIT. Bring a snack if you'd like.
If you take THYROID MEDICATION, please DO NOT take it the morning of your appointment

WHAT TO EXPECT DURING YOUR INITIAL FUNCTIONAL MEDICINE CONSULTATION

Please plan 2 hours for your initial consultation. Bring a snack if you'd like.

1. Complete and sign policies, consent forms, and medical forms if not done previously
2. Picture is taken
3. Pay for consult
4. Vitals are taken
5. Body Composition Scale
6. Consult with Dr. Brown (60-90 min)
7. Blood draw with on-site phlebotomist (please come fasting)
8. Pay for additional labs and any supplements purchased (if applicable)
9. Schedule follow up appointment(s)

FUNCTIONAL MEDICINE INITIAL FOLLOW UP CONSULTS:

- Consult with Dr. Brown to review labs and progress (50 min)

Thank you, we're looking forward to working with you to achieve optimal health!

PRACTICE POLICIES FOR PATIENTS

Our goal is to provide you with the highest level of personalized care possible. We are committed to helping you achieve optimal health.

It is important to read all the enclosed information carefully and return it to our office. You can return it to our office by mail, email or fax. Our system is not interactive, so you will need to print out and complete the documents and scan them if you choose to email them to us.

Having these forms completed in advance will allow Dr. Brown to help solve your issues more efficiently and enhance your overall quality of care. If your intake forms are not received in advance of your visit, it may take Dr. Brown and the staff up to 30 minutes of appointment time to review them.

■ WEBSITE
Information about PBPM, Dr. Brown and all patient forms are available on our website www.pbpmed.com.

■ MEDICAL RECORDS FROM OTHER DOCTORS/CLINICS/HOSPITALS
Medical records can only be released with your authorization. **It is your responsibility to obtain previous medical records from other physicians, or health care providers that you wish Dr. Brown to review**. If you feel your medical records are pertinent to your appointment with Dr. Brown, please contact your physician or other health care provider to obtain these records and make sure that we have received them at least 7 days prior to your initial appointment. Your medical records can be faxed to (561) 296-9215 or mailed to our office.

■ COPIES OF MEDICAL RECORDS & LABS FROM OUR OFFICE
You will be given a copy of your labs at each visit to keep for your records. Should you need additional copies of your medical records; a $25 fee will be charged for copies and postage.

■ CONSULTATION FEES
- Initial Consultation is $250 and includes a 60 to 90-minute appointment with Dr. Brown.
- The first follow-up appointment is $150 and also includes an appointment with Dr. Brown.
- All other consultations with Dr. Brown are $150 for 50 minutes.

* Length of your first follow-up appointment is determined at the time of your new patient visit and is based on the complexity of your health issues.

■ LAB TESTS --- PLEASE ARRIVE FASTING! **---**
Our onsite staff will draw your blood just after your appointment. Some labs that involve stool, urine or saliva samples are done by you in your home. You will be given all lab kits and step-by-step instructions for at-home tests at the time of your consult or they will be mailed to you. Once all lab results are received, we'll review them at your follow-up visit.

■ SUPPLEMENTS
Most supplements that are recommended by Dr. Brown are available for purchase online; some are available in the office.

■ CREDIT CARDS
We require a credit card number at the time of scheduling your first appointment. This credit card will be used to hold your appointment and will be kept on file to use for all appointments, labs and supplements unless otherwise specified by you at the time of check out.

■ CANCELLATION AND RESCHEDULING OF APPOINTMENTS
There is a 24-hour cancellation and rescheduling policy. **Your appointment must be cancelled or rescheduled at least 24 hours prior to your consultation time or you will be charged for the visit, unless we are able to fill your appointment time.** The cancellation fee for a new patient appointment is **half the cost of the appointment**. The cancellation fee for all other appointments is **the full cost of the appointment**. You may cancel your appointment by calling the office 512-296-9200 or emailing frontdesk@pbpmed.com.

■ LATE ARRIVAL APPOINTMENTS

We are committed to being on time with patient appointments in order to prevent clients from waiting. If you arrive late to the office for your consult your appointment will end at the scheduled time and you will be charged for the length of the originally scheduled visit.

■ FOLLOW UP APPOINTMENTS

When scheduled for a follow-up, we assume you will honor this appointment time unless you notify us otherwise at least 24 hours prior to your scheduled appointment. Although you may get reminders from our office about appointments, these reminders are a courtesy and the ultimate responsibility is the patient's.

■ PAYMENT OPTIONS

Cash or credit cards (MasterCard, Visa, AMEX, Discover) are all accepted methods of payment for services. When you schedule the initial visit, we request a credit card on file to hold the appointment for you. No charges will be applied to your credit card unless you miss or cancel an appointment without proper notice. On the day of your scheduled appointment, all charges for consultations, laboratory testing and nutritional supplements will be itemized, and payment is due on the day of service.

Follow-up phone, or in-person consultations will be billed to your credit card on file unless you provide other payment information and instructions prior to your appointment. If additional lab tests are required and our office sends test kits, the appropriate fees will be charged to your account. Credit card on file will also be used for supplements mailed unless otherwise specified.

■ DISABILITY FORMS

Dr. Brown does not fill out medical disability forms for patients. On very rare occasions Dr. Brown will write a letter to detail the medical necessity of testing. Under such circumstances, Dr. Brown bills at his hourly rate to write such letters and does not submit his medical notes to support disability claims.

