Date_____

PATIENT INFORMATION

Last Name_____ First Name_____ MI_____

Circle One: Mr. Mrs. Ms. Nickname_____

Date of Birth: _____/_____/_____ Birthplace_____ Circle One: Male Female

Home Phone_____ Cell Phone_____ Work Phone_____

Street Address: _____

City:_____ State:_____ Zip Code:_____

E-mail Address:_____ Social Security No._____

Person Responsible for Payment_____ Relationship to Patient:_____

Address_____ Phone_____

Signature_____

Note: We do not submit insurance. Out-of-pocket costs include clinic consultations, infusion clinic services and testing.

Employer_____ Occupation_____

Employer Address_____

Emergency Contact_____ Phone_____

Education: Years in High School_____ Years in College_____ Years Post-Grad_____

Marital Status (circle one): Single Married Divorced Widowed

Weight: Now_____ One year ago_____ Maximum_____ When_____

Height: _____feet _____inches

Primary Care Doctor _____Date of last physical exam_____

Phone _____

Address _____

E-mail _____

Pharmacy Name_____ Phone_____

Reason for Visit_____

_____

_____

Referred by: ☐ Physician (name):_____

☐ Friend or family member (name):_____

☐ Other (please specify):_____

Please check the color that best describes your hair:

☐ Brown ☐ Black ☐ Blonde ☐ Red ☐ White ☐ Grey ☐ Bald

Please check the color that best describes your eyes:

☐ Blue ☐ Brown ☐ Green ☐ Grey ☐ Hazel

Please check which best describes your handedness:

☐ Right-handed ☐ Left-handed ☐ Ambidextrous

Please check the body type that best describes yours.

☐ Ectomorph (slim, thinner body type)

☐ Endomorph (rounder, plump body type)

☐ Mesomorph (thicker, muscular body type)

Please rank your most troubling symptoms by level of concern to you.

PROBLEM	ONSET	FRQUENCY	SEVERITY
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

What diagnosis or explanations have been given in the past?

