

JAMIE CHAN-ORTEGA, Ph.D., L.Ac.

Oasis Healing Arts

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562-789-1588

[www.drjamiemphd.com](http://www.drjamiemphd.com)

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heal@oasishealingforyou.com

# **FUNCTIONAL MEDICINE NEW PATIENT INTAKE FORMS**

PLEASE BRING THESE FORMS FULLY COMPLETED  
TO YOUR FIRST APPOINTMENT

\*PLEASE KEEP PAGES 1 - 5 FOR YOUR RECORDS\*

Dear Patient,

Welcome! We are happy that you have chosen the path of Functional Medicine to address your health concerns. We believe Functional Medicine offers the best of both worlds: cutting-edge laboratory diagnostics based on the latest scientific research, coupled with lifestyle medicine and ancient wisdom: rest, stress management, diet, nutrition, movement, breathing, quiet time, and botanical and nutritional supplements. We are looking forward to partnering with you to achieve true wellness.

**FUNCTIONAL MEDICINE INITIAL CONSULTATION:**

In-depth health history intake and consult with Dr. Jamie (60 min)  
Review of body systems  
Review of relevant FM diagnostic labs  
Pay for consult, labs, and any supplements purchased  
Please plan 60 minutes for the initial consult and an additional 15-20 minutes to go over tests and/or supplements

**FUNCTIONAL MEDICINE - SECOND CONSULTATION:**

Consult with Dr. Jamie (50-60 min)  
Review lab results  
Review personalized treatment program created for you by Dr. Jamie  
Pay for consultation and any supplements purchased  
Schedule follow-up appointment in 8-10 weeks

**FUNCTIONAL MEDICINE ONGOING CONSULTATIONS:**

Consult with Dr. Jamie (45-50 min)  
Evaluate progress / advance to next stages  
Review and/or modify treatment program as necessary  
Pay for follow-up and any supplements purchased  
Schedule follow-up appointments

**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 vibrant health and true wellness.  
It is important to read all of the enclosed information carefully, complete all the forms, and bring them to your first appointment.

**WEBSITE**

Information about Oasis Healing Arts and all relevant patient forms are available through the website: [www.oasishealingforyou.com](http://www.oasishealingforyou.com) OR [www.drjamielphd.com](http://www.drjamielphd.com).

**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 require a letter of medical necessity for any tests or supplements there will be a \$30 fee and a one week turn-around time.

## **FUNCTIONAL MEDICINE CONSULTATION FEES**

Initial Consultation with Dr. Jamie: \$275 (60 min)  
Second Consultation with Dr. Jamie: \$200 (45 min)  
Ongoing Consultations with Dr. Jamie: \$200 (45 min)

## **LAB TESTS**

*We do not accept insurance to cover lab tests.*

All labs involve stool, urine, saliva, or bloodspot (skin prick) samples and can be done on your own in the comfort of your home. You will be given all lab kits and step-by-step instructions for home test kits at the time of your consult. Once all of the final lab results are received, we will review them with you at your follow-up visits.

## **SUPPLEMENTS**

All of the supplements that are recommended by Dr. Jamie are available for purchase in our office or online through our webstore. Supplements purchased online will be mailed directly to you. Dr. Jamie will educate you and recommend foods and nutritional supplements as part of your treatment program, but you are under no obligation to purchase supplements from our office or website.

## **RETURNS/REFUNDS**

Supplements (except for probiotics and protein powders) and Functional Lab kits may be returned for a refund or exchange if in original condition and unopened or unused within 7 days of purchase.

## **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. We do not take American Express.

## **CANCELLATION AND RESCHEDULING OF APPOINTMENTS**

There is a 72-hour (3 business days) cancellation and rescheduling policy for Functional Medicine appointments. **Your appointment must be cancelled or rescheduled at least 72 hours (3 business days) prior to your consultation time or you will be charged a \$75 cancellation fee.** You may cancel your appointment by calling the office at 562-789-1588 or emailing [heal@oasishealingforyou.com](mailto:heal@oasishealingforyou.com). Your phone call to cancel or your email to cancel must be time-stamped no less than 72 hours (3 business days) prior to your appointment time or your credit card will be charged the late cancellation fee.

## **LATE ARRIVAL APPOINTMENTS**

We are committed to being on time with patients' appointments in order to prevent increased waiting times. 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**

At the time of check out you will be scheduled for a follow-up appointment. We will assume you will honor this appointment time unless you notify us otherwise at least 72 hours / 3 business days prior to your scheduled appointment.