■ OFFICE HOURS

Our office hours are Tuesday – Saturday, 9 am to 5 pm EST.

■ PHONE CALLS, MESSAGES AND EMAIL

- **Phone messages left will be responded to within 24 hours (during business hours).**
- To reach the office, please call (561) 296-9200 or email frontdesk@pbpmed.com
- If you call after hours, the office staff will return your call on the next business day.
- **IF YOU HAVE A MEDICAL EMERGENCY, CALL 911 OR GO TO THE NEAREST ER.**

When leaving a message, please be brief and include the following information: your Full name, spell your last name, and date of birth; Reason for the call; your Phone number(s) and email address (if desired)

■ PRESCRIPTION REFILL REQUESTS

For prescription refills, please contact your pharmacy and have them fax the refill request to (561) 296.9200. **It may take up to 72 business hours to process a prescription refill**. Please note that Dr. Brown is not in the office on Mondays to authorize refills. Please plan ahead to avoid any interruptions in your medications.

By signing, I acknowledge that I have read and understand the above Practice Polices.

Print name: _____

Signature: _____ Date: _____

■ FREQUENTLY ASKED QUESTIONS

What is your website address?
Information about the practice can be found at www.pbpmed.com

How may I purchase supplements?
Most supplements that Dr. Brown recommends are available for purchase online and some are also available in the office. If you'd like to have your supplements ready for you to pick up at our office, please call or email us 48 hours in advance at frontdesk@pbpmed.com

Do you think you can help me with my health problem?
Dr. Brown and his team use an innovative systems approach to assessing and treating your health care concerns. Perhaps you have experienced being examined by your doctor, having blood tests done, x-rays or other diagnostic tests taken, only for your doctor to report back that "all your tests are normal". Yet, both you and your doctor know that you don't feel well. Unfortunately, this experience is all too common.

Most physicians are trained to look only in specific places for the answers, using the same familiar labs or diagnostic tests. Yet, many causes of illness cannot be found in these places. The usual tests do not look for food allergies, hidden infections, environmental toxins, mold exposures, nutritional deficiencies and metabolic imbalances. New gene testing can uncover underlying genetic predispositions that can be modified through diet, lifestyle, supplements or medications.

At PBPM, we use innovative testing to help patients prevent illness and recover from many chronic and difficult-to-treat conditions. Dr. Brown is skilled in evaluating and treating chronic problems such as fibromyalgia, fatigue syndromes, autoimmune diseases, inflammatory disorders, mood and behavior disorders, Irritable Bowel Syndrome (IBS), seasonal allergies, and other chronic, complex conditions. Dr. Brown also focuses on the prevention and treatment of heart disease, diabetes, dementia, hormonal imbalances and digestive disorders.

How will lab tests be performed at PBPM?
Some testing can be done through conventional laboratories and others are only available through functional medicine laboratories. During your medical consultation, Dr. Brown will determine which tests are needed and review with you testing recommendations, instructions (ex. fasting or non-fasting, etc.) and costs. Some testing requires collecting urine, saliva or stool at home. Others may require you to go to a local laboratory to have blood drawn. In all cases, we will assist you in coordinating initial and follow-up testing.

Do you take insurance?
We do not accept insurance or Medicare; we do not file insurance claims on your behalf; nor do we assist with claim resolution. We expect payment in full by cash or credit card due at the time services are provided.

What credit cards do you accept?
We accept the following credit cards: MasterCard, Visa Amex and Discover.

Is Dr. Brown a primary care physician?
Dr. Brown is board certified in Family Medicine and can handle many of your primary care needs, however he requests that you maintain a primary care doctor for an annual physical exam, Pap smear, etc. Dr. Brown also does not provide acute care services. He is happy to work closely with you as a consultant and coach in preventive, nutritional and functional medicine to help you address the root causes of chronic health problems. Dr. Brown is also happy to confer with your primary care doctor if desired.

Do I have to see the physician in person for my medical consultation?
Yes, Florida requires that Dr. Brown meet a patient in person in the state of Florida to provide an initial medical consultation. Follow-up appointments can be arranged by telephone or in person.

ALL MEDICARE PATIENTS MUST SIGN THIS FORM

NOTICE OF POSSIBLE MEDICARE DENIAL

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

MEDICARE NOTICE

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

PATIENT ACKNOWLEDGEMENT

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

Print name: _____

Signature: _____ Date: _____

INFORMED CONSENT REGARDING EMAIL/INTERNET USE OF PROTECTED HEALTH INFORMATION

We provide patients the opportunity to communicate with them by email. Transmitting confidential health information by email, however, has risks, both general and specific, that should be considered before using email.

1. Risks:

a) General email risks are the following: email can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward email to other recipients without the original sender(s) permission, or knowledge; users can easily misaddress an email; email is easier to falsify than handwritten, or signed documents; backup copies of email may exist even after the sender, or recipient has deleted their history.

b) Specific email risks are the following: email containing information pertaining to diagnosis and/or treatment must be included in the protected personal health information; all individuals who have access to the protected personal health information will have access to the email messages; patients who send, or receive email from their place of employment risk having their employer read their email.

