FALLING LEAVES
HEALTH

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General Information

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

Preferred Name: _____ Gender: ☐ Female ☐ Male

Date of Birth: *(mm/dd/yyyy)* _____ Current Age: _____

Highest Education Level: ☐ High School ☐ Graduate ☐ Post-Graduate Job Title: _____

Nature of Work: _____

Your Primary Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ ☐ Home ☐ Mobile ☐ Work

Alt Phone: _____ ☐ Home ☐ Mobile ☐ Work

Best time and place to reach you: _____

E-Mail: _____

Emergency Contact: _____ Phone: _____

City: _____ Alt Phone: _____

Primary Pharmacy: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip Code: _____

Who may we thank for referring you? _____ _____

Insurance Information: If we are in network, or if you have out of network benefits, and you would like to submit your claim directly to your insurance company, please fill out the info below. We will need a copy of your current insurance card. Please carefully read the additional insurance forms you will need to fill out separately from this intake.

Assignment and Release: I certify that I, (*print name*) _____ and/or my dependent(s), have insurance coverage with (*print name of insurance company*) _____ _____ and assign directly to Dr. Kenna S. Ducey-Clark, D.C., P.C. and Falling Leaves Health all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance for the purpose of benefits payable for related services.

Signature: _____

Printed Name: _____ Date: _____

Relationship to Patient: ☐ Self ☐ Parent ☐ Guardian ☐ Representative

Payment Information: Payment is due at time of service, no exceptions. If you would like us to submit a claim for payment of services to your insurance company, we will do so. However, please note that you are financially responsible for all services rendered to you, even if your insurance company denies claims. Knowledge and awareness of insurance coverage is the sole responsibility of the patient.

Is the reason why you scheduled your appointment today related to: *please circle*

Chiropractic Care	Trauma Recovery	Laser Therapy	Functional Medicine
Nutritional Needs	Health/Life Coaching	All of the above	Other _____

Health Concerns and Goals: *Please list current and/or ongoing areas of concern you would like to address in order of priority.*

What do you hope to achieve with your visits here? _____

_____

_____

When was the last time you felt exceptionally well? _____

Health Concern or Goal #1 (*Please describe as many details as you can*) _____

_____

When did you first notice symptoms? _____ Was there a trigger? _____

Is this condition getting ☐ Better ☐ Worse ☐ About the same

What treatments have you tried (from home remedies to medical interventions)? _____

_____

What makes it better? _____

What makes it worse? _____

Type of pain, if present: ☐ Sharp ☐ Dull ☐Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

How often do you experience this condition? _____

Is it constant, or does it come and go? _____

Any other important information about this condition? _____

Health Concern or Goal #2 (*Please describe as many details as you can*) _____

_____

When did you first notice symptoms? _____ Was there a trigger? _____

Is this condition getting ☐ Better ☐ Worse ☐ About the same

What treatments have you tried (from home remedies to medical interventions)? _____

_____

What makes it better? _____

What makes it worse? _____

Type of pain, if present: ☐ Sharp ☐ Dull ☐Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

How often do you experience this condition? _____

Is it constant, or does it come and go? _____

Any other important information about this condition? _____ _____

Health Concern or Goal #3 (*Please describe as many details as you can*) _____

_____

When did you first notice symptoms? _____ Was there a trigger? _____

Is this condition getting ☐ Better ☐ Worse ☐ About the same

What treatments have you tried (from home remedies to medical interventions)? _____