## **PAYMENT OPTIONS**

Cash, check, and credit card (MasterCard, Visa, 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 will be due. Over-the-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.

### **INSURANCE INFORMATION**

Medical insurance is not accepted for Functional Medicine consults and our office cannot assist you with claim resolution. Dr. Jamie does not submit her Functional Medicine medical notes to insurance companies.

### **DISABILITY FORMS**

Dr. Jamie does not fill out medical disability forms for patients, nor does she submit her Functional Medicine medical notes to support disability claims.

### **OFFICE HOURS**

Our office hours are Mondays through Fridays 9:00am to 5:30pm PST.

If you are going to stop by the office to pick up supplements we ask that you kindly email your order to us at [heal@oasishealingforyou.com](mailto:heal@oasishealingforyou.com) prior to your visit, and notify us of the approximate time you will be stopping in. You may also call it in at 562-789-1588.

### **PHONE CALLS AND MESSAGES**

Phone messages will be responded to within 24 hours (during business hours).

If you call after hours, please leave a message and the office staff will return your call on the next business day.

If you have a medical emergency, call 911 or go directly to the nearest ER.

When leaving a message, please be brief, speak slowly, and include the following information:

- Full name and date of birth
- Reason for call
- Phone number(s) - please repeat this twice
- E-mail address (if desired)

### **EMAIL**

If you would like to schedule / reschedule / cancel an appointment, want to pick up supplements, or have questions about labs or anything administrative, please email [heal@oasishealingforyou.com](mailto:heal@oasishealingforyou.com).

If you have a BRIEF medical question for Dr. Jamie please email her at [DrJamieOHA@gmail.com](mailto:DrJamieOHA@gmail.com).

Please note that it can take Dr. Jamie up to 72 hours to respond to emails, particularly if it is the weekend.

Wishing you true wellness,

Dr. Jamie and the Oasis Healing Arts team

## **IMPORTANT PATIENT INFORMATION**

### **APPOINTMENTS**

- Initial consult is \$275 and ongoing consultations are \$200.
- There is a 72 hour / 3 business day cancellation policy (please see cancellation policy in Practice Policies for Patients).

We reserve the right to charge your credit card \$50 if the appointment is not canceled or rescheduled 72 hours (3 business days) prior to your appointment. By signing below you agree to our cancellation policy and authorize Oasis Healing Arts to charge your credit card on file for any missed visits.

### **LAB TESTS & SUPPLEMENTS**

- All lab results will be reviewed with you during your second consultation (or whichever consultation immediately follows the time Dr. Jamie has received your results from the lab(s), reviewed them, and created your treatment program).
- Supplements (except probiotics and protein powders) and Functional Lab kits may be returned for a refund or exchange if in original condition and unopened or unused within 7 days of purchase.

### **RETURN CHECK FEE**

- A \$35 fee will be assessed for all checks returned for insufficient funds.

### **BILLING/INSURANCE**

- Payment for the office visit/consultation, phone consultation, or lab tests is expected at time of service. All credit card payments will be processed the same day of the visit or video consultation.
- Oasis Healing Arts does not accept insurance for Functional Medicine consults.

### **PRIMARY CARE PHYSICIAN**

Please note that Dr. Jamie is not your primary care physician and we recommend that you have a primary care physician.

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Patient Signature

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Date

## **INFORMED CONSENT REGARDING E-MAIL OR THE INTERNET USE OF PROTECTED PERSONAL INFORMATION**

Oasis Healing Arts provides patients the opportunity to communicate with them by e-mail. Transmitting confidential health information by e-mail, however, has a number of risks, both general and specific, that should be considered before using e-mail.