2. It is our policy that all email messages sent or received, which concern the diagnosis, or treatment, of the patient will be a part of that patient's protected personal health information and we will treat such email messages, or internet communications, with the same degree of confidentiality as afforded other portions of the protected personal health information. We will use reasonable means to protect the security and confidentiality of email, or internet communication. Because of the risks outlined above, we cannot, however, guarantee the security and confidentiality of email, or internet communications.

3. Patients must consent to the use of email for confidential medical information after having been informed of the above risks. Consent to the use of email includes agreement with the following conditions:

a) All email to, or from, patients concerning diagnosis and/or treatment will be made a part of the protected personal health information. As a part of the protected personal health information, other individuals, Dr. Brown and other healthcare practitioners, administrative staff, and upon written authorization other healthcare providers may have access to email messages contained in protected personal health information.

b) PBPM practitioners may forward email messages within the practice as necessary for diagnosis and treatment. We will not, however, forward the email outside our organization without the consent of the patient as required by law.

c) We will endeavor to read email promptly but can provide no assurance that the recipient of the particular email will read the email message promptly. Therefore, email must not be used in a medical emergency.

d) It is the responsibility of the sender to determine whether the intended recipient received the email and when the recipient will respond.

e) Because some medical information is so sensitive that unauthorized disclosure can be very damaging, email should not be used for communications concerning diagnosis, or treatment of AIDS/HIV infection; other

sexually transmissible, or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; Behavioral health, Mental health, or developmental disability; or alcohol and drug abuse.

f) PBPM cannot guarantee that electronic communications will be private. However, we will take reasonable steps to protect the confidentiality of the email, or internet communication. However, Dr. Brown is not liable for improper disclosure of confidential information not caused by an employee's gross negligence, or wanton misconduct.

g) If consent is given for the use of email, it is the responsibility of the patient to inform our staff of any type of information you do not want to be sent by email.

h) It is the responsibility of the patient to protect their password or other means of access to email sent to or received from PBPM. We are not liable for breaches of confidentiality caused by the patient.

Any further use of email initiated by the patient that discusses diagnosis, or treatment, constitutes informed consent to the foregoing.

I understand that my consent to the use of email may be withdrawn at any time by email, or written communication, to PBPM at frontdesk@pbpmed.com.

I have read this form carefully and understand the risks and responsibilities associated with the use of email. I agree to assume all risks associated with the use of email.

Print name: _____

Signature: _____ Date: _____

GENERAL INFORMATION

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

Preferred Name:

Date of Birth: **Age:**

Gender: ○Male ○Female

Genetic Background: O African O European O Native American O Mediterranean O Asian O Ashkenazi O Middle Eastern

Highest Education Level: ○High School ○Under-Graduate ○Post-Graduate

Job Title:

Nature of Business:

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

City *State* *Zip*

Home Phone 1:

Home Phone 2:

Work Phone:

Cell Phone:

Fax:

E-mail:

Emergency Contact: *Name* *Phone Number:*

Address *Apt. No.*

City *State* *Zip*

Physician's Name:

Phone Number Fax

Referred by:
○Google (which words)_____ ○Media_____
○Family Member_____ ○Friend_____
○Other_____

PHARMACY INFORMATION

Primary Pharmacy: *Name* *Phone Number:*

Address

City *State* *Zip*

E-mail *Fax**

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

Compounding/Supplement Pharmacy:

Name *Phone Number:*

Address

City *State* *Zip*

E-mail *Fax**

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

MEDICAL QUESTIONNAIRE

ALLERGIES

Medication/ Supplement/Food: _____

_____

_____

Reaction: _____

_____

_____

COMPLAINTS/CONCERNS

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

_____

_____

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

1. _____

2. _____

3. _____

When was the last time you felt well?_____

Did something trigger your change in health? _____

What makes you feel worse? _____

What makes you feel better? _____

MEDICAL HISTORY DISEASES/DIAGNOSIS/CONDITIONS

Check the appropriate box and provide date of onset

GASTROINTESTINAL

- ☐ Irritable Bowel Syndrome _____
- ☐ Inflammatory Bowel Disease _____
- ☐ Crohn's _____
- ☐ Ulcerative Colitis _____
- ☐ Gastritis or Peptic Ulcer Disease _____
- ☐ GERD (reflux) _____
- ☐ Celiac Disease _____
- ☐ Other _____

CARDIOVASCULAR

- ☐ Heart Attack _____
- ☐ Other Heart Disease _____
- ☐ Stroke _____
- ☐ Elevated Cholesterol _____
- ☐ Arrythmia (irregular heart rate) _____
- ☐ Hypertension (high blood pressure)_____
- ☐ Rheumatic Fever _____
- ☐ Mitral Valve Prolapse _____
- ☐ Other _____

METABOLIC/ENDOCRINE

- ☐ Type 1 Diabetes _____
- ☐ Type 2 Diabetes _____
- ☐ Hypoglycemia _____
- ☐ Metabolic Syndrome _____
- ☐ Insulin Resistance or Pre-Diabetes _____
- ☐ Hypothyroidism (low thyroid) _____
- ☐ Hyperthyroidism (overactive thyroid)_____
- ☐ Endocrine Problems_____
- ☐ Polycystic Ovarian Syndrome (PCOS) _____
- ☐ Infertility_____
- ☐ Weight Gain_____
- ☐ Weight Loss _____
- ☐ Frequent Weight Fluctuations_____
- ☐ Bulimia _____
- ☐ Anorexia _____
- ☐ Binge Eating Disorder_____
- ☐ Night Eating Syndrome_____
- ☐ Eating Disorder (non-specific _____
- ☐ Other_____