_____

_____

_____

_____

_____

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?_____

_____

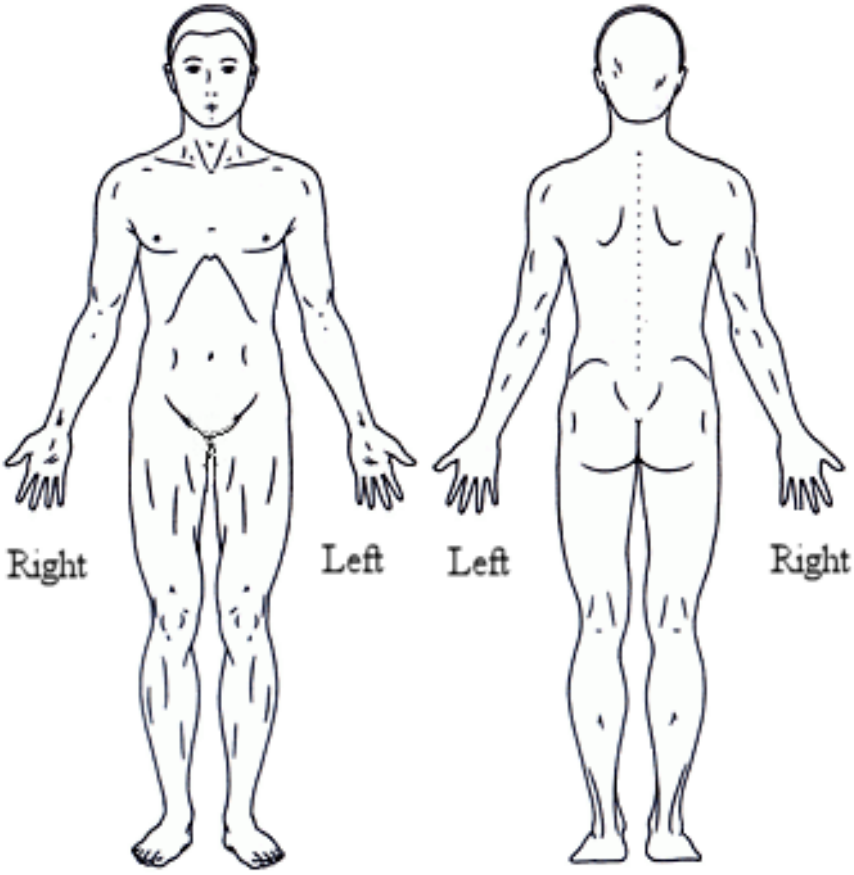
What makes you feel worse?_____

_____

What makes you feel better?_____

_____

Please mark the location(s) of your pain with an "X" on the diagram below. If whole areas are painful, shade in entire area.



How often do you have your pain?

- ☐ Constantly (100% of the time)
- ☐ Nearly constantly (60-90% of the time)
- ☐ Intermittently (30-60% of the time)
- ☐ Occasionally (less than 30% of the time)

MEDICATIONS

How many times and at what ages have you taken:

	Infancy	**Childhood**	**Teen**	**Adulthood**
Antibiotics				
Steroids				

What medications and supplements are you taking now? Include non-prescription drugs as well as vitamins, minerals, and other nutritional supplements. Indicate the mg or IUs and the form (e.g. calcium vs. calcium lactate) when possible.

Supplements/Medications	**Dose**	**Units**	**Frequency**	**Start Date**	**Stop Date**
				___/___/_____	___/___/_____
				___/___/_____	___/___/_____
				___/___/_____	___/___/_____
				___/___/_____	___/___/_____
				___/___/_____	___/___/_____
				___/___/_____	___/___/_____
				___/___/_____	___/___/_____
				___/___/_____	___/___/_____
				___/___/_____	___/___/_____
				___/___/_____	___/___/_____
				___/___/_____	___/___/_____
				___/___/_____	___/___/_____
				___/___/_____	___/___/_____
				___/___/_____	___/___/_____
				___/___/_____	___/___/_____
				___/___/_____	___/___/_____
				___/___/_____	___/___/_____
				___/___/_____	___/___/_____

Please list the dates of the following operations, illnesses, etc. below.

OPERATIONS:

Tonsillectomy _____ Appendectomy _____

Hysterectomy _____ Hernia _____

Gall Bladder _____ P.E. Tubes in ears _____

1st Dental Filling _____ 1st Root Canal _____

Other Surgeries *(and dates):* _____

_____

_____

ILLNESSES:

Chicken Pox _____ Mononucleosis _____

Measles _____ German Measles _____

Mumps _____ Hepatitis _____

Other (*and dates*): _____

_____

INJURIES:

Head Injury _____ Broken_____ _____

Neck Injury _____ Broken_____ _____

Back Injury _____ Broken_____ _____

Other (*and dates*):_____

_____

DIAGNOSTIC STUDIES:

When have you had a(n):

Chest X-ray _____

Mammogram _____

EKG _____

Sigmoidoscopy _____

Colonoscopy _____

Upper GI Series _____

Barium Enema _____

MRI of Brain _____

MRI of Abdomen _____

MRI of Spine _____

Liver Scan _____

Bone Scan _____

Neck X-ray _____

IMMUNIZATIONS:

Pneumovax _____

Hepatitis Vaccination_____

Flu _____

Completed Childhood Vaccines:

_____

Last Tetanus Booster _____

Please indicate any personal history below.

CONSTITUTIONAL SYMPTOMS

Good general health lately……..Yes No
Recent weight change……Yes No
Decreased appetite……..Yes No
Fever/night sweats……..Yes No
Fatigue/weakness……Yes No
Headaches……...…Yes No

EYES

Eye disease or injury……..Yes No
Wear glasses/contact lenses……...…Yes No
Blurred or double vision……Yes No
Glaucoma/cataracts……..……Yes No

EARS/NOSE/THROAT

Hearing loss or ringing……Yes No
Earaches or drainage……Yes No
Chronic sinus problems……Yes No
Nose bleeds……..Yes No
Mouth sores……..Yes No
Sore throat or voice change……..Yes No
Swollen glands in neck…….Yes No

