Clinical Paradigms

INTAKE QUESTIONNAIRE

General Information Today's Date _____

First Name: _____Middle Name: _____Last Name: _____

Gender/Identity: _____ Birth Date: _____/____/____ Place of birth: _____ Age: _____

Address: _____City: _____ State: _____

ZIP: _____ Email: _____

Home Phone:(_____) _____-_____ Cell: (_____) _____-_____

Place of Birth: _____ City or town & country if not US

Referred by: _____

Primary Care Physician: _____

Height: ___′ ____ ″ Weight: ____ Weight 6 months ago: _____ Weight 1 year ago: _____

Would you like your weight to be different? _____ If so, what? _____

1. Please check applicable box(es):

__ African American __ Hispanic __ Mediterranean __ Asian __ Native American __ Caucasian __ Northern European __ Other

Relationship status: _____ Children: _____

Occupation: _____

Hours worked per week: _____

What makes you feel worse? _____

What makes you feel better? _____

At what point in your life did you feel the best? What were you doing then?

_____

Which procedures have made you feel worse?

_____

Past Medical and Surgical History

Please check each of the following health conditions/challenges in both columns that apply to you.

ILLNESS	Please check here if this applies to you	Illness	Please check here if this applies to you
Anemia		Hepatitis	
Arthritis		High blood fats (cholesterol, triglycerides)	
Asthma		High blood pressure (hypertension)	
Autism Spectrum Disorder		Hypotension	
Blood Disorder		IBS (constipation or diarrhea)	
Autoimmune Small Fiber Neuropathy		IgE Food Allergies	
Bronchitis		Immunodeficiency	
Cancer		Kidney stones/Prostate issues	
Chronic Fatigue Syndrome		Marfan's or other connective tissue disease	
Crohn's Disease, Ulcerative Colitis, Celiac		Mast Cell Activation Disorder	
Diabetes (Type 1 or 2)		Mononucleosis (kissing disease/EBV)	

Diverticulitis/losis		Osteoporosis	
Dementia/Multi-infarct		Parathyroid Disease	
Ehlers-Danlos Syndrome		RA/SLE/MS	
Emphysema or COPD		Sinusitis	
Epilepsy, convulsions, or seizures		Sleep apnea	
Fertility/PCOS		Speech/Hearing problems	
Fibromyalgia		Stroke	
Food sensitivities		Thyroid disease	
Gallstones		Others (Lyme/Mycoplasma, EDS, etc.)	
Gout			
Heart attack/Angina (chest pain)			
Heart failure			

INJURIES	DATE	COMMENTS
Back injury		
Broken bones (describe)		
Head injury		
Neck injury		
Other (describe)		

Surgeries

Check box if yes and provide date (year) of surgery.

Surgery Type	Date/Year
Adenoid Removal	
Appendectomy	
Hysterectomy +/- Ovaries	
Gallbladder	
Hernia	
Tonsillectomy	
Dental Surgery	
Joint Replacement—Knee/Hip	
Orthopedic	
Neurosurgery	
Heart Surgery—Bypass/Valve	
Angioplasty or Stent	

Pacemaker	
Other	

During childhood

1. Have you frequently had:

Issue	**Yes**	**No**
Migraines		
Sprains		
Wounds (knees, forehead, hands, other)		
Bruises		
Nosebleeds		
Earache		
Bronchitis		
Asthma Attacks		
Angina/Sinusitis		

Issue	**Yes**	**No**
1. Have you had joint pain (shoulders, wrists, hands, knees)?		
2. Have you been tired often?		
3. Wounds (knees, forehead, hands, other)		
4. Were you very flexible (one foot behind your head, sucking your big toe, doing the splits)?		
5. Were you clumsy (bumping into door frames, corners of the table, dropping objects, stumbling, falling)?		
6. Did you have cold feet (and / or hands, nose, ears)?		
7. Did you have severe stomach pain?		
8. Have you been constipated?		
9. Did you have difficulties at school?		
10. Were you easily distracted?		

History

Please list your current medical issues in ascending order.