CANCER

- ☐ Lung Cancer _____
- ☐ Breast Cancer _____
- ☐ Colon Cancer _____
- ☐ Ovarian Cancer _____
- ☐ Prostate Cancer _____
- ☐ Skin Cancer _____
- ☐ Other _____

GENITAL AND URINARY SYSTEMS

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

MUSCULOSKELETAL/PAIN

- ☐ Osteoarthritis _____
- ☐ Fibromyalgia _____
- ☐ Chronic Pain _____
- ☐ Other _____

INFLAMMATORY/AUTOIMMUNE

- ☐ Chronic Fatigue Syndrome _____
- ☐ Autoimmune Disease _____
- ☐ Rheumatoid Arthritis _____
- ☐ Lupus SLE_ _____
- ☐ Immune Deficiency Disease _____
- ☐ Herpes-Genital _____
- ☐ Severe Infectious Disease _____
- ☐ Poor Immune Function _____
- ☐ Frequent Infections _____
- ☐ Food Allergies _____
- ☐ Environmental Allergies _____
- ☐ Multiple Chemical Sensitivities _____
- ☐ Latex Allergy _____
- ☐ Other _____

MEDICAL HISTORY (continued)

Diseases/Diagnosis/Conditions check the appropriate box and provide date of onset

RESPIRATORY DISEASES

- ☐ Asthma_____
- ☐ Chronic Sinusitis _____
- ☐ Bronchitis_____
- ☐ Emphysema _____
- ☐ Pneumonia _____
- ☐ Tuberculosis _____
- ☐ Sleep Apnea _____
- ☐ Other _____

SKIN DISEASES

- ☐ Eczema _____
- ☐ Psoriasis _____
- ☐ Acne _____
- ☐ Fungal _____
- ☐ Other _____

NEUROLOGIC/MOOD

- ☐ Depression _____
- ☐ Anxiety _____
- ☐ Bipolar Disorder _____
- ☐ Schizophrenia _____
- ☐ Headaches _____
- ☐ Migraines _____
- ☐ ADD/ADHD_____
- ☐ Autism _____
- ☐ Mild Cognitive Impairment _____
- ☐ Memory Problems _____
- ☐ Parkinson's Disease _____
- ☐ Multiple Sclerosis _____
- ☐ ALS _____
- ☐ Seizures_____
- ☐ Other Neurological Problems _____

PREVENTIVE TESTS AND DATE OF LAST TEST

- ☐ Full Physical Exam _____
- ☐ Bone Density _____
- ☐ Colonoscopy _____
- ☐ Cardiac Stress Test_____
- ☐ EBT Heart Scan _____
- ☐ EKG _____
- ☐ Hemoccult Test-*stool test for blood* _____
- ☐ MRI _____
- ☐ CT Scan _____
- ☐ Upper Endoscopy _____
- ☐ Upper GI Series _____
- ☐ Ultrasound _____

INJURIES *Check box if yes:* ☐Back Injury ☐Head Injury ☐Neck Injury ☐Broken Bones

SURGERIES AND DATE OF SURGERY

- ☐ Appendectomy _____
- ☐ Hysterectomy +/- Ovaries _____
- ☐ Gall Bladder _____
- ☐ Hernia _____
- ☐ Tonsillectomy _____
- ☐ Dental Surgery _____
- ☐ Joint Replacement –Knee/Hip _____
- ☐ Heart Surgery–Bypass Valve _____
- ☐ Angioplasty or Stent _____
- ☐ Pacemaker _____
- ☐ Other _____
- ☐ None _____

BLOOD TYPE: ☐A ☐B ☐AB ☐O ☐Rh+ ☐Unknown

HOSPITALIZATIONS: ☐ *Check here if you've never been hospitalized*

Date:	Reason:

GYNECOLOGIC HISTORY

~ FOR WOMEN ONLY ~

OBSTETRIC HISTORY *(Check box if yes and provide number)*

□ Pregnancies_____ □ Caesarean_____ □ Vaginal deliveries_____

□ Miscarriage_____ □ Abortion_____ □ Living Children_____

□ Post-Partum Depression □ Toxemia □ Gestational Diabetes (Baby Over 8 Pounds)

□ Breast Feeding For how long?_____

MENSTRUAL HISTORY

Age at First Period:_____ Menses Frequency:_____ Length:_____ □Pain □Clotting

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

Last Menstrual Period:_____

Use of hormonal contraception such as: □Birth Control Pills □Patch □Nuva Ring

How long?_____

Do you use contraception? ○Yes ○No, □Condom □Diaphragm □IUD □Partner Vasectomy

WOMEN'S DISORDERS/HORMONAL IMBALANCES

□Fibrocystic Breasts	□Breast Tenderness	□Endometriosis	□Fibroids
□Painful Periods	□Heavy periods	□ Ovarian Cysts	□ PCOS
□Hot Flashes	□Mood Swings	□Concentration/Memory Issues	□Vaginal Dryness
□Joint Pain	□Headaches	□ Loss of Control of Urine	□Heavy Bleeding
□Palpitations	□Weight Gain	□ Decreased Libido	□PMS
□Infertility	□Night Sweats	□ Painful Intercourse	

Last Mammogram:_____ Breast Biopsy/Date:_____

Last PAP Test:_____ □Normal □Abnormal

Last Bone Density:_____ Results: □High □Low □Within Normal Range

Are you in menopause? □Yes □No

Age at Menopause_____

□Use of hormone replacement therapy How long?_____

MEN'S HISTORY (FOR MEN ONLY!)