_____

What makes it better? _____

What makes it worse? _____

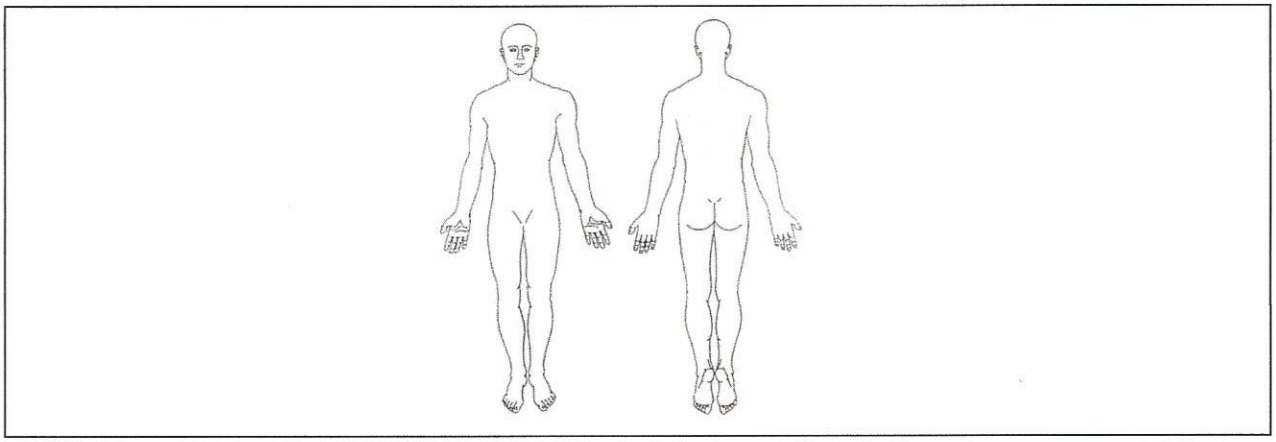
Type of pain, if present: ☐ Sharp ☐ Dull ☐Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning
☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

How often do you experience this condition? _____

Is it constant, or does it come and go? _____

Any other important information about this condition? _____

Please mark any areas of concern with as much detail as you can. Write anywhere in the box.



Other important comments: _____

_____

_____

Medical History: *Please list healthcare providers from whom you have received treatment within the last 10 years.*

☐ Doctor of Chiropractic Name: _____ City: _____
Treatment Focus: _____

☐ M.D. / D.O. Name: _____ City: _____
Treatment Focus: _____

☐ Acupuncture Name: _____ City: _____
Treatment Focus: _____

☐ Other Name: _____ City: _____

_____ Treatment Focus: _____

Medical History: *Continued*

Hospitalizations ☐ None

Date: _____ Reason: _____

Date: _____ Reason: _____

Date: _____ Reason: _____

Allergies ☐ None

Medication, supplement, food: _____ *Reaction:* _____

Medication, supplement, food: _____ *Reaction:* _____

Surgeries ☐ None

Date: _____ Reason: _____

Date: _____ Reason: _____

Date: _____ Reason: _____

Diseases/Diagnosis/Conditions:

Check appropriate box and provide month/year of onset ☐ Past Condition ○ Ongoing Condition

Gastrointestinal
- ☐ ○ Irritable Bowel Syndrome ___/_____
- ☐ ○ Inflammatory Bowel Disease ___/_____
- ☐ ○ Crohn's ___/_____
- ☐ ○ Ulcerative Colitis ___/_____
- ☐ ○ Gastritis/Peptic Ulcer Disease ___/_____
- ☐ ○ GERD (reflux) ___/_____
- ☐ ○ Celiac Disease ___/_____
- ☐ ○ Hemorrhoids ___/_____
- ☐ ○ Other _____ ___/_____

Cardiovascular
- ☐ ○ Heart Attack ___/_____
- ☐ ○ Other Heart Disease ___/_____
- ☐ ○ Stroke ___/_____
- ☐ ○ Elevated Cholesterol ___/_____
- ☐ ○ Arrhythmia (irregular heartbeat) ___/_____
- ☐ ○ Hypertension (high blood pressure) ___/_____
- ☐ ○ Rheumatic Fever ___/_____
- ☐ ○ Mitral Valve Fever ___/_____
- ☐ ○ Other _____ ___/_____

Cancer
- ☐ ○ Lung Cancer ___/_____
- ☐ ○ Breast Cancer ___/_____
- ☐ ○ Colon Cancer ___/_____
- ☐ ○ Ovarian Cancer ___/_____
- ☐ ○ Prostate Cancer ___/_____
- ☐ ○ Skin Cancer ___/_____
- ☐ ○ Other _____ ___/_____

Genital & Urinary Systems
- ☐ ○ Kidney Stones ___/_____
- ☐ ○ Gout ___/_____
- ☐ ○ Interstitial Cystitis ___/_____
- ☐ ○ Frequent Urinary Tract Infections ___/_____
- ☐ ○ Erectile or Sexual Dysfunctions ___/_____
- ☐ ○ Other _____ ___/_____

Metabolic/Endocrine
- ☐ ○ Type 1 Diabetes ___/_____
- ☐ ○ Type 2 Diabetes ___/_____
- ☐ ○ Hypoglycemia ___/_____
- ☐ ○ Metabolic Syndrome (insulin resistance/pre-diabetes) ___/_____
- ☐ ○ Hypothyroidism (low thyroid) ___/_____
- ☐ ○ Hyperthyroidism (overactive thyroid) ___/_____
- ☐ ○ Endocrine Problems ___/_____
- ☐ ○ Polycystic Ovarian Syndrome (PCOS) ___/_____
- ☐ ○ Infertility ___/_____
- ☐ ○ Weight Gain ___/_____
- ☐ ○ Weight Loss ___/_____
- ☐ ○ Frequent Weight Fluctuations ___/_____
- ☐ ○ Bulimia ___/_____
- ☐ ○ Anorexia ___/_____
- ☐ ○ Binge Eating Disorder ___/_____
- ☐ ○ Night Eating Syndrome ___/_____
- ☐ ○ Eating Disorder (non-specific) ___/_____
- ☐ ○ Other _____ ___/_____

Musculoskeletal/Pain
- ☐ ○ Osteoarthritis ___/_____
- ☐ ○ Fibromyalgia ___/_____
- ☐ ○ Chronic Pain ___/_____
- ☐ ○ Tendonitis ___/_____
- ☐ ○ Tension Headaches ___/_____
- ☐ ○ TMU Problems ___/_____
- ☐ ○ Foot Cramps ___/_____
- ☐ ○ Joint Deformity ___/_____
- ☐ ○ Joint Pain ___/_____
- ☐ ○ Other _____ ___/_____

Inflammatory/Autoimmune
- ☐ O Chronic Fatigue Syndrome ___/_____
- ☐ O Autoimmune Disease ___/_____
- ☐ O Rheumatoid Arthritis ___/_____
- ☐ O Immune Deficiency Disease ___/_____
- ☐ O Herpes - Genital ___/_____
- ☐ O Cold Sores ___/_____
- ☐ O Severe Infectious Disease ___/_____
- ☐ O Poor Immune Function (frequent infections) ___/_____
- ☐ O Food Allergies ___/_____
- ☐ O Environmental Allergies ___/_____
- ☐ O Multiple Chemical Sensitivities ___/_____
- ☐ O Latex Allergy ___/_____
- ☐ O Other _____ ___/_____

Respiratory Diseases
- ☐ O Asthma ___/_____
- ☐ O Chronic Sinusitis ___/_____
- ☐ O Bronchitis ___/_____
- ☐ O Emphysema ___/_____
- ☐ O Pneumonia ___/_____
- ☐ O Tuberculosis ___/_____
- ☐ O Sleep Apnea ___/_____
- ☐ O Other _____ ___/_____

Head, Eyes, & Ears
- ☐ O Conjunctivitis ___/_____
- ☐ O Distorted Sense of Smell ___/_____
- ☐ O Distorted Taste ___/_____
- ☐ O Ear Fullness ___/_____
- ☐ O Ear Pain ___/_____
- ☐ O Hearing Loss ___/_____
- ☐ O Hearing Problems ___/_____
- ☐ O Headache ___/_____
- ☐ O Migraine ___/_____
- ☐ O Sensitivity to Loud Noises ___/_____
- ☐ O Vision Problems (other than glasses) ___/_____
- ☐ O Macular Degeneration ___/_____
- ☐ O Vitreous Detachment ___/_____
- ☐ O Retinal Detachment ___/_____
- ☐ O Other _____ ___/_____

Nails
- ☐ O Bitten ___/_____
- ☐ O Brittle ___/_____
- ☐ O Curved Up ___/_____
- ☐ O Frayed ___/_____
- ☐ O Fungus - Fingers ___/_____
- ☐ O Fungus - Toes ___/_____
- ☐ O Pitting ___/_____
- ☐ O Ragged Cuticles ___/_____
- ☐ O Ridges ___/_____
- ☐ O Soft Nails ___/_____
- ☐ O Thickening of Finger Nails ___/_____
- ☐ O Thickening of Toenails ___/_____
- ☐ O White Spots or Lines ___/_____
- ☐ O Other _____ ___/_____

Skin Diseases
- ☐ O Acne on Back ___/_____
- ☐ O Acne on Chest ___/_____
- ☐ O Acne on Face ___/_____
- ☐ O Acne on Shoulders ___/_____
- ☐ O Athlete's Foot ___/_____
- ☐ O Bumps on Back of Upper Arms ___/_____
- ☐ O Cellulite ___/_____
- ☐ O Dark Circles Under Eyes ___/_____
- ☐ O Ears Get Red ___/_____
- ☐ O Easy Bruising ___/_____
- ☐ O Lack of Sweating ___/_____
- ☐ O Hives ___/_____
- ☐ O Jock Itch ___/_____
- ☐ O Lackluster Skin ___/_____
- ☐ O Moles that Change Color/Size ___/_____
- ☐ O Oily Skin ___/_____
- ☐ O Pale Skin ___/_____
- ☐ O Patchy Dullness ___/_____
- ☐ O Rash ___/_____
- ☐ O Red Face ___/_____
- ☐ O Sensitive to Bites ___/_____
- ☐ O Sensitive to Poison Ivy/Oak ___/_____
- ☐ O Shingles ___/_____
- ☐ O Skin Darkening ___/_____
- ☐ O Strong Body Odor ___/_____
- ☐ O Hair Loss ___/_____
- ☐ O Vitiligo (loss of pigment) ___/_____
- ☐ O Eczema ___/_____
- ☐ O Psoriasis ___/_____
- ☐ O Melanoma ___/_____
- ☐ O Skin Cancer ___/_____
- ☐ O Other _____ ___/_____

Neurologic/Mood
- ☐ O Depression ___/_____
- ☐ O Anxiety ___/_____
- ☐ O Bipolar Disorder ___/_____
- ☐ O Schizophrenia ___/_____
- ☐ O Headaches ___/_____
- ☐ O Migraines ___/_____
- ☐ O ADD/ADHD ___/_____
- ☐ O Autism ___/_____
- ☐ O Mild Cognitive Impairment ___/_____
- ☐ O Parkinson's Disease ___/_____
- ☐ O Multiple Sclerosis ___/_____
- ☐ O ALS ___/_____
- ☐ O Seizures ___/_____
- ☐ O Other _____ ___/_____

Blood Type

☐ A ☐ B ☐ AB ☐ O ☐ Rh+ ☐ Unknown

Injuries (provide date/description)
- ☐ Back Injury ___/_____ _____
- ☐ Head Injury ___/_____ _____
- ☐ Neck Injury ___/_____ _____
- ☐ Broken Bones ___/_____ _____
- ☐ Other ___/_____ _____

Female Reproductive
- ☐ O Breast Cysts ___/_____
- ☐ O Breast Lumps ___/_____
- ☐ O Breast Tenderness ___/_____
- ☐ O Ovarian Cysts ___/_____
- ☐ O Poor Libido (sex drive) ___/_____
- ☐ O Vaginal Discharge ___/_____
- ☐ O Vaginal Odor ___/_____
- ☐ O Vaginal Itch ___/_____
- ☐ O Vaginal Pain with Sex ___/_____
- ☐ O Other _____ ___/_____

Surgeries (provide date/description) ☐ None
- ☐ Appendectomy ___/_____
- ☐ Hysterectomy (+ or - Ovaries) ___/_____
- ☐ Gall Bladder Removed ___/_____
- ☐ Hernia ___/_____
- ☐ Tonsillectomy ___/_____
- ☐ Dental Surgery ___/_____
- ☐ Joint Replacement (Knee or Hip) ___/_____
- ☐ Heart Surgery (Bypass or Valve) ___/_____
- ☐ Angioplasty or Stent ___/_____
- ☐ Pacemaker ___/_____
- ☐ Other ___/_____ _____

Male Reproductive
- ☐ O Discharge from Penis ___/_____
- ☐ O Ejaculation Problems ___/_____
- ☐ O Genital Pain ___/_____
- ☐ O Impotence ___/_____
- ☐ O Prostate or Urinary Infection ___/_____
- ☐ O Lumps in Testicles ___/_____
- ☐ O Poor Libido (sex drive) ___/_____
- ☐ O Other _____ ___/_____

Preventive Tests (provide date of most recent test)
- ☐ Blood Tests ___/_____
- ☐ Full Physical Exam ___/_____
- ☐ X-Ray ___/_____ Body Part: _____
- ☐ Dental X-Ray ___/_____
- ☐ Bone Density ___/_____
- ☐ Colonoscopy ___/_____
- ☐ Cardiac Stress Test ___/_____
- ☐ EKG ___/_____
- ☐ Hemoccult Test (stool test for blood) ___/_____
- ☐ MRI ___/_____
- ☐ CT Scan ___/_____
- ☐ Upper Endoscopy ___/_____
- ☐ Upper GI Series ___/_____
- ☐ Ultrasound ___/_____
- ☐ Other ___/_____ _____

Gynecologic History *(for women only)*

Obstetric History *Check box if applicable and provide quantity*

☐ Pregnancy _____ ☐ Vaginal Delivery _____ ☐ Caesarean _____ ☐ Miscarriage _____ ☐ Abortion _____

☐ Living Children _____ ☐ Post Partum Depression _____ ☐ Toxemia _____ ☐ Gestational Diabetes _____

☐ Baby over 8 pounds _____ ☐ Premature Birth _____

☐ Breastfeeding _____ How long? _____ ☐ Oral Contraceptives *How long*? _____

Menstrual History

Age at first period: _____ Menses Frequency: _____ Length: _____ Pain: ☐ mild ☐ moderate ☐ severe

Clotting: ☐ Yes ☐ No Has your period ever skipped? ☐ Yes ☐ No *How long*? _____

Last Menstrual Period: _____

Do you use contraception? ☐ Yes ☐ No *If yes*: ☐ Condom ☐ Diaphragm ☐ IUD ☐ Partner Vasectomy

Women's Disorders / Hormonal Imbalances *Check box if applicable*

☐ Fibrocystic Breasts ☐ Endometriosis ☐ Fibroids ☐ Infertility ☐ Painful Periods ☐ Heavy Periods ☐ PMS

Last Mammogram (date/result): ☐ Thermogram _____ ☐ Breast Biopsy _____

Last PAP Test: ☐ Normal ☐ Abnormal

Date of last Bone Density Test: _____ ☐ Within Normal Range ☐ High ☐ Low

Are you in menopause? ☐ Yes ☐ No Age of onset: _____

Do you have? ☐ Hot Flashes ☐ Mood Swings ☐ Concentration/Memory Problems ☐ Vaginal Dryness ☐ Decreased Libido
☐ Heavy Bleeding ☐ Joint Pain ☐ Headaches ☐ Weight Gain ☐ Loss of Bladder Control ☐ Palpitations

☐ Use of hormone replacement therapy? How Long? _____

What hormones/dosage: _____

Men's Health History (*for men only*)

Have you had a PSA done? ☐ Yes ☐ No Date of last test: _____

Highest PSA Level: ☐ 0 - 2 ☐ 2 - 4 ☐ 4 - 10 ☐ > 10

Are you experiencing? ☐ Prostate Enlargement ☐ Prostate Infection ☐ Change in Libido ☐ Impotence

☐ Prostate Cancer ☐ Nocturia (frequent urination at night) How many times a night? _____

☐ Urgency/Hesitancy/Change in Urinary Stream ☐ Loss of Bladder Control

Medications

Current Medications (*both prescription and over-the-counter, use separate sheet if necessary*)

Medication	Dose	Frequency	Start Date (mo/yr)	Reason for Use

Nutritional Supplements (*vitamins, minerals, herbs, homeopathy*)

Medication	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 (3 days or longer) or regular use of NSAIDs (i.e. Advil, Aleve, Motrin, Aspirin, etc)? ☐ Yes ☐ No

Have you had prolonged or regular use of Tylenol (acetaminophen)? ☐ Yes ☐ No

For what reason and how long did you use pain relievers? _____

How often do you use NSAIDs currently? ☐ Never ☐ Daily ☐ Weekly ☐ Monthly

Have you had prolonged or regular use of Acid Blocking Drugs (i.e. Tagament, Zantac, Prilosec, etc.)? ☐ Yes ☐ No

Have you taken antibiotics more than once per year? ☐ Yes ☐ No

Approximately how many times have you taken antibiotics throughout your lifetime? _____

Have you ever used steroids (i.e. prednisone, nasal allergy inhalers, skin/joint creams, etc.)? ☐ Yes ☐ No

Gastrointestinal History

Have you traveled to a foreign country? ☐ Yes ☐ No Where? _____

Have you gone wilderness camping? ☐ Yes ☐ No Where? _____

Have you had severe: ☐ Gastroenteritis ☐ Diarrhea

Do you feel like you digest your feed well? ☐ Yes ☐ No Do you feel bloated after meals? ☐ Yes ☐ No

Diet

Do you have known adverse food reactions, allergies, or sensitivities? ☐ Yes ☐ No *If yes, list foods and reactions/ symptoms:* _____

_____

Adverse reaction to caffeine? ☐ Yes ☐ No *Does caffeine make you feel*: ☐ Irritable/Wired ☐ Aches/Pains ☐Headache

Do you adversely react to: ☐ Monosodium Glutamate (MSG) ☐ Aspartame (NutraSweet) ☐ Preservatives (ex. sodium benzoate)

☐ Cheese ☐ Citrus foods ☐ Chocolate ☐ Alcohol ☐ Red Wine ☐ Bananas ☐ Garlic ☐ Onion

☐ Sulfite containing foods (wine, dried fruit, salad bars) ☐ Other: _____

Environmental & Detoxification Assessment *Do any of the following significantly affect you?*

☐ Cigarette Smoke ☐ Perfumes/Colognes ☐ Vehicle Exhaust Fumes ☐ Other: _____

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

How often do you use your cell phone? _____ hrs/day Your computer? _____ hrs/day _____ hrs/week

Have you ever been jaundiced (yellow skin)? ☐ 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: ☐ Herbicides ☐ Pesticides

☐ Insecticides (exterminator use) ☐ Organic Solvents ☐ Heavy Metals ☐ Other_____

Chemical(s): name/date/length of exposure if known: _____

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

Do you have any pets or farm animals? ☐ Yes ☐ No *Describe*: _____

Please list the brand names of the products you use: Detergents/Soaps: _____

Deodorant: _____Beauty Products (*lotions, hair products, make-up, etc*):_____

_____

Other:

_____

_____

_____

_____

Family History

Check boxes for family members' history	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age, if still alive												
Age at death, if deceased												
Colon Cancer												
Breast Cancer												
Other Cancers												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis *(Rheumatoid, Psoriatic, etc.)*												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Disease *(ex. Lupus)*												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities, or Intolerance												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse *(such as alcoholism)*												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar / Mood Disorder												
Other:												

Social History

Weight Info

Height _____ft. _____in. Current Weight _____ Usual Weight Range *(+/- 5 lbs.)* _____

Desired Weight Range *(+/- 5 lbs.)* _____ Highest Adult Weight _____ Lowest Adult Weight _____

Have you experienced weight fluctuations greater than 10 lbs? ☐ Yes ☐ No Body fat % _____

Is your weight, in the recent past, increasing, decreasing, or staying the same? *Describe*: _____

_____

Nutrition History

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

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

_____

Do you currently follow a special diet or nutritional program? ☐ Yes ☐ No *If yes, mark all that apply.*

☐ Low Fat ☐ Low Carbohydrate ☐ High Protein ☐ Low Sodium ☐ Diabetic ☐ No Dairy ☐ No Wheat

☐ Gluten Restricted ☐ Vegetarian ☐ Vegan ☐ Ultrametabolism ☐ Macrobiotic ☐ Paleo

☐ Specific Program for weight loss/maintenance: _____ ☐ Other _____

Do you avoid any particular foods? ☐ Yes ☐ No *If yes, what and why?* _____

_____

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 eat organic foods? ☐ Yes ☐ No *% of your food that is organic (pesticide free, non-GMO, etc.)?* _____ %

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

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

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

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

_____

What foods would be the hardest to reduce or eliminate? _____

Smoking

Currently smoking? ☐ Yes ☐ No How many years? _____ Packs per day? _____ Attempts to quit? _____

Previous smoking? ☐ Yes ☐ No How many years? _____ Packs per day? _____ Date quit? _____

Secondhand smoke exposure? *Describe*: _____

Social History: *Continued*

Alcohol Intake

How many drinks do you drink per week? (1 drink = 1 oz. liquor/spirit, 5 oz. wine, 12 oz. beer)

☐ None ☐ 1 - 3 ☐ 4 - 6 ☐ 7 - 10 ☐ > 10 Most common beverage: _____

Other Substances

☐ Coffee ☐ Tea *Cups per day*: ☐ 1 ☐ 2 - 4 ☐ >4

☐ Caffeinated soda/diet soda *12 oz. servings per day*: ☐ 1 ☐ 2 - 4 ☐ >4 Favorite soda? _____

Exercise

Activity	Type	Frequency Per Week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength			
Other *(yoga, pilates, gyrotonics, etc.)*			
Sports or Leisure Activities *(golf, tennis, rollerblading)*			

Rate your level of motivation for including exercise in your life: ☐ Low ☐ Medium ☐ High

List any problems that limit your activity: _____

_____

Do you feel unusually fatigued after exercise? ☐ Yes ☐ No *If yes, please describe*: _____

_____

Do you usually sweat when exercising? ☐ Yes ☐ No

Psychosocial

Are you content? ☐ Yes ☐ Mostly ☐ 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

Stress / Coping

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

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

How do you deal with stress? _____

Daily Stressors: rate on a scale of 1 - 10:

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

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

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

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

If yes, explain: _____

How would you describe your overall attitude towards life? _____

Have you ever sought counseling? ☐ Yes ☐ No *Describe*: _____

Are you currently in therapy? ☐ Yes ☐ No *Describe*: _____

Sleep / Rest

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

What time do you typically go to sleep? _____:_____ am/pm 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 *If yes, what*? _____

Roles / Relationships

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Long Term Partnership ☐ Widow/Widower

Name of significant other, if applicable: _____

Any Children?

Child's Name	Age	Gender

Who is living in your household? Number _____ Names _____

If working, their occupation: _____

Resources for emotional support? ☐ Spouse/Partner ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other:_____

How well have things been going for you?	Very Well	Fine	Poorly	Does Not Apply
Overall				
At school				
At your job				
In your social life				
With close friends				
With your parents				
With your attitude				
With your significant other				
With your children				

4-Day Diet Dairy Instructions

It is important to keep an accurate record of your usual food and beverage intake as part of your treatment plan. Please complete this Diet Diary for 4 consecutive days, including one weekend day. You will find a convenient 4-day diary at the end of this packet. Please carry it with you, as it is often easier to write down what you consume shortly after you consume it, rather than waiting until the end of the day.

- Do not change your eating behavior at this time, as the purpose of this food record is to analyze your present eating habits.
- Record information as soon as possible after the food has been consumed.
- Describe the food or beverage as accurately as possible, for example, milk (2% or non-fat?); toast (whole wheat, white, buttered?); chicken (fried, baked, or breaded?); coffee (decaf, wt sugar, cream?)
- Record the amount of each food or beverage consumed using standard measurements such as 8 oz., 1/2 cup, 1 tsp, etc.
- Include any added items, for example, tea with 1 tsp honey, potato with 2 tsps butter, etc.
- Include any additional comments about your eating habits (ex. craving sweets, skipped meal and why, when the meal was eaten at a restaurant, etc.)
- Please note all bowel movements and their consistency (regular, loose, firm, etc.)