1. Risks:
  - a. General e-mail risks are the following: e-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward email to other recipients with or without the original sender(s) permission, or knowledge; users can easily misaddress an e-mail; e-mail is easier to falsify than handwritten, or signed documents; backup copies of e-mail may exist even after the sender, or recipient has deleted his/her history.
  - b. Specific e-mail risks are the following: e-mail 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 e-mail messages; patients who send, or receive e-mail from their place of employment risk having their employer read their e-mail.
2. It is the policy of Oasis Healing Arts that all e-mail 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 e-mail messages, or internet communications, with the same degree of confidentiality as afforded other portions of the protected personal health information. Oasis Healing Arts will use reasonable means to protect the security and confidentiality of e-mail or internet communication. Because of the risks outlined above, we cannot, however, guarantee the security and confidentiality of e-mail, or internet communications.
3. Patients must consent to the use of e-mail for confidential medical information after having been informed of the above risks. Consent to the use of e-mail includes agreement with the following conditions:
  - a. All e-mail 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, Dr. Jamie, other healthcare practitioners, insurance coordinators, and upon written authorization other healthcare providers and insurers will have access to e-mail messages contained in protected personal health information.
  - b. Oasis Healing Arts practitioners may forward e-mail messages within the practice as necessary for diagnosis and treatment. We will not, however, forward the e-mail outside the practice without the consent of the patient as required by law.
  - c. We at Oasis Healing Arts will endeavor to read e-mails promptly, but can provide no assurance that the recipient of the particular e-mail will read the e-mail message promptly. Therefore, e-mail must not be used in a medical emergency. It is the responsibility of the sender to determine whether the intended recipient received the e-mail and when the recipient will respond.
  - d. Because some medical information is so sensitive that unauthorized disclosure can be very damaging, e-mail 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.
  - e. Oasis Healing Arts cannot guarantee that electronic communications will be private. However, we will take reasonable steps to protect the confidentiality of the e-mail, or

internet communication. However, Dr. Jamie is not liable for improper disclosure of confidential information not caused by its employee's gross negligence, or wanton misconduct.

- f. If consent is given for the use of e-mail, it is the responsibility of the patient to inform Oasis Healing Arts staff of any type of information you do not want to be sent by e-mail.
- g. It is the responsibility of the patient to protect their password or other means of access to e-mail sent, or received, from Oasis Healing Arts, to protect confidentiality. Oasis Healing Arts is not liable for breaches of confidentiality caused by the patient. Any further use of e-mail initiated by the patient that discusses diagnosis, or treatment, constitutes informed consent to the foregoing. I understand that my consent to the use of e-mail may be withdrawn at any time by e-mail, or written communication, to Oasis Healing Arts at [heal@oasishealingforyou.com](mailto:heal@oasishealingforyou.com)

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

Name Printed: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## GENERAL INFORMATION

Full Name:

\_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Gender: + Male + Female

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

Job Title:

\_\_\_\_\_

Nature of Occupation / Business:

\_\_\_\_\_

Primary Address:

\_\_\_\_\_  
Number & Street City State Zip

Cell Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

\_\_\_\_\_  
Number & Street City State Zip

Physician's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### Who Referred you to Dr. Jamie / Oasis Healing Arts?

+ Google (What was your words did you Google search include?) \_\_\_\_\_

+ Social Media \_\_\_\_\_

+ Family Member \_\_\_\_\_

+ Friend \_\_\_\_\_

+ Other \_\_\_\_\_



# OASIS HEALING ARTS FUNCTIONAL MEDICINE MEDICAL QUESTIONNAIRE

## ALLERGIES

Medication / Supplement / Food:

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Reaction:

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## COMPLAINTS / CONCERNS

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

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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?

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Did something trigger your change in health?

---

What makes you feel worse?

---

What makes you feel better?

---

Please list top three current and ongoing problems in order of priority:

Describe Problem	Mild	Moderate	Severe
Ex: headaches		X	

Prior Treatment / Therapeutic Approach	Excellent	Good	Fair
Ex: Elimination Diet	X		

## MEDICAL HISTORY - DISEASES / DIAGNOSIS / CONDITIONS

**Check the box next to the conditions you have and provide date of onset**

### GASTROINTESTINAL

- |   |                          |
|---|--------------------------|
| + Irritable Bowel Syndrome _____          | + Celiac Disease _____   |
| + Inflammatory Bowel Disease _____        | + Constipation _____     |
| + Crohn's Disease _____                   | + Loose Stools _____     |
| + Ulcerative Colitis _____                | + Bloating _____         |
| + Gastritis or Peptic Ulcer Disease _____ | + Flatulence (gas) _____ |
| + GERD (reflux) _____                     | + Other _____            |
|   | _____                    |

### CARDIOVASCULAR

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

### METABOLIC / ENDOCRINE

- |                         |                     |
|-------------------------|---------------------|
| + Type 1 Diabetes _____ | + Weight Gain _____ |
| + Type 2 Diabetes _____ | + Weight Loss _____ |