Have you had digital rectal exam? ○Yes ○No If yes, date?_____
Have you had a PSA done? ○Yes ○No
PSA Level: □-2 □2-4 □4-10 □>10
□Prostate Enlargement □Prostate infection □Change in Libido
□Difficulty Obtaining an Erection □Difficulty Maintaining an Erection □Impotence
□Nocturia (urination at night) How many times at night? _____
□Urgency/Hesitancy/Change in Urinary Stream □Loss of Control of Urine

GI HISTORY

Foreign Travel? ○Yes ○No Where? _____
Wilderness Camping? ○Yes ○No Where? _____
Have you ever had severe: ○Gastroenteritis ○Diarrhea
Do you feel like you digest your food well? ○Yes ○No
Do you feel bloated after meals? ○Yes ○No

PATIENT BIRTH HISTORY

○Term ○Premature
Pregnancy Complications: _____
Birth Complications: _____
□Breast-fed □Bottle-fed

DENTAL HISTORY

□ Silver Mercury Fillings How many? _____
□ Gold Fillings
□ Root Canals How many? _____
□ Implants
□ Tooth Pain
□ Bleeding Gums
□ Gingivitis
□ Problems with Chewing

Do you floss regularly? ○Yes ○No
Do you have regular dental cleanings? ○Yes ○No

MEDICATIONS & SUPPLEMENTS

CURRENT MEDICATIONS

Medication	Dose	Frequency	Start Date (month/year)	Reason for use

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

Supplement/Brand	Dose	Frequency	Start Date (month/year)	Reason for use

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

Describe: _____

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin?. . . . ○Yes ○No

Have you had prolonged or regular use of Tylenol? . . . . . ○Yes ○No

Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.) . . . ○Yes ○No

Frequent antibiotics > 3 times/year . . . . . ○Yes ○No

Long term antibiotics. . . . . ○Yes ○No

Use of steroids (prednisone, nasal allergy inhalers) in the past . . . . . ○Yes ○No

Use of oral contraceptives . . . . . ○Yes ○No

FAMILY HISTORY

Check family members that apply.	MOTHER	FATHER	BROTHER(S)	SISTER(S)	CHILDREN	MATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	PATERNAL GRANDFATHER	AUNTS	UNCLES	OTHER
Age (if still alive)												
Age at death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Sondylitis)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Thyroid Problems												
Lupus												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												
Other:												

SOCIAL HISTORY

NUTRITION HISTORY

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

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

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

Check all that apply:

□ Low Fat □ Low Carbohydrate □ High Protein □ Low Sodium □ Diabetic □ No Dairy
□ No Wheat □ Gluten Restricted □ Vegetarian □ Vegan
□ Specific Program for Weight Loss/Maintenance Type: _____
□ Other _____

_____

Height (feet/inches) _____ Current Weight _____ Weight Fluctuations (> 10 lbs.) ○Yes ○No
Usual Weight +/- 5 lbs _____ Desired Weight +/- 5 lbs _____ Body Fat % _____
Highest adult weight _____ Lowest adult weight _____

_____

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

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

Do you avoid any particular foods? ○Yes ○No

If yes, types and reason _____

_____

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

_____

Do you grocery shop? ○Yes ○No

If no, who does the shopping? _____

Do you read food labels? ○Yes ○No

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

How many meals do you eat out per week? □ 0-1 □ 1-3 3-5 □ >5 meals per week

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

□ Fast eater
□ Erratic eating pattern
□ Eat too much
□ Late night eating
□ Dislike healthy food
□ Time constraints
□ Eat more than 50% meals away from home
□ Travel frequently
□ Non-availability of healthy foods
□ Do not plan meals or menus
□ Reliance on convenience items
□ Poor snack choices
□ Significant other/family members don't like healthy foods
□ Significant other or family members have special dietary needs or food preferences
□ Love to eat
□ Eat because I have to
□ Have a negative relationship to food
□ Struggle with eating issues
□ Emotional eater (eat when sad, lonely depressed, bored)
□ Eat too much under stress
□ Eat too little under stress
□ Don't care to cook
□ Eating in the middle of the night
□ Confused about nutrition advice

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

_____

_____

SMOKING

Currently Smoking? Cigarettes? ○Yes ○No Cigars? ○Yes ○No Vaping? ○Yes ○No
How many years? _____ Amount per day?_____ Attempts to quit: _____
Previous Smoking: How many years? _____ Amount per day?_____
Second Hand Smoke Exposure? _____

ALCOHOL INTAKE

How many drinks currently per week? *1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits*
□ None □ 1-3 □4-6 □ 7-10 □> 10 *If "None," skip to Other Substances*
Previous alcohol intake? ○Yes (○Mild ○Moderate ○High) ○ None
Have you ever been told you should cut down your alcohol intake? ○Yes ○No
Do you get annoyed when people ask you about your drinking? ○Yes ○No
Do you ever feel guilty about your alcohol consumption? ○Yes ○No
Do you ever take an eye-opener? ○Yes ○No
Do you notice a tolerance to alcohol (can you "hold" more than others)? ○Yes ○No
Have you ever been unable to remember what you did during a drinking episode? ○Yes ○No
Do you get into arguments or physical fights when you have been drinking? ○Yes ○No
Have you ever been arrested or hospitalized because of drinking? ○Yes ○No
Have you ever thought about getting help to control or stop your drinking? ○Yes ○No