DESCRIBE PROBLEM/ DIAGNOSIS	**MILD/ MODERATE/ SEVERE**	**TREATMENT APPROACH**	**SUCCESS?**
Example: Allergies	*Moderate*	*Zyrtec*	*Still have seasonal issues.*

1. At what age did the symptoms become conspicuous and debilitating (disabling)?

_____

2. Were there significant accidental injuries (falls, sports or traffic accidents)? ____Yes ____No

What kind of accidents? (Please specify). _____

At what age did the accident(s) occur? _____

Has there been an increase in symptoms after the accident(s)? ____Yes ____No

3. What are the medical diagnoses that were made or mentioned prior to the suspicion

of Ehlers-Danlos syndrome? _____

4. Have you had a surgery? ____Yes ____No

If so, explain the interventions with data: _____

_____

5. Are there other people in your family who have had symptoms similar to yours?

____Yes ____No If so, who? _____

6. Other information you would like to provide: _____

Family History

For each condition below please indicate family members who have/had the condition by using the following abbreviations:

Uncle (U), Aunt (A), Paternal Grandfather (PGF), Paternal Grandmother (PGM), Maternal Grandfather (MGF), Maternal Grandmother (MGM), Sister (S), Brother (B), Son (SN), Daughter (D), Father (F), Mother (M)

Condition	**Family Members Affected**
Food Intolerance/Allergy	
Rhinitis	
Eczema	
Sinus Problems/Polyps	
Pneumonia	
Asthma	
Bronchitis	
Heartburn	
Irritable Bowel Syndrome	
Inflammatory Bowel Disease (IBD)	
Headache Disorder	
Hypertension	
Heart Disease	
Stroke	
Arthritis	
Thyroid (indicate hyper- or hypothyroid	
Cancer (indicate type—breast, prostate, colon)	
Diabetes (indicate type 1 or type 2)	
Neuropathy	
Connective Tissue Disease	
Celiac Disease	
Anxiety	
Depression	
Autoimmune Disease (indicate type)	

1. Pain

Issue	**Yes**	**No**
1. Do you often have pain around or at the level of your joints (back, shoulders, elbows, hands, hips, knees, feet)?		

2. Do you have pain (cramps, twisting, "muscle tears") in your muscles (neck muscles, thighs, calves, hands, feet)?		
3. Do you have severe pain (cramping) in your stomach?		
4. Do you have rib pain?		
5. Is your period very painful?		
6. Is your skin very sensitive?		
7. Do you have migraines?		
8. Do you have headaches?		

In what circumstances does the pain occur? _____

_____

What do you do for pain relief? _____

_____

2. Fatigue

Issue	**Yes**	**No**
1. Are you often tired?		
2. Do you a great need for sleep during the day?		

3. Sleep

Issue	**Yes**	**No**
1. Are you having trouble falling asleep?		
2. Do you often wake up at night		
3. Are you restless while you sleep?		
4. Do you have rib pain?		
5. Are you tired when you wake up?		
6. Do you recall your dreams?		

4. Mobility - motion control

Issue	**Yes**	**No**
1. Are your joints very flexible (Little finger bendable, hyperextensible elbows and knees, excessive mobility of the shoulders)?		
2. Do you often twist your ankles, fingers, or knees?		
3. Do your joints crack often?		
4. Do you have joint blockages (back, neck, limbs)?		

5. Do you have any displacements in your joints (shoulder, elbows, wrists, fingers, jaw)?		
6. Are you clumsy (hit corners or get caught on door handles, furniture corners, or drop things)?		
7. Do you have involuntary movements (twitches)?		
8. Do you have trembling?		
9. Do you have muscle twitches (face, thighs)?		
10. Do you have leg twitching when you fall asleep?		
11. Do you have trouble raising your arms?		
12. Do you have difficulty writing?		
13. Do you have difficulty standing upright?		
14. Do you have difficulty sitting?		
15. Do you have trouble getting up?		
16. Do you have difficulty walking?		
17. Do you have trouble running?		
18. Do you fall down?		
19. Do you have trouble doing your hair?		
20. Do you have trouble getting dressed?		
21. Do you have trouble cutting bread?		
22. Do you have trouble with drinking?		

5. The skin

Issue	**Yes**	**No**
1. Is your skin thin, transparent (can you see small veins through it)?		
2. Does it feel soft (“baby skin”, velvety)?		
3. Is it sensitive (easily grazed, poor healing, early stretch marks—since childhood or numerous, is it stretch on the neck or face?		