- + Hypoglycemia \_\_\_\_\_
- + Metabolic Syndrome \_\_\_\_\_
- + Insulin Resistance or Pre-Diabetes \_\_\_\_\_
- + Hypothyroidism (low thyroid) \_\_\_\_\_
- + Hyperthyroidism (overactive thyroid) \_\_\_\_\_
- + Polycystic Ovarian Syndrome (PCOS) \_\_\_\_\_
- + Infertility \_\_\_\_\_

- + 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 \_\_\_\_\_
- 

**GENITOURINARY**

- + Kidney Stones \_\_\_\_\_
- + Gout \_\_\_\_\_
- + Interstitial Cystitis \_\_\_\_\_
- + Frequent Urinary Tract Infections \_\_\_\_\_

- + Frequent Yeast Infections \_\_\_\_\_
  - + Erectile and/or Sexual Dysfunction \_\_\_\_\_
  - + Other \_\_\_\_\_
- 

**MUSCULOSKELETAL / PAIN**

- + Osteoarthritis \_\_\_\_\_
- + Fibromyalgia \_\_\_\_\_

- + Chronic Pain \_\_\_\_\_
  - + Other \_\_\_\_\_
- 

**INFLAMMATORY / IMMUNE**

- + Chronic Fatigue Syndrome \_\_\_\_\_
- + Autoimmune Disease \_\_\_\_\_
- + Rheumatoid Arthritis \_\_\_\_\_
- + Lupus SLE \_\_\_\_\_
- + Immune Deficiency Disease \_\_\_\_\_
- + Herpes-Genital \_\_\_\_\_
- + Severe Infectious Disease \_\_\_\_\_

- + Poor Immune Function \_\_\_\_\_
  - + Food Allergies \_\_\_\_\_
  - + Environmental Allergies \_\_\_\_\_
  - + Multiple Chemical Sensitivities \_\_\_\_\_
  - + Latex Allergy \_\_\_\_\_
  - + Other \_\_\_\_\_
-

## RESPIRATORY DISEASES

- + Asthma \_\_\_\_\_
- + Chronic Sinusitis \_\_\_\_\_
- + Bronchitis \_\_\_\_\_
- + Emphysema \_\_\_\_\_

- + Pneumonia \_\_\_\_\_
  - + Tuberculosis \_\_\_\_\_
  - + Sleep Apnea \_\_\_\_\_
  - + Other \_\_\_\_\_
- 

## SKIN DISEASES

- + Eczema \_\_\_\_\_
- + Psoriasis \_\_\_\_\_
- + Acne \_\_\_\_\_

- + Melanoma \_\_\_\_\_
  - + Skin Cancer \_\_\_\_\_
  - + Other \_\_\_\_\_
- 

## NEUROLOGIC / MOOD

- + Depression \_\_\_\_\_
- + Anxiety \_\_\_\_\_
- + Bipolar Disorder \_\_\_\_\_
- + Headaches \_\_\_\_\_
- + Migraines \_\_\_\_\_
- + ADD/ADHD \_\_\_\_\_
- + Autism \_\_\_\_\_

- + Mild Cognitive Impairment \_\_\_\_\_
  - + Memory Problems \_\_\_\_\_
  - + Parkinson's Disease \_\_\_\_\_
  - + Multiple Sclerosis \_\_\_\_\_
  - + ALS \_\_\_\_\_
  - + Seizures \_\_\_\_\_
  - + Other \_\_\_\_\_
- 

## INJURIES

Check box if yes: + Back Injury + Head Injury + Neck Injury + Broken Bones

## SURGERIES

Check box if yes and provide date of surgery

- + Appendectomy \_\_\_\_\_
- + Hysterectomy +/- Ovaries \_\_\_\_\_
- + Gall Bladder \_\_\_\_\_
- + Hernia \_\_\_\_\_
- + Tonsillectomy \_\_\_\_\_
- + Dental Surgery \_\_\_\_\_

- + Joint Replacement –Knee/Hip \_\_\_\_\_
  - + Spinal Surgery \_\_\_\_\_
  - + Heart Surgery–Bypass Valve \_\_\_\_\_
  - + Angioplasty or Stent \_\_\_\_\_
  - + Pacemaker \_\_\_\_\_
  - + Other \_\_\_\_\_
-

**HOSPITALIZATIONS**

+ None

Date: Reason:


**GYNECOLOGIC HISTORY (for women only)**

**OBSTETRIC HISTORY**

(Check box if yes and provide number)