OTHER SUBSTANCES

Caffeine Intake: ○Yes ○No
Coffee cups/day: □1 □2-4 □>4 | Tea cups/day: □1 □2-4 □>4
Caffeinated Sodas or Diet Sodas Intake: ○Yes ○No
12oz. can/bottle: □1 □2-4 □>4 per day
List favorite type (Ex. Diet Coke, Pepsi, etc.): _____
Are you currently using any recreational drugs? ○Yes ○No
Type_____
Have you ever used IV or inhaled recreational drugs? ○Yes ○No

EXERCISE

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

ACTIVITY	TYPE	TIMES PER WEEK	DURATION IN MINUTES
Stretching			
Cardio/Aerobics			
Strength			
Other (yoga, pilates, gyrotonics, etc.)			
Sports or Leisure Activities (golf, tennis, rollerblading, etc.)			

Rate your level of motivation for including exercise in your life? ○ Low ○ Medium ○ High
List problems that limit activity: _____
_____
_____

Do you usually sweat when exercising? ○Yes ○ No
Do you feel unusually fatigued after exercise? ○Yes ○ No
If yes, please describe: _____
_____
_____

PSYCHOSOCIAL

Do you feel significantly less vital than you did a year ago? ○Yes ○No

Are you happy? ○Yes ○No

Do you feel your life has meaning and purpose? ○Yes ○No

Do you believe stress is presently reducing the quality of your life? ○Yes ○No

Do you like the work you do? ○Yes ○No

Have you ever experienced major losses in your life? ○Yes ○No

Do you spend the majority of your time and money to fulfill responsibilities and obligations? ○Yes ○No

Would you describe your experience as a child in your family as happy and secure? ○Yes ○No

STRESS/COPING

Have you ever sought counseling? ○Yes ○No

Are you currently in therapy? ○Yes ○No
Describe: _____

Do you feel you have an excessive amount of stress in your life? ○Yes ○No

Do you feel you can easily handle the stress in your life? ○Yes ○No

Daily Stressors: Rate on scale of 1-10
Work _____ Family _____ Social _____ Finances_____ Health_____ Other_____

Do you practice meditation or relaxation techniques? ○Yes ○No How often? _____

Check all that apply: □Yoga □Meditation □Imagery □Breathing □Tai Chi □Prayer
□Other: _____

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

SLEEP/REST

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

Do you have trouble falling asleep? ○Yes ○No

Do you feel rested upon awakening? ○Yes ○No

Do you have problems with insomnia? ○Yes ○No

Do you snore? ○Yes ○No

Do you take naps? ○Yes ○No

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

ROLES/RELATIONSHIP

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

Who is living in Household? Number: _____

Resources for emotional support?
Check all that apply:

□Spouse □Family □Friends □Religious/Spiritual □Pets □Other: _____

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

How well have things been going for you?	VERY WELL	FINE	POORLY	DOES NOT APPLY
Overall	☐	☐	☐	☐
At School	☐	☐	☐	☐
In your job	☐	☐	☐	☐
In your social life	☐	☐	☐	☐
With your friends	☐	☐	☐	☐
With sex	☐	☐	☐	☐
With your attitude	☐	☐	☐	☐
With your boyfriend/girlfriend	☐	☐	☐	☐
With your children	☐	☐	☐	☐
With your parents	☐	☐	☐	☐
With your spouse	☐	☐	☐	☐

ENVIRONMENTAL & DETOXIFICATION ASSESSMENT

Known adverse food reactions or sensitivities? ○Yes ○No If yes,describe symptoms:_____

_____

Any food allergies or sensitivites? ○Yes ○No If yes, list all: _____

_____

Do you have an adverse reaction to caffeine? ○Yes ○No
When you drink caffeine do you feel: ○Irritable or wired ○Aches & Pains

Do you adversely react to (*Check all that apply):*
□Monosodium glutamate (MSG) □Aspartame (Nutrasweet) □Caffeine □Bananas
□Garlic □Onion □Citrus Foods □Cheese □Chocolate □Alcohol □Red Wine
□Sulfite Containing Foods (wine, dried fruit, salad bars) □Preservatives (ex. sodium benzoate)
□Other: _____

Which of these significantly affect you? *Check all that apply:*
□Cigarette Smoke □Perfumes/Colognes □Auto Exhaust Fumes □Other: _____

In your work or home environment, are you exposed to:
□Chemicals □Electromagnetic Radiation □Mold □Scented Candles □Scented Plug-ins

Have you ever turned yellow (jaundiced)? ○Yes ○No
Have you ever been told you have Gilbert's syndrome or a liver disorder? ○Yes ○No
Explain: _____

Do you have a known history of significant exposure to any harmful chemicals such as:
□Herbicides □Insecticides (frequent visits of exterminator) □Pesticides □Organic Solvents
□Heavy Metals □Other_____
Chemical Name, Date, Length of Exposure: _____