6. Deviating reactions of the autonomic nervous system ("autonomic dysfunction")

Issue	**Yes**	**No**
1. Are you sensitive to the cold?		
2. Do you have a raised body temperature even when there is no infection?		
3. Do you sweat profusely (sweat attacks in the are of the head and upper body at night, sweaty hands and feet, armpits)?		
4. Do you have “hot flashes”?		
5. Is your mouth dry?		

6. Do you have an accelerated pulse (palpitations)? (At rest, the heart rate can be as low as 40 or 50)		
7. Do you have low blood pressure?		
8. Do you have cold feet (hands, nose ears)?		

7. Bleeding

Issue	Yes	No
1. Do you easily get bruises even after minor bumps?		
2. Are your veins fragile with significant bruises when drawing blood?		
3. Do your wounds bleed a lot and for a long time?		
4. Do you have heavy and frequent nosebleeds?		
5. Do your gums bleed when you brush your teeth?		
6. Do you have a heavy menstrual period?		

8. Digestive tract, abdomen

Issue	Yes	No
1. Do you have a bowel movement every day?		
2. If not, how many times per week do you have a bowel movement? _____		
3. Do you have gas?		
4. Do you choke?		
5. Are you having trouble swallowing?		
6. Do you have acid reflux (heartburn)?		
7. Do you have hernias (externalization of a piece of intestine through the abdominal wall) at the level of the abdomen (around the navel, on the abdomen, just above the thigh)?		
8. Have you had surgery on your stomach?		

9. Bladder-perineum

Issue	Yes	No
1. Can you last a day without wanting to urinate?		
2. When you have an urgent need to urinate do you sometimes lose urine?		
3. Do you have an “organ prolapse”?		
4. Have you had urinary tract infections?		

10. Mouth and teeth

Issue	Yes	No
1. Do you have pain in your jaw?		
2. Do you have blockages or dislocations in your jaw?		
3. Are your gums painful?		
4. Are your teeth breaking?		
5. Are your teeth moving?		
6. Have your teeth grown irregularly?		

11. Hearing-voice generation-smell

Issue	Yes	No
1. Are you bothered by noise?		
2. Do you have very fine hearing (do you hear "small noises" that others cannot hear)?		
3. Do you have a musical ear?		
4. Are you a musician?		
5. Do you have trouble hearing, especially when there is noise or voices around you?		
6. Do you sing well?		
7. Do you hear spontaneous noises in your ears (tinnitus)?		
8. Do you have a very fine sense of smell?		
9. Do you feel dizzy (when you turn forwards, backwards, to your sides, or turn around, or the landscape revolves around you, sways or wobbles) when you switch from lying down to standing or when you tilt your head?		

12. Vision

Issue	Yes	No
1. Are you nearsighted?		
2. Do you have astuteness (astigmatism)?		
3. Do you have visual fatigue (reading, screen) with your glasses?		
4. Do you have double vision?		
5. Are you sensitive to light?		
6. Do your eyes get irritiated?		

13. Breathing, lungs, bronchi

Issue	Yes	No
1. Do you have airway blockages / do you sometimes spontaneously stop breathing?		
2. Are you short of breath when climbing stairs?		
3. Do you have or have you had bronchitis?		
4. Do you have a husky voice (low voice, complete hoarseness)?		

14. Gynecology (For women only)

Issue	Yes	No	N/A
1. Do you have problems having sexual intercourse?			
2. Did you have difficulty giving birth?			
3. Did your symptoms decrease during pregnancy?			
4. Have you had miscarriages?			

For women only:

Have you ever been pregnant? □ Yes □ No

Number of miscarriages _____ Number of terminations _____

Number of premature births _____ Number of term/live births _____

Birth weight of largest baby _____ Weight of smallest baby _____

Did you develop pre-eclampsia or eclampsia (high blood pressure)? □ Yes □ No

Are there any additional complications regarding fertility or pregnancy? □ Yes □ No If yes, please describe. _____

Date of last Pap Smear _____ Normal/Abnormal

Date of last Mammogram _____ Normal/Abnormal

Age of first period _____ Are your periods regular? _____

Average length of menstruation? _____

Date of last period: _____ What is your average cycle length? _____

Would you consider your periods to be heavy or light? _____

Do you experience painful cramps or moodiness during menstruation? Please explain.

Do you spot in between your periods? _____

Do you experience increased stool frequency or diarrhea at the onset of your period? □ Yes □ No

Do you currently use contraception? □ Yes □ No

Current birth controlled used: _____

What birth control have you used in the past? _____

Do you experience yeast infections or urinary tract infections? Please explain.

Reached or approaching menopause? Please explain: _____

If yes, age of last period. _____

If you are menopausal, are you having symptoms? Please explain?

_____

Are you using hormone replacement therapy? □ Yes □ No

If yes, which type and dosages?

_____

How long have you been using hormone replacement therapy (if applicable)?

_____

Do you have any of the following currently or in the past (circle all that apply)?

Hot flashes ● PMS ● Cramps ● Tender breasts ● Infertility ● PCOS ● Endometriosis

Uterine polyps ● Uterine fibroids ● Breast/ovarian/uterine cancer ● Facial hair growth

● Hypothyroidism ●Migraines ● Hysterectomy

_____

For Men Only:

For men, please indicate any issues with urinary frequency or erectile dysfunction.

_____

_____

_____

Do you get regular prostrate exams? _____

Any history of elevated PSA? _____

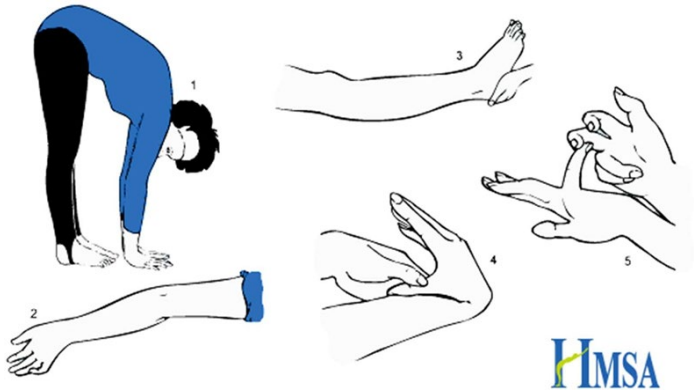
Any issues with infertility? _____

Have you had a vasectomy? _____

Assessment of Joint Hypermobility/Flexibility

Have you been diagnosed with a connective tissue disorder? _____
If so, which disorder and who confirmed the diagnosis? _____

Issue	Yes	No	N/A
1. Can you now (or could you ever) place your hands flat on the floor without bending your knees?			
2. Can you now (or could you ever) bend your thumb to touch your forearm?			
3. As a child did you amuse family or friends by contorting (bending) your body into strange shapes or could you do splits?			
4. As a child did you amuse family or friends by contorting (bending) your body into strange shapes or could you do splits?			
5. Do you consider yourself double jointed?			



Neuropathy Screening Questionnaire Initial Development and Validation of a Patient-Reported Symptom Survey for Polyneuropathy, RoiTreister*† et al, 2017	**Please place a check mark if a "yes" to the questions below:**
Are your legs and/or feet numb?	
Do you ever have any burning pain in your legs and/or feet?	
Are your feet too sensitive to touch?	
Do you get muscle cramps in your legs and/or feet?	
Do you ever have any prickling feelings in your legs or feet?	
Does it hurt when the bed covers touch your skin?	
When you get into the tub or shower, are you able to tell the hot water from the cold water?	
Have you ever had an open sore on your foot?	
Has your doctor ever told you or suspected that you have a neuropathy?	
Do you feel weak all over most of the time?	
Are your symptoms worse at night?	
Do you have vision eye difficulties (dry, sensitive to light, hard to focus)?	
Do your legs hurt when you walk?	
Are you able to sense your feet when you walk?	
Do you experience fast or strong heart beats?	
Do feel dizzy or faint when standing up?	
Does your stomach quickly full or feel bloated after meals?	
Do you experience episodes of nausea or vomiting?	
Have you experienced a changed pattern of sweating on body- too little or excessive?	
Do you have difficulty starting to urinate or have had accidents?	
Do have or experience blisters or sores inside mouth?	
Do you have less hair growth on lower legs or feet?	

Screening questionnaire for an immune deficiency syndrome/disorder:

Signs and symptoms of immune deficiency (lacking components of your immune system)	**Yes or No**
Have you or your child been treated for 4 or more new ear infections within 1 year?	
Have you or your child been treated for 2 or more serious sinus infections within 1 year?	
Have you or your child received 2 or more months on antibiotics with little effect?	
Have you or your child been treated for Two or more pneumonias within 1 year?	
Did you or your child have a history of failure of an infant to gain weight or grow normally?	
Have you or your child been treated for recurrent, deep skin or organ abscesses?	
Have you or your child been treated for persistent or recurrent thrush in mouth or fungal infection on skin	
Have you or your child needed for intravenous antibiotics to clear infections?	
Have you or your child been treated for 2 or more deep-seated infections including septicemia (blood infection)?	
Have you ever been evaluated for recurrent fevers (fevers of unknown origin)?	
Has a family member been treated for recurrent or severe infections, diagnosed with primary immune deficiency disorder?	

Medications and side effects

Issue	**Yes**	**No**
1. Have your medications or supplements ever caused you unusual side effects or problems?		
2. Describe:		
3. Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin?		
4. Have you had prolonged or regular use of Tylenol?		
5. Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.)		
6. Frequent antibiotics > 3 times/year		
7. Long term antibiotics		

8. Use of steroids (prednisone, nasal allergy inhalers) in the past		
9. Use of oral contraceptives		

Food Intake Frequency – General			
Food/Drink	**How often do you consume? (never, seldom, monthly, daily), etc.**	**Food/Drink**	**How often do you consume? (never, seldom, monthly, daily), etc.**
Caffeine		Milk/cream	
Diet Soda		Cheese	
Regular Soda		Yogurt	
Beer		Soy Products	
Wine		Whole grains	
Other alcohol_____		Bread	
Herb tea		Pasta	
Beef		Crackers	
Lamb		"Junk/Fast Food"	
Pork		Oils & Fats	
Sausage/Deli		Ghee	
Chicken		Olive Oil	
Turkey		Coconut	
Eggs, Whole		Canola	
Egg whites		Other: _____	
Fish/Shellfish		Vegetables	
Nuts & Seeds		Fresh	
Fruits		Frozen	
Fresh		Canned	

Frozen		Lentils	
Canned		Beans	
Artificial Sweeteners (Aspartame, Equal, Sucralose, Truvia)			

Digestive Symptoms/Food Patterns

Are you following a special diet (please check all that apply)?

Ovo-Lacto vegetarian		Vegetarian		Vegan	
Dairy-free		Gluten-free		Diabetic/Low sugar	
Low sodium/DASH		Low histamine		Low salicylate	
Low oxalate		Low sulfur		Low FODMAP	
Ketogenic/Keto-adapted		Atkins		Yeast/Mold	
Specific Carbohydrate		Paleo		Autoimmune Paleo	
Other, please describe					
How long have you been on the diet?					

If you could change one thing about your diet to improve your health, what would it be?

_____

_____

Do you eat breakfast? □ Yes □ No If so, what do you typically eat for breakfast?

_____

What do you typically eat for lunch?

_____

What do you typically eat for dinner?

_____

Do you snack? □ Yes □ No If yes, what do you usually snack on?

_____

Describe what you typically drink during the day.

_____

How often do you skip meals? _____

How do you feel when you've skipped a meal? _____

Are you ravenous or can you take it in stride? _____

How do you feel after eating?	Better	Worse	No Difference or Not Applicable
High fat foods			
High protein foods			
High carbohydrate foods (pasta, bread, potatoes)			
Refined sugar/Junk Food			
Fried Foods			
1 to 2 alcoholic beverages			

Please recall in detail what you have eaten, swallowed, smoked, chewed and/or consumed in the last 24 hours:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Environmental & Lifestyle Intake

What type of home do you currently live in (single family home, apartment/condo, mobile home, etc.)? _____

What type of work environment do you currently work in (home, office building, factory, restaurant, shops, etc.)? _____

Approximately what year was your home built? _____

With whom do you live? _____

_____

Do you have any pets or farm animals? If yes, what kind and where do they live? _____

_____

Has your home had any previous water or fire damage? _____

What is the current water source for your home (well, public water, bottled, etc.)? _____

_____

Do you feel safe in your environment? _____

To your knowledge have you been exposed to toxic metals in your job or at home? _____

If yes, which one(s) (lead, arsenic, aluminum, cadmium, mercury) and how long were you exposed? _____

Do odors or chemicals affect you? If so, which ones (smoke, perfume, cleaning products, etc.)?

_____

In your work or home environment, are you (or have you been) exposed to any of the following regularly:

____ Chemicals	____ Electromagnetic radiation	____ Mold
____ Dry cleaning	____ Automobile exhaust	____ Aerosols

____ Radio tower ____ Paint fumes ____ Smoke

____ Landfill/dump ____ Hydro tower ____ Herbicides

____ Heavy metals ____ Organic solvents ____ Pesticides

____ Harsh chemicals (varnish, gas, glue, acid, cleaning) ____ Airplane travel

____ Farm/industrial/power plant/lines ____ Modeling clay

____ Photo developing/dark room

Do you have regular exposure at home or work to:

____ Forced air heat ____ Renovations

____ Basement cracks/dirt floors ____ Damp basement/crawl space

____ Wet windows ____ Visible mold

____ Crumbling pipe insulation ____ Crumbling wall/ceiling insulation

____ Old or cracking paint ____ Old/cracked ceiling tiles/flooring

____ Carpets or rugs ____ Stagnant or stuffy air

____ Gas or propane stove (or other gas) ____ Coal or wood stove

____ Crumbling wall/ceiling insulation ____Water leaks (ceiling/walls/floors)

Have you ever worked at a job or hobby in which you came in contact with any of the following by breathing, touching, or ingesting (swallowing)? If yes, please check or circle the name.

____ Acids	____ Alcohols (industrial)	____ Alkalis
____ Ammonia	____ Arsenic	____ Asbestos
____ Benzene	____ Beryllium	____ Cadmium
____ Carbon tetrachloride	____ Chlorinated naphthalenes	____ Chloroform
____ Chloroprene Chromates	____ Coal dust	____ Dichlorobenzene
____ Ethylene dibromide	____ Ethylene dichloride	____ Fiberglass Halothane
____ Isocyanates	____ Ketones	____ Lead or Mercury
____ Methylene chloride	____ Nickel	____ PBBs
____ PCBs	____ Perchloroethylene	____ Pesticides
____Phenol	____ Phosgene	____ Radiation

____ Rock dust	____ Silica powder	____ Solvents
____ Styrene	____ Talc	____ Toluene
____ TDI or MDI	____ Trichloroethylene	____ Trinitrotoluene
____ Vinyl chloride	____ Welding fumes	____ X-rays

Other (specify): _____

_____

Do you live next to or near an industrial plant, commercial business, dump site, highway or nonresidential property?

_____

Which of the following do you have in your home? (circle those that apply)

Air conditioner	Air purifier	Central heating (gas or oil?)	Gas stove
Fireplace	Wood stove	Humidifier	Water filters

Have you recently acquired new furniture or carpet, refinished furniture, or remodeled your home? _____

Have you weatherized your home recently? _____

Are pesticides or herbicides (bug or weed killers; flea and tick sprays, collars, powders, or shampoos) used in your home or garden, or on pets? _____

Do you work on your car? _____

Have you ever changed your residence because of a health problem? _____

Do you have mercury amalgam fillings? If so, for how long have you had them? _____

_____

Do you have any artificial joints or implants? If so, for how long have you had them?

_____

Do you feel worse at certain times of the year? If so, when? _____

_____

Lifestyle

Have you lived or traveled outside of the United States? If so, when and where?

_____

_____

Have you ever used alcohol? □ Yes □ No If yes, how often do you now drink alcohol (Please circle)?

No longer drinking alcohol ● Average 1-3 drinks per week ● Average 4-6 drinks per week

Average 7-10 drinks per week ● Average >10 drinks per week

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

If yes, please indicate time period (month/year): From _____ to _____.

Have you ever used recreational drugs? □ Yes □ No

If yes, please indicate what types_____

Have you ever used tobacco? □ Yes □ No

If yes, number of years as a nicotine user: _____. Amount per day: ____. Year quit: ____.

If yes, what type(s) of nicotine have you used (circle all that apply)?

Cigarette ● Smokeless ● Cigar ● Pipe ● Patch/gum

Have you ever been exposed to second-hand smoke regularly? □ Yes □ No

How many caffeinated beverages do you consume per day? _____

Please list your personal care products used on a daily basis:

_____

_____

_____

Emotional Health/Stress

What do you feel is the major cause of your stress (for example — spouse, family, friends, work, finances, wedding, pregnancy, legal, commute)? _____
How do you cope with stress?

_____

On a scale of 1-10, please answer the following questions. 1 is never and 10 is always.

How often do you feel you have something that must be done?	How often do you feel overwhelmed?
How often do you have difficulty falling into deep, restful sleep?	Do you ever feel paranoid?
How often do you feel sad or down for no reason?	Have you lost your enthusiasm for your favorite activities?
Have you ever had self-destructive thoughts?	How often do you have an inability to handle stress?
How often do you prefer to isolate yourself from others?	Do you find it difficult to finish tasks?
Do you feel like your libido has been decreased?	Do you ever feel anxious or panicked for no reason?
How difficult is it to turn your mind off when you want to relax?	How stressful is your life?

Have you ever been diagnosed with any of the following?

□ Depression □ Anxiety □ Bipolar disorder □ ADD/ADHD □ OCD □ Schizophrenia □ PTSD

□ Autism Spectrum Disorder □ Other:

_____

Does anyone in your family suffer from any kind of mental illness, including depression, bipolar disorder, schizophrenia, anxiety, autism spectrum disorder or seasonal affective disorder?

_____

Are you taking an anti-depressant or other psychiatric medicine? □ Yes □ No

If yes, which medication(s) are you taking? _____

_____

Have you ever had psychotherapy or counseling? Yes____ No____ Currently? _____

Previously? _____ If previously, from _____ to _____.

What type of therapy?

_____

Have you or your family recently experienced any major life changes or losses? Yes__ No__

If yes, please comment

_____

How much time have you lost from work or school in the past year?

a. _____ 0-2 days

b. _____ 3 –14 days

c. _____ > 15 days

Previous jobs:

_____

_____

Do you find joy in your job or jobs? _____

Have you witnessed or experienced any physical or emotional trauma that could be impacting your health or wellbeing? If so, have you sought counseling for these traumatic events?

_____

How important is religion (or spirituality) for you and your family's life?

a. _____ not at all important

b. _____ somewhat important

c. _____ extremely important

Do you currently practice any form of meditation, breathing exercises, stretching, qi gong, tai chi, yoga, Pilates, etc.? _____

_____

Hobbies and leisure activities:

_____

_____

Where do you find emotional support?

____ Spouse ____ Family ____ Friends ____ Pets

____ Religious/Spiritual ____ Other

Sleep

Average number of hours you sleep per night: _____

What time do you go to sleep? _____ Wake up? _____

Do you sleep with any lights or sounds on? _____

Please check if you have any of the following:

____Trouble falling asleep ____ Feeling unrested or tired after waking

____ Wake during the night ____ Snoring or sleep apnea

____ Strange dreams or nightmares ____ Night sweats

Exercise/Recreation

Do you exercise? □ Yes □ No

If yes, please describe your exercise frequency:

Daily ● 5 to 6X per week ● 3 to 5X/week ● 1 to 3X per week

What type(s) of exercise do you participate in (circle all that apply)?

Cardiovascular (walk, bike, run) ● Strength training ● Pilates ● Yoga ● Flexibility ● Group exercise ● Personal training ● Martial arts ● Boxing/kickboxing ● Basketball ● Baseball ● Tennis ● Other: _____

When you exercise, how long is each session?

15 minutes or less ● 16 to30 minutes ● 31 to 45 minutes

46 to 60 minutes ● 61 to 90 minutes ● more than 90 minutes

Readiness to Change

Will family and/or fiends be supportive of your desire to make food and/or lifestyle changes?

_____

Are you willing to change what you believe about health and the body to improve your health?

_____

Are there any patterns in childhood or adulthood that has contributed to your health problems?

_____

_____

Is there anything else you would like to share?

_____

_____