- + Pregnancies \_\_\_\_\_ + Caesarean \_\_\_\_\_ + Vaginal deliveries \_\_\_\_\_
- + Miscarriage \_\_\_\_\_ + Abortion \_\_\_\_\_ + Living Children \_\_\_\_\_
- + Postpartum Depression + Toxemia + Gestational Diabetes
- + Baby Over 8 Pounds + Breastfeeding For how long? \_\_\_\_\_

**MENSTRUAL HISTORY**

Age at First Period: \_\_\_\_\_ Menses Frequency: \_\_\_\_\_ Length: \_\_\_\_\_

Pain: + Yes + No Clotting: + Yes + No

Has your period ever skipped? + Yes + No 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 (for women only)**

+ Fibrocystic + Breasts + Endometriosis + Fibroids Infertility

+ Painful Periods + Heavy periods + PMS

Last PAP Test: \_\_\_\_\_ + Normal + Abnormal

Are you in menopause? + Yes + No

Age at Menopause: \_\_\_\_\_

+ Hot Flashes + Mood Swings + Concentration / Memory Problems

+ Vaginal Dryness + Decreased Libido

+ Heavy Bleeding + Joint Pains + Headaches + Weight Gain

+ Loss of Control of Urine + Palpitations

+ Use of hormone replacement therapy How long? \_\_\_\_\_

### **MEN'S HISTORY (for men only)**

- + Prostate Enlargement + Prostate infection + Change in Libido + Impotence
- + Difficulty Obtaining an Erection + Difficulty Maintaining an Erection
- + 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

### **DENTAL HISTORY**

- Silver Mercury Fillings: + Yes + No How many? \_\_\_\_\_
- + Gold Fillings
- + Root Canals If yes, how many? \_\_\_\_\_
- + Implants If yes, how many? \_\_\_\_\_
- + Tooth Pain
- + Bleeding Gums
- + Gingivitis
- + Problems with Chewing
- Do you floss regularly? + Yes + No

## MEDICATIONS

### CURRENT MEDICATIONS

MEDICATION	DOSE	FREQUENCY	START DATE (mo/yr)	REASON FOR USE

### PREVIOUS MEDICATIONS: (Last 5 years)

MEDICATION	DOSE	FREQUENCY	START DATE (mo/yr)	REASON FOR USE

### NUTRITIONAL SUPPLEMENTS (VITAMINS / MINERALS / HERBS / HOMEOPATHY)

SUPPLEMENT & BRAND	DOSE	FREQUENCY	START DATE (mo/yr)	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 Blockers (Tagamet, Zantac, Prilosec, etc.) + Yes + No

Frequent antibiotics (> 2 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

## NUTRITION HISTORY

Have you ever had a nutritional 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 + No Gluten + Vegetarian + Vegan

Specific Program for Weight Loss/Maintenance Type:

Other

Height (feet/inches) \_\_\_\_\_ Current Weight \_\_\_\_\_

Usual Weight Range +/- 5 lbs \_\_\_\_\_ Desired Weight Range +/- 5 lbs \_\_\_\_\_

Highest adult weight \_\_\_\_\_ Lowest adult weight \_\_\_\_\_

Weight Fluctuations (> 10 lbs.) + Yes + No Body Fat % \_\_\_\_\_

Do you avoid any particular foods? + Yes + No

If yes, types and reason:

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:

<ul style="list-style-type: none"><li>+ Fast eater</li><li>+ Erratic eating pattern</li><li>+ Eat too much</li><li>+ Late night eating</li><li>+ Dislike healthy food</li><li>+ Time constraints</li><li>+ Eat more than 50% meals away from home</li><li>+ Travel frequently</li><li>+ Non-availability of healthy foods</li><li>+ Do not plan meals or menus</li><li>+ Reliance on convenience items</li><li>+ Family members don't like healthy foods</li></ul>	<ul style="list-style-type: none"><li>+ Significant other or family members have special dietary needs or food preferences</li><li>+ Love to eat</li><li>+ Have a negative relationship with food</li><li>+ Struggle with eating issues</li><li>+ Emotional eater (eat when sad, lonely, depressed, bored)</li><li>+ Eat too much under stress</li><li>+ Eat too little under stress</li><li>+ Don't care to cook</li><li>+ Eating in the middle of the night</li><li>+ Confused about nutrition advice</li></ul>
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## SMOKING

Currently Smoking? + Yes + No

How many years? \_\_\_\_\_ Packs per day: \_\_\_\_\_ Attempts to quit: \_\_\_\_\_

Previous Smoking: How many years? \_\_\_\_\_ Packs per day? \_\_\_\_\_

Second Hand Smoke Exposure? \_\_\_\_\_



## ALCOHOL INTAKE

How many drinks currently per week? 1 drink = 5 ounces wine, 12 ounces beer, or 1.5 ounces spirits  
+ None + 1-3 + 4-6 + 7-10 + >10 If "None," skip to Other Substances

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

Have you ever been told you should cut down your alcohol intake? + Yes + No

Do you ever feel guilty about your alcohol consumption? + 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

12-ounce can/bottle + 1 + 2-4 + >4 per day

Are you currently using any recreational drugs (marijuana, ecstasy, etc)? + Yes + No

Type \_\_\_\_\_

Have you ever used IV recreational drugs? + Yes + No

## EXERCISE

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

Activity	Type	Frequency per Week	Duration in Minutes
Stretching			
Cardio / Aerobics			
Strength			
Other			
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 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:

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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 + Prayer + Imagery + Breathing + Tai Chi

Other:

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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: + >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 use sleeping aids? + Yes + No

Explain: \_\_\_\_\_

## ROLES / RELATIONSHIPS

Marital status: + Single + Married + Divorced + Long Term Partnership + Widow

# of Children \_\_\_\_\_ Age of Each Child: \_\_\_\_\_

Who else is living in household? \_\_\_\_\_

Under what circumstances? (ex: my mother - dementia) \_\_\_\_\_

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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 in your life				
At school				
In your job				
In your social life				
With your friends				
With sex				
With your spouse / significant other				
With your children				
With your parents				
With having a positive attitude				

## ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

Do you have known adverse food reactions or sensitivities? + Yes + No

If yes, describe

symptoms: \_\_\_\_\_

Do you have any food allergies or sensitivities? + 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 any of the following?:

+ Monosodium glutamate (MSG) + Aspartame (NutraSweet) + Caffeine

+ Garlic + Onion + Cheese + Citrus Foods + Chocolate + Alcohol + Red Wine

+ Sulfite Containing Foods (wine, dried fruit, salad bars) + Preservatives (ex. sodium benzoate)

+ Cigarette Smoke + Perfumes/Colognes + Auto Exhaust Fumes

+ Other: \_\_\_\_\_

In your work or home environment, are you exposed to:

+ Chemicals + Electromagnetic Radiation + Mold

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 \_\_\_\_\_

Do you dry clean your clothes frequently? Y+ Yes + No

Do you or have you lived or worked in a damp or moldy environment? + Yes + No

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

## SYMPTOM REVIEW

Please check all symptoms experienced within the past 6 months to the present.

<p><b>GENERAL</b></p> <ul style="list-style-type: none"> <li>+ Cold Hands &amp; Feet</li> <li>+ Cold Intolerance</li> <li>+ Low Body Temperature</li> <li>+ Low Blood Pressure</li> <li>+ Daytime Sleepiness</li> <li>+ Difficulty Falling Asleep</li> <li>+ Early Waking</li> <li>+ Fatigue</li> <li>+ Fever</li> <li>+ Heat Intolerance</li> <li>+ Night Waking</li> <li>+ Nightmares</li> <li>+ No Dream Recall</li> </ul> <p><b>HEAD, EYES &amp; EARS</b></p> <ul style="list-style-type: none"> <li>+ Conjunctivitis</li> <li>+ Distorted Sense of Smell</li> <li>+ Distorted Taste</li> <li>+ Ear Fullness</li> <li>+ Ear Pain</li> <li>+ Ear Ringing/Buzzing</li> <li>+ Eye Pain</li> <li>+ Hearing Problems</li> <li>+ Headache</li> <li>+ Migraine</li> <li>+ Sensitivity to Loud Noises</li> <li>+ Vision problems (other than glasses)</li> <li>+ Macular Degeneration</li> </ul> <p><b>MUSCULOSKELETAL</b></p> <ul style="list-style-type: none"> <li>+ Back Muscle Spasm</li> <li>+ Calf Cramps</li> <li>+ Chest Tightness</li> <li>+ Foot Cramps</li> <li>+ Joint Deformity</li> <li>+ Joint Pain</li> <li>+ Joint Redness</li> <li>+ Joint Stiffness</li> <li>+ Muscle Pain</li> <li>+ Muscle Spasms</li> <li>+ Muscle Stiffness</li> <li>+ Muscle Twitches - eyes</li> <li>+ Muscle Twitches - arms, legs</li> </ul>	<ul style="list-style-type: none"> <li>+ Muscle Weakness</li> <li>+ Neck Muscle Spasm</li> <li>+ Tendonitis</li> <li>+ Tension Headache</li> <li>+ TMJ Problems</li> </ul> <p><b>MOOD / NERVES</b></p> <ul style="list-style-type: none"> <li>+ Anxiety</li> <li>+ Blackout</li> <li>+ Depression</li> </ul> <p><b>Difficulty:</b></p> <ul style="list-style-type: none"> <li>+ Concentrating</li> <li>+ With Balance</li> <li>+ With Thinking</li> <li>+ With Speech</li> <li>+ With Memory</li> </ul> <ul style="list-style-type: none"> <li>+ Dizziness / Vertigo</li> <li>+ Fainting</li> <li>+ Fearfulness</li> <li>+ Irritability</li> <li>+ Lightheadedness</li> <li>+ Numbness</li> <li>+ Phobias: _____</li> <li>+ Panic Attacks</li> <li>+ Paranoia</li> <li>+ Seizures</li> <li>+ Suicidal Thoughts</li> <li>+ Tremor/Trembling</li> </ul> <p><b>EATING</b></p> <ul style="list-style-type: none"> <li>+ Binge Eating</li> <li>+ Bulimia</li> <li>+ Can't Gain Weight</li> <li>+ Can't Lose Weight</li> <li>+ Can't Maintain Healthy Weight</li> <li>+ Frequent Dieting</li> <li>+ Poor Appetite</li> <li>+ Salt Cravings</li> <li>+ Carbohydrate Craving (breads, pastas)</li> <li>+ Sweet Cravings (candy, cookies, cakes)</li> <li>+ Chocolate Cravings</li> <li>+ Caffeine Dependency</li> </ul>	<p><b>DIGESTION</b></p> <ul style="list-style-type: none"> <li>+ Anal Spasms</li> <li>+ Bad Teeth</li> <li>+ Bleeding Gums</li> <li>+ Bloating</li> <li>+ Bloating After Meals</li> <li>+ Blood in Stools</li> <li>+ Burping</li> <li>+ Canker Sores</li> <li>+ Cold Sores</li> <li>+ Constipation</li> <li>+ Cramps</li> <li>+ Diarrhea</li> <li>+ Alternating Diarrhea and Constipation</li> <li>+ Difficulty Swallowing</li> <li>+ Dry Mouth</li> <li>+ Excess Flatulence/Gas</li> <li>+ Fissures</li> <li>+ Foods "Repeat" (Reflux)</li> <li>+ Gas</li> <li>+ Heartburn</li> <li>+ Hemorrhoids</li> <li>+ Indigestion</li> <li>+ Nausea</li> <li>+ Vomiting</li> </ul> <p><b>Intolerance to:</b></p> <ul style="list-style-type: none"> <li>+ Lactose</li> <li>+ All Dairy Products</li> <li>+ Wheat</li> <li>+ Gluten (Wheat, Rye, Barley)</li> <li>+ Corn</li> <li>+ Eggs</li> <li>+ Fatty Foods</li> <li>+ Yeast</li> </ul> <ul style="list-style-type: none"> <li>+ Liver Disease/Jaundice</li> <li>+ Lower Abdominal Pain</li> <li>+ Mucus in Stools</li> <li>+ Periodontal Disease</li> <li>+ Sore Tongue</li> <li>+ Strong Stool Odor</li> <li>+ Undigested Food in Stools</li> </ul>
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<p><b>SKIN &amp; HAIR PROBLEMS</b></p> <ul style="list-style-type: none"> <li>+ Acne on Face</li> <li>+ Acne on Body</li> <li>+ Athlete's Foot</li> <li>+ Bumps on Back of Upper Arms</li> <li>+ Easy Bruising</li> <li>+ Eczema</li> <li>+ Hair Loss</li> <li>+ Hives</li> <li>+ Jock Itch</li> <li>+ Oily Skin</li> <li>+ Pale Skin</li> <li>+ Rash</li> <li>+ Red Face / Ears</li> <li>+ Sensitivity to Insect Bites</li> <li>+ Shingles</li> <li>+ Strong Body Odor</li> <li>+ Sweating - Excessive</li> <li>+ Sweating - None</li> <li>+ Vitiligo</li> </ul> <p><b>ITCHING SKIN</b></p> <ul style="list-style-type: none"> <li>+ Skin in General</li> <li>+ Anus</li> <li>+ Arms</li> <li>+ Ear Canals</li> <li>+ Eyes</li> <li>+ Feet</li> <li>+ Hands</li> <li>+ Legs</li> <li>+ Nipples</li> <li>+ Nose</li> <li>+ Penis</li> <li>+ Roof of Mouth</li> <li>+ Scalp</li> <li>+ Throat</li> </ul> <p><b>SKIN, DRYNESS OF</b></p> <ul style="list-style-type: none"> <li>+ Eyes</li> <li>+ Feet</li> <li>+ Hair</li> <li>+ Hands</li> <li>+ Mouth/Throat</li> <li>+ Scalp</li> <li>+ Skin In General</li> </ul>	<p><b>LYMPH NODES</b></p> <ul style="list-style-type: none"> <li>+ Enlarged/neck</li> <li>+ Tender/neck</li> <li>+ Other Enlarged/Tender</li> </ul> <p><b>NAILS</b></p> <ul style="list-style-type: none"> <li>+ Bitten</li> <li>+ Brittle</li> <li>+ Fungus-Fingers</li> <li>+ Fungus-Toes</li> <li>+ Ridges</li> <li>+ Soft</li> </ul> <p><b>Thickening of:</b></p> <ul style="list-style-type: none"> <li>+ Fingernails</li> <li>+ Toenails</li> <li>+ White Spots/Lines</li> </ul> <p><b>RESPIRATORY</b></p> <ul style="list-style-type: none"> <li>+ Bad Breath</li> <li>+ Cough-Dry</li> <li>+ Cough-Productive</li> <li>+ Hoarseness</li> <li>+ Sore Throat</li> <li>+ Hay Fever, seasonal</li> <li>+ Hay Fever, perennial (all year)</li> <li>+ Nasal Stuffiness</li> <li>+ Nose Bleeds</li> <li>+ Post Nasal Drip</li> <li>+ Sinus Fullness</li> <li>+ Sinus Infection</li> <li>+ Snoring</li> <li>+ Wheezing</li> </ul> <p><b>CARDIOVASCULAR</b></p> <ul style="list-style-type: none"> <li>+ Angina/chest pain</li> <li>+ Breathlessness</li> <li>+ Heart Murmur</li> <li>+ Irregular Pulse</li> <li>+ Palpitations</li> <li>+ Swollen Ankles/Feet</li> <li>+ Varicose Veins</li> </ul> <p><b>URINARY</b></p> <ul style="list-style-type: none"> <li>+ Bed Wetting</li> <li>+ Hesitancy (trouble getting started)</li> <li>+ Infection</li> </ul>	<ul style="list-style-type: none"> <li>+ Kidney Disease</li> <li>+ Leaking/Incontinence</li> <li>+ Pain/Burning</li> <li>+ Prostate Infection</li> <li>+ Urgency</li> </ul> <p><b>MALE REPRODUCTIVE</b></p> <ul style="list-style-type: none"> <li>+ Discharge From Penis</li> <li>+ Ejaculation Problem</li> <li>+ Genital Pain</li> <li>+ Impotence</li> <li>+ Prostate or Urinary Infection</li> <li>+ Lumps In Testicles</li> <li>+ Poor Libido (Sex Drive)</li> </ul> <p><b>FEMALE REPRODUCTIVE</b></p> <ul style="list-style-type: none"> <li>+ Breast Cysts</li> <li>+ Breast Lumps</li> <li>+ Breast Tenderness</li> <li>+ Ovarian Cyst</li> <li>+ Poor Libido (Sex Drive)</li> <li>+ Vaginal Discharge</li> <li>+ Vaginal Odor</li> <li>+ Vaginal Itch</li> <li>+ Vaginal Pain with Sex</li> </ul> <p><b>Premenstrual:</b></p> <ul style="list-style-type: none"> <li>+ Bloating</li> <li>+ Breast Tenderness</li> <li>+ Carbohydrate Cravings</li> <li>+ Chocolate Cravings</li> <li>+ Constipation</li> <li>+ Decreased Sleep</li> <li>+ Diarrhea</li> <li>+ Fatigue</li> <li>+ Increased Sleep</li> <li>+ Irritability</li> </ul> <p><b>Menstrual:</b></p> <ul style="list-style-type: none"> <li>+ Cramps</li> <li>+ Heavy Periods</li> <li>+ Irregular Periods</li> <li>+ No Periods</li> <li>+ Scanty Periods</li> <li>+ Spotting Between</li> </ul>
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## 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

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**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

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**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

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