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

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

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

SYMPTOM REVIEW

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

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

HEAD, EYES & EARS
- ☐ Conjunctivitis
- ☐ Distorted Sense of Smell
- ☐ Distorted Taste
- ☐ Ear Fullness
- ☐ Ear Pain
- ☐ Ear Ringing/Buzzing
- ☐ Lid Margin Redness
- ☐ Eye Crusting
- ☐ Eye Pain
- ☐ Hearing Loss
- ☐ Hearing Problems
- ☐ Headache
- ☐ Migraine
- ☐ Sensitivity to Loud Noises
- ☐ Vision problems (other than glasses)
- ☐ Macular Degeneration
- ☐ Vitreous Detachment
- ☐ Retinal Detachment

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

Muscle Twitches:
- ☐ Around Eyes
- ☐ Arms or Legs
- ☐ Muscle Weakness
- ☐ Neck Muscle Spasm
- ☐ Tendonitis
- ☐ Tension Headache
- ☐ TMJ Problems

MOOD/NERVES
- ☐ Agoraphobia
- ☐ Anxiety
- ☐ Auditory Hallucinations
- ☐ Black-out
- ☐ Depression

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

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

EATING
- ☐ Binge Eating
- ☐ Bulimia
- ☐ Can't Gain Weight
- ☐ Can't Lose Weight
- ☐ Can't Maintain Healthy Weight
- ☐ Frequent Dieting
- ☐ Poor Appetite
- ☐ Salt Cravings
- ☐ Carbohydrate Craving (breads, pastas)
- ☐ Sweet Cravings (candy, cookies, cakes)
  - ☐ Chocolate Cravings
  - ☐ Caffeine Dependency

DIGESTION
- ☐ Anal Spasms
- ☐ Bad Teeth
- ☐ Bleeding Gums

Bloating of:
- ☐ Lower Abdomen
- ☐ Whole Abdomen
- ☐ Bloating After Meals

- ☐ Blood in Stools
- ☐ Burping
- ☐ Canker Sores
- ☐ Cold Sores
- ☐ Constipation
- ☐ Cracking at Corner of Lips
- ☐ Cramps
- ☐ Dentures w/Poor Chewing
- ☐ Diarrhea
- ☐ Alternating Diarrhea and Constipation
- ☐ Difficulty Swallowing
- ☐ Dry Mouth
- ☐ Excess Flatulence/Gas
- ☐ Fissures
- ☐ Foods "Repeat" (Reflux)
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Upper Abdominal Pain
- ☐ Vomiting

Intolerance to:
- ☐ Lactose
- ☐ All Dairy Products
- ☐ Gluten (Wheat, Rye, Barley)
- ☐ Corn
- ☐ Eggs
- ☐ Fatty Foods
- ☐ Yeast

- ☐ Liver Disease/Jaundice (Yellow Eyes or Skin)
- ☐ Abnormal Liver Function Tests
- ☐ Lower Abdominal Pain
- ☐ Mucus in Stools
- ☐ Periodontal Disease
- ☐ Sore Tongue
- ☐ Strong Stool Odor
- ☐ Undigested Food in St

SKIN PROBLEMS
- ☐ Acne on Back
- ☐ Acne on Chest
- ☐ Acne on Face
- ☐ Acne on Shoulders
- ☐ Athlete's Foot
- ☐ Bumps on Back of Upper Arms
- ☐ Cellulite
- ☐ Dark Circles Under Eyes
- ☐ Ears Get Red
- ☐ Easy Bruising
- ☐ Lack Of Sweating
- ☐ Eczema
- ☐ Hives
- ☐ Jock Itch
- ☐ Lackluster Skin
- ☐ Moles w/Color/Size Change
- ☐ Oily Skin
- ☐ Pale Skin
- ☐ Patchy Dullness
- ☐ Rash
- ☐ Red Face
- ☐ Sensitivity to Bites
- ☐ Sensitivity to Poison Ivy/Oak
- ☐ Shingles
- ☐ Skin Darkening
- ☐ Strong Body Odor
- ☐ Hair Loss
- ☐ Vitiligo

ITCHING SKIN
- ☐ Skin in General
- ☐ Anus
- ☐ Arms
- ☐ Ear Canals
- ☐ Eyes
- ☐ Feet
- ☐ Hands
- ☐ Legs
- ☐ Nipples
- ☐ Nose
- ☐ Penis
- ☐ Roof of Mouth
- ☐ Scalp
- ☐ Throat
- ☐ Skin, Dryness of

CARDIOVASCULAR
- ☐ Angina/chest pain
- ☐ Breathlessness
- ☐ Heart Murmur
- ☐ Irregular Pulse
- ☐ Palpitations
- ☐ Phlebitis
- ☐ Swollen Ankles/Feet
- ☐ Varicose Veins

SKIN, DRYNESS OF
- ☐ Eyes
- ☐ Feet
  - ○ Cracking?
  - ○ Peeling?
- ☐ Hair
  - ○ Unmanageable?
- ☐ Hands
  - ○ Cracking or Peeling?
- ☐ Mouth/Throat
- ☐ Scalp
  - ○ Dandruff?
- ☐ Skin In General

LYMPH NODES
- ☐ Enlarged/neck
- ☐ Tender/neck
- ☐ Other Enlarged/Tender
- ☐ Lymph Nodes

NAILS
- ☐ Bitten
- ☐ Brittle
- ☐ Curve Up
- ☐ Frayed
- ☐ Fungus-Fingers
- ☐ Fungus-Toes
- ☐ Pitting
- ☐ Ragged Cuticles
- ☐ Ridges
- ☐ Soft