CARDIOVASCULAR

Heart trouble…….Yes No
Chest pain or angina pectoris……Yes No
Palpitation……Yes No
Shortness of breath walking or lying…Yes No
Swelling of feet, ankles, or hands…….Yes No

RESPIRATORY

Chronic or frequent coughs……..…Yes No
Spitting up blood……..Yes No
Shortness of breath……..……Yes No
Asthma or wheezing…….Yes No

INITEGUMENTARY (skin, breast)

Rash or itching……..Yes No
Change in skin color…….Yes No
Change in hair or nails……..Yes No
Varicose veins……...Yes No
Breast pain…….Yes No
Breast lump…..……..Yes No
Breast discharge……Yes No

NEUROLOGICAL

Frequent or recurring headaches……Yes No
Light headed or dizzy**...**…….Yes No
Convulsions or seizures…….……Yes No
Shakes**...**……Yes No
Paralysis…….Yes No
Stroke…….……Yes No
Head injury…….Yes No

PSYCHIATRIC

Memory loss or confusion…….……...Yes No
Nervousness…..…….Yes No
Depression……Yes No
Difficulty sleeping……Yes No

GASTROINTESTINAL

Loss of appetite…….**.....**……..Yes No
Change in bowel movement**.**……...…**.**Yes No
Nausea or vomiting……...……Yes No
Frequent diarrhea……...……...…Yes No
Painful bowel movements or constipation…Yes No
Rectal bleed or blood in stool……Yes No
Abdominal pain……Yes No
Ulcer (stomach or duodenal)…….Yes No

GENITOURINARY

Frequent urination……..Yes No
Burning or painful urination……...Yes No
Awaken at night to urinate……..Yes No
Blood in urine……Yes No
Change in force of stream when urinating…..Yes No
Incontinence or dribbling……Yes No
Sores or discharge……..……Yes No
Kidney stones……..Yes No
Sexual difficulty……..Yes No
Male testicular pain/lumps……..Yes No
Female – pain with periods…….....Yes No
Female – irregular periods……..Yes No
Female – vaginal discharge……Yes No
Female - # of pregnancies……...Yes No
Female - # of miscarriages……..Yes No
Female – date of last pap smear:_____

MUSCULOSKELETAL

Joint pain…….Yes No
Joint stiffness or swelling……Yes No
Weakness of muscles or joints…….Yes No
Muscle pain or cramps…….Yes No
Back pain……..Yes No
Difficulty in walking……Yes No

ENDOCRINE

Glandular or hormone problem……Yes No
Thyroid disease……Yes No
Diabetes *(insulin or non insulin –* ***circle one)..***Yes No
Excessive thirst or urination……Yes No
Heat or cold intolerance……Yes No

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts……..……Yes No
Bleeding or bruising tendency……..……...Yes No
Anemia……..Yes No
Blood clots……..…Yes No
Blood transfusion……..Yes No
Enlarged glands…….Yes No

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to:
Penicillin or other antibiotics……..…….Yes No
Morphine, Demerol, or other narcotics**..**……..Yes No
Novocain or other anesthetics……..Yes No
Aspirin or other pain remedies……..Yes No
Tetanus antitoxin or other serums…….Yes No
Iodine, Merthiolate or other antiseptic……..Yes No

ALLERGIC/IMMUNOLOGIC (continued)

Other drugs/medications:

_____

_____

_____

Known food allergies:

_____

_____

Environmental allergies:

Excessive exposure at home or work to:

Fumes?.....Yes No
Dust?.....Yes No
Solvents?.....Yes No
Air borne participles?.....Yes No

Others:_____

_____

_____

_____

SOCIAL HISTORY

Use of alcohol: ☐ Never ☐ On occasion ☐ Moderately ☐ Daily

Use of tobacco: ☐ Never ☐ Previously, but quit ☐ Currently smoking – packs/day_____

Use of drugs: ☐ Never ☐ Type/frequency:_____

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

If yes, describe: _____

Check all that apply:

☐ Low fat ☐ Low Carbohydrate ☐ High Protein ☐ Low Sodium ☐ Diabetic

☐ No Wheat ☐ Gluten Restricted ☐ Vegetarian ☐ Vegan ☐ Ultrametabolism

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

Height (feet/inches):_____ Current Weight: _____

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

Highest adult weight:_____ Lowest adult weight:_____

Weight Fluctuations (greater than 10 lbs): ☐ Yes ☐ No Body Fat %:_____

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

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

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

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

_____

Do you grocery shop? ☐ 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 ☐ More than 5

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

☐ Fast eater
☐ Eat too much
☐ Late night eating
☐ Dislike healthy food
☐ Time constraints
☐ Eat more than 50% of meals away from home
☐ Travel frequently
☐ Non-availability of healthy foods
☐ Do no plan meals or menus
☐ Reliance on convenience items
☐ Poor snack choices
☐ Family members don't like healthy foods
☐ Love to eat
☐ Eat because I have to
☐ Have a negative relationship to food
☐ Struggle with eating issues
☐ Emotional eater (eat when sad, lonely, depressed, bored)
☐ Eat too much under stress
☐ Eat too little under stress
☐ Don't care to cook
☐ Eating in the middle of the night
☐ Confused about nutrition advice
☐ Erratic eating pattern
☐ Family members have special dietary needs or preferences

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

_____

_____

PSYCHOSOCIAL

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

Are you happy? ☐ Yes ☐ No

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

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

Do you like the work you do? ☐ Yes ☐ No

Have you experienced major losses in your life? ☐ Yes ☐ No

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

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

STRESS/COPING

Have you ever sought counseling? ☐ Yes ☐ No

Are you currently in therapy? ☐ Yes ☐ No If yes, 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 a scale of 1 – 10 (1 being the least stress and 10 being the most stress)

Work _____ Family _____ Social _____ Finances _____ Health _____ Other _____

Do you practice meditation or relaxation techniques? ☐ Yes ☐ No If yes, how often?_____

Check all that apply:

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

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

SLEEP/REST

Average number of hours you sleep per night: _____

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 ☐ Sometimes

Do you use sleeping aids? ☐ Yes ☐ No If yes, explain: _____

ROLES/RELATIONSHIPS

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Gay/Lesbian ☐ Long Term Partnership

List Children:

Child's Name	Age	Gender

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

Their occupation: _____

Check all that apply: ☐ Spouse ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets

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

Please mark with an "X" what best describes you.

How well have things been going for you?	Does Not Apply	Poor (1)	Mediocre (2)	Fine (3)	Good (4)	Excellent (5)
Overall						
At school						
In your job						
In your social life						
With close friends						
With sex						
With your attitude						
With your boyfriend/girlfriend						
With your children						
With your parents						
With your spouse						

ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

Do you have known adverse food reactions or sensitivities? ☐ Yes ☐ No If yes, describe symptoms: _____

_____

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

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

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

☐ Monosodium glutamate (MSG) ☐ Aspartame (NutraSweet) ☐ Caffeine ☐ Bananas

☐ Garlic ☐ Onion ☐ Cheese ☐ Citrus ☐ Chocolate ☐ Alcohol ☐ Red wine

☐ Sulfite-containing foods (wine, dried fruit, salad bars) ☐ Preservatives (*Example: Sodium Benzoate)*

☐ Other: _____

Which of these significantly affect you? (*Check all that apply*)

☐ Cigarette smoke ☐ Perfumes/Colognes ☐ Auto exhaust fumes ☐ Other_____

In your work or home environment, are you exposed to: ☐ Chemicals ☐ Electromagnetic radiation ☐ Mold

Have you ever turned yellow (jaundiced)? ☐ Yes ☐ No

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

If yes, explain: _____

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

☐ Herbicides ☐ Insecticides (frequent visits of exterminator) ☐ Pesticides ☐ Organic solvents

☐ Heavy metals ☐ Other:_____

Chemical name, date, length of exposure: _____

Do you dry clean you clothes frequently? ☐ Yes ☐ No

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

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

_____

GI HISTORY

Foreign travel? ☐ Yes ☐ No If yes, where? _____

Wilderness camping? ☐ Yes ☐ No If yes, where? _____

Have you ever had severe: Stomach pain: ☐ Yes ☐ No Diarrhea: ☐ Yes ☐ No

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: ☐ Yes ☐ No If yes, how long? _____

Bottle fed: ☐ Yes ☐ No

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

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

DENTAL HISTORY

Check all that apply:

☐ Silver mercury fillings: How many? _____

☐ Gold fillings ☐ Root canals ☐ Implants ☐ Tooth pain ☐ Bleeding gums

☐ Gingivitis ☐ Problems with chewing

Do you floss regularly? ☐ Yes ☐ No

FAMILY HISTORY

Please complete the following information as it relates to your family's health history.

	If Living		If Deceased			If Living		If Deceased	
	Age	**Health**	**Death Age**	**Cause**		**Age**	**Health**	**Death Age**	**Cause**
Father					**Spouse**				
Mother					**Child**				
Sibling					**Child**				
Sibling					**Child**				
Sibling					**Child**				

Place an "X" in the appropriate column for any illnesses that your blood relatives have experienced. Take your time filling out this questionnaire and feel free to discuss these items with your family members.

ILLNESSES	**Father**	**Mother**	**Siblings**	**Grand-parents**	**Children**	**ILLNESSES**	**Father**	**Mother**	**Siblings**	**Grand-parents**	**Children**
Alcoholism						Undiagnosed Chronic Illness					
Allergies						Jaundice					
Anemia						Kidney or bladder problems					
Appendicitis						Meningitis					
Arthritis/Rheumatism						Menstrual Problems					
Asthma						Mental Illness					
Bleeding						Miscarriage / Spontaneous Abortion					
Blood pressure - high						Neuritis / Neuralgia					
Blood pressure – low						Obesity					
Bronchitis – Chronic						Pleurisy					
Bursitis, Sciatica, Lumbago						Pneumonia					
Cancer						Polio					
Cholesterol - high						Prostate problems					
Cirrhosis						Rheumatic Fever					
Colon problem						Skin Problems					
Physical Abnormalities/ Birth Defects						Stroke					
Convulsions						Stomach or Small Intestinal Disease					
Depression						Suicide- Attempt or Successful					
Diabetes						Surgeries					
Emphysema						Teeth/Gum problems					
Gall bladder disease						Transfusions					
Headache						Triglycerides-high					
Heart problems						Tuberculosis					
Hepatitis						Ulcers					
Hernia						Vaginal problems					
Hemorrhoids						Varicose Veins					
Hypoglycemia						Venereal Disease					

MSQ – MEDICAL SYMPTOM / TOXICITY QUESTIONNAIRE

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

POINT SCALE

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

DIGESTIVE TRACT
☐ Nausea or vomiting
☐ Diarrhea
☐ Constipation
☐ Bloated feeling
☐ Belching, or passing gas
☐ Heartburn
☐ Intestinal / Stomach pain
Total: ☐☐___

EARS
☐ Itchy ears
☐ Earaches, ear infections
☐ Drainage from ear
☐ Ringing in ears, hearing loss
Total: ☐☐___

EMOTIONS
☐ Mood swings
☐ Anxiety, fear or nervousness
☐ Anger, irritability, or aggressiveness
☐ Depression
Total: ☐☐___

ENERGY / ACTIVITY
☐ Fatigue, sluggishness
☐ Apathy, lethargy
☐ Hyperactivity
☐ Restlessness
Total : ☐☐___

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

HEAD
☐ Headaches
☐ Faintness
☐ Dizziness
☐ Insomnia
Total: ☐☐____

HEART
☐ Irregular or skipped heartbeat
☐ Rapid or pounding heartbeat
☐ Chest pain
Total: ☐☐___

JOINTS / MUSCLES
☐ Pain or aches in muscles
☐ Arthritis
☐ Stiffness
☐ Pain or aches in muscles
☐ Feeling of weakness
Total : ☐☐___

LUNGS
☐ Chest congestion
☐ Asthma, bronchitis
☐ Shortness of breath
☐ Difficult breathing
Total : ☐☐___

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

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

NOSE
☐ Stuffy nose
☐ Sinus problems
☐ Hay fever
☐ Sneezing attacks
☐ Excessive mucus formation
Total: ☐☐___

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

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

OTHER
☐ Frequent illness
☐ Frequent or urgent urination
☐ Genital itch or discharge
Total: ☐☐___

GRAND TOTAL: ☐☐☐

KEY TO QUESTIONNAIRE

Add individual scores and total each group. Add each group scores and give a grand total.

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

SF – 36 (QUALITY OF LIFE ASSESSMENT)

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

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

☐ Excellent ☐ Fair
☐ Very good ☐ Poor
☐ Good

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

☐ Much better than one year ago ☐ Somewhat worse now than on year ago
☐ Somewhat better now than one year ago ☐ Much worse now than one year ago
☐ About the same as one year ago

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

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

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? (*Please select one answer on each line*)

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

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

	Yes	**No**
Cut down on the amount of time you spent on work or other activities		
Accomplished less than you would like		
Didn't do work or other activities as carefully as usual		

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

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

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

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

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

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

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

	All of the time	**Most of the time**	**Good bit of the time**	**Some of the time**	**A little of the time**	**None of the time**
Did you feel full of life?						
Have you been a very nervous person?						
Have you felt calm and peaceful?						
Did you have a lot of energy?						
Have you felt downhearted and blue?						
Did you feel worn out?						
Have you been a happy person?						
Did you feel tired?						

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

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

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

	Definitely True	**Mostly True**	**Don't Know**	**Mostly False**	**Definitely False**
I seem to get sick a little easier than other people					
I am as health as anybody I know					
I expect my health to get worse					
My health is excellent					

FOR FEMALES ONLY: WOMEN'S HEALTH QUESTIONNAIRE

Obstetric History

How many times have you been pregnant? _____

Number of vaginal deliveries? _____ Number of Cesarean deliveries? _____

Reason for Cesarean delivery? _____

Number of living children? _____ Number of adopted children? _____

Largest infant? _____ Number of miscarriages? _____

Number of ectopic pregnancies? _____ Number of elective abortions? _____

Number of premature births? _____ Stillbirths? _____

Any complications of pregnancy? _____

_____

Gynecologic History

Date of the first day of your last menstrual period? _____ Normal?: Yes / No

Do you use birth control? ☐ Yes ☐ No Type: _____

Menstrual periods come every _____ days and last for _____ days.

Age of your first menstrual period? _____

Any recent changes in your period? Yes / No If yes, please explain: _____

_____

Do you have any of the following? (*Please circle yes or no*)

Excessive pain with your period? Yes / No

Excessive bleeding with your period? Yes / No

Premenstrual symptoms (PMS)? Yes / No

Explain: _____

Date of last PAP smear: _____ Normal / Abnormal

Would you like to be scheduled for a Gynecological Exam including a PAP smear? Yes / No

It is recommended that you have a Gynecological Exam completed within the past 12 months prior to treatment.

Have you ever had an abnormal PAP smear? Yes / No Date: _____

Date of last Mammogram: _____ Normal / Abnormal

Would you like to be referred for a mammogram? Yes / No

Have you ever had a breast lump or breast biopsy? Yes / No

Are you currently sexually active? Yes / No

Do you have pain with sexual relations? Yes / No

Have you ever had sexually transmitted disease? Yes / No

If yes, circle all that apply:

Herpes Venereal Warts Chlamdia HIV

Gonorrhea Syphilis Pelvic Inflammatory Disease Other

Have you stopped having menstrual periods? Yes / No When?_____

Hysterectomy? Yes / No Surgical removal of ovaries? Yes / No

Do you take Hormone Replacement Therapy? Yes / No

If yes, which medication are you taking and how do you take them? _____

Have you ever had vaginal bleeding since menopause? Yes / No

Accidental loss of urine? Yes / No Vaginal dryness? Yes / No

Hot flashes? Yes / No Pain with intercourse? Yes / No Pelvic pressure? Yes / No