Thickening of:
- ☐ Fingernails
- ☐ Toenails
- ☐ White Spots/Lines

RESPIRATORY
- ☐ Bad Breath
- ☐ Bad Odor in Nose
- ☐ Cough-Dry
- ☐ Cough-Productive
- ☐ Hoarseness
- ☐ Sore Throat
- ☐ Hay Fever
  - ○ Spring
  - ○ Summer
  - ○ Fall
  - ○ Change Of Season
- ☐ Nasal Stuffiness
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Fullness
- ☐ Sinus Infection
- ☐ Snoring
- ☐ Wheezing
- ☐ Winter Stuffiness

URINARY
- ☐ Bed Wetting
- ☐ Hesitancy
  (trouble getting started)
- ☐ Infection
- ☐ Kidney Disease
- ☐ Leaking/Incontinence
- ☐ Pain/Burning
- ☐ Prostate Infection
- ☐ Urgency

MALE REPRODUCTIVE
- ☐ Discharge From Penis
- ☐ Ejaculation Problem
- ☐ Genital Pain
- ☐ Impotence
- ☐ Prostate or Urinary Infection
- ☐ Lumps In Testicles
- ☐ Poor Libido (Sex Drive)

FEMALE REPRODUCTIVE
- ☐ Breast Cysts
- ☐ Breast Lumps
- ☐ Breast Tenderness
- ☐ Ovarian Cyst
- ☐ Poor Libido (Sex Drive)
- ☐ Vaginal Discharge
- ☐ Vaginal Odor
- ☐ Vaginal Itch
- ☐ Vaginal Pain with Sex

Premenstrual:
- ☐ Bloating Breast Tenderness
- ☐ Carbohydrate Cravings
- ☐ Chocolate Cravings
- ☐ Constipation
- ☐ Decreased Sleep
- ☐ Diarrhea
- ☐ Fatigue
- ☐ Increased Sleep
- ☐ Irritability

Menstrual:
- ☐ Cramps
- ☐ Heavy Periods
- ☐ Irregular Periods
- ☐ No Periods
- ☐ Scanty Periods
- ☐ Spotting Between

READINESS ASSESSMENT

Rate on a scale of 5 (very willing) to 1 (not willing):

In order to improve your health, how willing are you to:

Significantly modify your diet..... [5] [4] [3] [2] [1]
Take several nutritional supplements each day ..... [5] [4] [3] [2] [1]
Keep a record of everything you eat each day ..... [5] [4] [3] [2] [1]
Modify your lifestyle (e.g., work demands, sleep habits) ..... [5] [4] [3] [2] [1]
Practice a relaxation technique ..... [5] [4] [3] [2] [1]
Engage in regular exercise ..... [5] [4] [3] [2] [1]
Have periodic lab tests to assess your progress..... [5] [4] [3] [2] [1]

Comments _____

_____

_____

Rate on a scale of 5 (very confident) to 1 (not confident at all):

How confident are you of your ability to organize and follow through on the above health related activities?

[5] [4] [3] [2] [1]

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities? _____

_____

_____

Rate on a scale of 5 (very supportive) to 1 (very unsupportive):

At the present time, how supportive do you think the people in your household will be to your implementing the above changes?

[5] [4] [3] [2] [1]

Comments: _____

_____

_____

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

How much on-going support and contact (e.g., telephone consults, e-mail correspondence) from our professional staff would be helpful to you as you implement your personal health program?

[5] [4] [3] [2] [1]

Comments: _____

_____

_____

MSQ - MEDICAL SYMPTOM/TOXICITY QUESTIONNAIRE

NAME: _____ **DATE:** _____

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

POINT SCALE

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

KEY TO QUESTIONNAIRE Add individual scores and total each group. Add each group score and give a grand total.
• Optimal is less than 10 • Mild Toxicity: 10-50 • Moderate Toxicity: 50-100 • Severe Toxicity: over 100

DIGESTIVE TRACT
___ Nausea or vomiting
___ Diarrhea
___ Constipation
___ Bloated feeling
___ Belching or passing gas
___ Heartburn
___ Intestinal/Stomach pain
___ **TOTAL**

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

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

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

EYES
___ Watery or itchy eyes
___ Swollen, reddened or sticky eyelids
___ Bags or dark circles under eyes
___ Blurred or tunnel vision (does not include near or far-sightedness)
___ **TOTAL**

HEAD
___ Headaches
___ Faintness
___ Dizziness
___ Insomnia
___ **TOTAL**

HEART
___ Irregular or skipped heartbeat
___ Rapid or pounding heartbeat
___ Chest pain
___ **TOTAL**

JOINTS/MUSCLES
___ Pain or aches in joints
___ Arthritis
___ Stiffness/limitation of movement
___ Pain or aches in muscles
___ Feeling of weakness or tiredness
___ **TOTAL**

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

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

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

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

SKIN
___ Acne
___ Hives, rashes or dry skin
___ Hair loss
___ Flushing or hot flushes
___ Excessive sweating
___ **TOTAL**

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

OTHER
___ Frequent illness
___ Frequent or urgent urination
___ Genital itch or discharge
___ **TOTAL**

_____ **GRAND TOTAL**

ADDITIONAL NOTES: