

## CLIENT INTAKE FORM

*Thank you for taking the time to fill out this form and provide us with details of your health, goals and medical history. Feel free to save this form to your computer and type in your answers at your convenience. The boxes where you type your responses will expand to accommodate your text, so you will have as much space as you need.*

At Functional Nutrition Alliance, we are committed to providing compassionate and effective care to all individuals seeking our Functional Nutrition clinical services. Our mission is to empower our clients to achieve their optimal health and we firmly believe that this journey should be accessible to everyone, regardless of their background, identity, or circumstances.

We adhere to the principles of inclusivity, diversity, and respect for all. We do not discriminate on the basis of age, race, ethnicity, physical ability or attributes, body size or weight, religion, sexual orientation, gender identity, or gender expression. We are dedicated to creating a safe, welcoming, and inclusive environment for every individual who walks through our doors.

Our commitment to inclusivity extends to every aspect of our practice including personalized care, cultural sensitivity, accessibility, confidentiality, non-discrimination, input and feedback on improvement. By choosing Functional Nutrition Alliance you are choosing a provider that values your history and identity and is dedicated to helping you achieve your health goals in an inclusive and respectful environment.

We look forward to partnering with you on your journey to optimal health.

### Client Information

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Country \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone (day) \_\_\_\_\_

Phone (cell) \_\_\_\_\_

Phone (night) \_\_\_\_\_

Email \_\_\_\_\_

Referred by \_\_\_\_\_

## History

Age \_\_\_\_\_ Birth date \_\_\_\_\_

Heritage (please specify more information if you'd like)

- |                                                             |                                           |                                               |
|-------------------------------------------------------------|-------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> American Indian /<br>Alaska Native | <input type="checkbox"/> Pacific Islander | <input type="checkbox"/> Mixed-Race           |
| <input type="checkbox"/> Asian                              | <input type="checkbox"/> White            | <input type="checkbox"/> Other                |
| <input type="checkbox"/> Black                              | <input type="checkbox"/> Latinx           | <input type="checkbox"/> Prefer not to answer |

Principle language

- |                                  |                                  |                                                 |
|----------------------------------|----------------------------------|-------------------------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Spanish | <input type="checkbox"/> Other (please specify) |
|----------------------------------|----------------------------------|-------------------------------------------------|

Birth weight (if known) \_\_\_\_\_

Birth order (please list ages of biological siblings) \_\_\_\_\_

Gender at birth \_\_\_\_\_

Pronouns (she/her, he/him, they/them, other) \_\_\_\_\_

Gender identity:

- |                                     |                                                        |                                               |
|-------------------------------------|--------------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Male       | <input type="checkbox"/> Transgender female /<br>woman | <input type="checkbox"/> Another identity     |
| <input type="checkbox"/> Female     | <input type="checkbox"/> Transgender male / man        | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Non-binary |                                                        |                                               |

Sexual orientation:

- |                                   |                                      |                                               |
|-----------------------------------|--------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Straight | <input type="checkbox"/> Bisexual    | <input type="checkbox"/> Another orientation  |
| <input type="checkbox"/> Lesbian  | <input type="checkbox"/> Asexual     | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> Gay      | <input type="checkbox"/> Questioning |                                               |

Height \_\_\_\_\_ Blood type (if known) \_\_\_\_\_

Weight (optional) \_\_\_\_\_ Weight one year ago (optional) \_\_\_\_\_

Relationship status (check all that apply):

- |                                                         |                                                         |                                  |
|---------------------------------------------------------|---------------------------------------------------------|----------------------------------|
| <input type="checkbox"/> Single                         | <input type="checkbox"/> Partnered, not living together | <input type="checkbox"/> Widowed |
| <input type="checkbox"/> Married or living with partner | <input type="checkbox"/> Divorced                       | <input type="checkbox"/> Other   |

Partner's pronouns (she/her, he/him, they/them, other) \_\_\_\_\_

If you have children, please list their age/ages \_\_\_\_\_

\_\_\_\_\_

Have you or your family recently experienced any major life changes? If so, please comment:

Occupation \_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Medical Status

- Please identify any current or past conditions and add a date for when the condition appeared. In the space below each list, please briefly describe your symptoms, chosen treatment(s), and dates.

### Gastrointestinal

PAST	NOW	DATE		PAST	NOW	DATE	
<input type="checkbox"/>	<input type="checkbox"/>	_____	Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	_____	Gut infections
<input type="checkbox"/>	<input type="checkbox"/>	_____	Crohn's	<input type="checkbox"/>	<input type="checkbox"/>	_____	Dysbiosis
<input type="checkbox"/>	<input type="checkbox"/>	_____	Ulcertative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Leaky gut
<input type="checkbox"/>	<input type="checkbox"/>	_____	Gastritis or Peptic Ulcer Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Food allergies, intolerances or reactions
<input type="checkbox"/>	<input type="checkbox"/>	_____	GERD (reflux or heartburn)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Gallstones
<input type="checkbox"/>	<input type="checkbox"/>	_____	Celiac Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Known absorption or assimilation issues
<input type="checkbox"/>	<input type="checkbox"/>	_____	SIBO	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

### Cardiovascular

PAST	NOW	DATE		PAST	NOW	DATE	
<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hypertension (high blood pressure)
<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	_____	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mitral Valve Prolapse
<input type="checkbox"/>	<input type="checkbox"/>	_____	Elevated cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other
<input type="checkbox"/>	<input type="checkbox"/>	_____	Arrhythmia (irregular heartbeat)				

Please briefly describe your symptoms, chosen treatment(s) and dates:

## Hormones/Metabolic

PAST	NOW	DATE		PAST	NOW	DATE	
<input type="checkbox"/>	<input type="checkbox"/>	_____	Type 1 Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Endocrine problems
<input type="checkbox"/>	<input type="checkbox"/>	_____	Type 2 Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Polycystic Ovarian Syndrome (PCOS)
<input type="checkbox"/>	<input type="checkbox"/>	_____	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Infertility
<input type="checkbox"/>	<input type="checkbox"/>	_____	Metabolic Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	_____	Weight gain
<input type="checkbox"/>	<input type="checkbox"/>	_____	Insulin Resistance or Pre-Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Weight loss
<input type="checkbox"/>	<input type="checkbox"/>	_____	Hypothyroidism (low thyroid)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Frequent weight fluctuations
<input type="checkbox"/>	<input type="checkbox"/>	_____	Hyperthyroidism (overactive thyroid)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Eating disorder
<input type="checkbox"/>	<input type="checkbox"/>	_____	Hashimoto's (autoimmune hypothyroid)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Menopause difficulties
<input type="checkbox"/>	<input type="checkbox"/>	_____	Grave's Disease (autoimmune hyperthyroid)	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hair loss
				<input type="checkbox"/>	<input type="checkbox"/>	_____	Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

## Cancer

PAST	NOW	DATE		PAST	NOW	DATE	
<input type="checkbox"/>	<input type="checkbox"/>	_____	Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Prostate Cancer
<input type="checkbox"/>	<input type="checkbox"/>	_____	Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Skin Cancer (Melanoma)
<input type="checkbox"/>	<input type="checkbox"/>	_____	Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Skin Cancer (Squamous, Basal)
<input type="checkbox"/>	<input type="checkbox"/>	_____	Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

## Genital & Urinary Systems

PAST	NOW	DATE		PAST	NOW	DATE	
<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	_____	Gout

- |                                                                                                    |                                                                                   |
|----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|
| <input type="checkbox"/> <input type="checkbox"/> _____ Frequent urinary tract infections          | <input type="checkbox"/> <input type="checkbox"/> _____ Interstitial Cystitis     |
| <input type="checkbox"/> <input type="checkbox"/> _____ Erectile Dysfunction or Sexual Dysfunction | <input type="checkbox"/> <input type="checkbox"/> _____ Frequent Yeast Infections |
|                                                                                                    | <input type="checkbox"/> <input type="checkbox"/> _____ Other                     |

Please briefly describe your symptoms, chosen treatment(s) and dates:

### Musculoskeletal/Pain

- |                                                   |                     |                |                                                   |                     |                                     |
|---------------------------------------------------|---------------------|----------------|---------------------------------------------------|---------------------|-------------------------------------|
| <small>PAST NOW</small>                           | <small>DATE</small> |                | <small>PAST NOW</small>                           | <small>DATE</small> |                                     |
| <input type="checkbox"/> <input type="checkbox"/> | _____               | Osteoarthritis | <input type="checkbox"/> <input type="checkbox"/> | _____               | Sore muscles or joints, undiagnosed |
| <input type="checkbox"/> <input type="checkbox"/> | _____               | Fibromyalgia   |                                                   |                     |                                     |
| <input type="checkbox"/> <input type="checkbox"/> | _____               | Chronic Pain   | <input type="checkbox"/> <input type="checkbox"/> | _____               | Other                               |

Please briefly describe your symptoms, chosen treatment(s) and dates:

### Immune/Inflammatory

- |                                                   |                     |                                            |                                                   |                     |                                                                             |
|---------------------------------------------------|---------------------|--------------------------------------------|---------------------------------------------------|---------------------|-----------------------------------------------------------------------------|
| <small>PAST NOW</small>                           | <small>DATE</small> |                                            | <small>PAST NOW</small>                           | <small>DATE</small> |                                                                             |
| <input type="checkbox"/> <input type="checkbox"/> | _____               | Chronic Fatigue Syndrome                   | <input type="checkbox"/> <input type="checkbox"/> | _____               | Environmental allergies                                                     |
| <input type="checkbox"/> <input type="checkbox"/> | _____               | Rheumatoid Arthritis                       | <input type="checkbox"/> <input type="checkbox"/> | _____               | Multiple chemical sensitivities                                             |
| <input type="checkbox"/> <input type="checkbox"/> | _____               | Lupus SLE                                  | <input type="checkbox"/> <input type="checkbox"/> | _____               | Latex allergy                                                               |
| <input type="checkbox"/> <input type="checkbox"/> | _____               | Raynaud's                                  | <input type="checkbox"/> <input type="checkbox"/> | _____               | Hepatitis                                                                   |
| <input type="checkbox"/> <input type="checkbox"/> | _____               | Psoriasis                                  | <input type="checkbox"/> <input type="checkbox"/> | _____               | Lyme (and co-infections)                                                    |
| <input type="checkbox"/> <input type="checkbox"/> | _____               | Mixed Connective Tissue Disease (MCTD)     | <input type="checkbox"/> <input type="checkbox"/> | _____               | Chronic Infections (Epstein-Barr, Cytomegalovirus, Herpes, HPV, STIs, etc.) |
| <input type="checkbox"/> <input type="checkbox"/> | _____               | Poor immune function (frequent infections) |                                                   |                     |                                                                             |
| <input type="checkbox"/> <input type="checkbox"/> | _____               | Food allergies                             | <input type="checkbox"/> <input type="checkbox"/> | _____               | Other                                                                       |

Please briefly describe your symptoms, chosen treatment(s) and dates:

## Respiratory Conditions

PAST	NOW	DATE		PAST	NOW	DATE	
<input type="checkbox"/>	<input type="checkbox"/>	_____	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Sleep Apnea
<input type="checkbox"/>	<input type="checkbox"/>	_____	Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Frequent or recurrent Colds/Flus
<input type="checkbox"/>	<input type="checkbox"/>	_____	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other
<input type="checkbox"/>	<input type="checkbox"/>	_____	Emphysema				
<input type="checkbox"/>	<input type="checkbox"/>	_____	Pneumonia				

Please briefly describe your symptoms, chosen treatment(s) and dates:

## Skin Conditions

PAST	NOW	DATE		PAST	NOW	DATE	
<input type="checkbox"/>	<input type="checkbox"/>	_____	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	_____	Acne
<input type="checkbox"/>	<input type="checkbox"/>	_____	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Skin Cancer (Melanoma)
<input type="checkbox"/>	<input type="checkbox"/>	_____	Dermatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Skin Cancer (Squamous, Basal)
<input type="checkbox"/>	<input type="checkbox"/>	_____	Hives	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other
<input type="checkbox"/>	<input type="checkbox"/>	_____	Rash, undiagnosed				

Please briefly describe your symptoms, chosen treatment(s) and dates:

## Neurologic/Mood

PAST	NOW	DATE		PAST	NOW	DATE	
<input type="checkbox"/>	<input type="checkbox"/>	_____	Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____	Autism
<input type="checkbox"/>	<input type="checkbox"/>	_____	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mild Cognitive Impairment
<input type="checkbox"/>	<input type="checkbox"/>	_____	Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Memory problems
<input type="checkbox"/>	<input type="checkbox"/>	_____	Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Parkinson's Disease
<input type="checkbox"/>	<input type="checkbox"/>	_____	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____	Multiple Sclerosis
<input type="checkbox"/>	<input type="checkbox"/>	_____	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____	ALS
<input type="checkbox"/>	<input type="checkbox"/>	_____	ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizures

- \_\_\_\_\_ Concussion/Traumatic Brain Injury        \_\_\_\_\_ Alzheimer's  
  \_\_\_\_\_ Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

### Miscellaneous

- |                          |                          |                     |                |                          |                          |                     |                                                      |
|--------------------------|--------------------------|---------------------|----------------|--------------------------|--------------------------|---------------------|------------------------------------------------------|
| <small>PAST</small>      | <small>NOW</small>       | <small>DATE</small> |                | <small>PAST</small>      | <small>NOW</small>       | <small>DATE</small> |                                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | _____               | Anemia         | <input type="checkbox"/> | <input type="checkbox"/> | _____               | Mumps                                                |
| <input type="checkbox"/> | <input type="checkbox"/> | _____               | Chicken Pox    | <input type="checkbox"/> | <input type="checkbox"/> | _____               | Whooping Cough                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | _____               | German Measles | <input type="checkbox"/> | <input type="checkbox"/> | _____               | Tuberculosis                                         |
| <input type="checkbox"/> | <input type="checkbox"/> | _____               | Measles        | <input type="checkbox"/> | <input type="checkbox"/> | _____               | Known genetic variants<br>(SNPs, polymorphisms, etc) |
| <input type="checkbox"/> | <input type="checkbox"/> | _____               | Mononucleosis  | <input type="checkbox"/> | <input type="checkbox"/> | _____               | Other                                                |

Please briefly describe your symptoms, chosen treatment(s) and dates:

2. Please check frequency of the following:

- |                                                         |                              |                             |                                    |
|---------------------------------------------------------|------------------------------|-----------------------------|------------------------------------|
| Short term memory impairment                            | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> sometimes |
| Shortened focus of attention and ability to concentrate | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> sometimes |
| Coordination and balance problems                       | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> sometimes |
| Problems with lack of inhibition                        | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> sometimes |
| Poor organization abilities                             | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> sometimes |
| Problems with time management (late or forget appts)    | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> sometimes |
| Mood instability                                        | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> sometimes |
| Difficulty understanding speech and word finding        | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> sometimes |
| Brain fog, brain fatigue                                | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> sometimes |
| Lower effectiveness at work, home or school             | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> sometimes |
| Judgment problems like leaving the stove on, etc        | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> sometimes |

## Stressful Life Events

*Studies show that past and continued traumas play a significant role in health and health outcomes. Our understanding of your history helps us to best support you throughout this process and moving forward.*

3. Have you experienced one or more of these stressful life events or traumas in your life?

Death of a family member, romantic partner or very close friend  
because of accident, homicide, or suicide  yes  no

Sexual or physical abuse by a family member, romantic partner,  
stranger, or someone else  yes  no

Emotional neglect or abuse such as ridicule, bullying, put downs,  
being ignored or told you were no good by a family member or  
romantic partner  yes  no

Discrimination  yes  no

Life-threatening accident or situation (military combat or  
lived in a war zone)  yes  no

Life-threatening illness  yes  no

Physical force or weapon threatened or used against you in a  
robbery or mugging  yes  no

Witness the murder, serious injury or assault of another person  yes  no

4. Is there anything else that you'd like to share about these stressful life events or traumas?



11. How much time have you had to take off from work or school for health related reasons in the last year? (add details if you can)

0 to 2 days

3 to 14 days

more than 15 days

12. How often did you take antibiotics in infancy/childhood?

13. How often have you taken antibiotics as a teen?

14. How often have you taken antibiotics as an adult?

15. List any medicine you are currently taking:

16. List all vitamins, minerals, herbs and nutritional supplements you are now taking:

## Nutritional Status

17. Which of the following foods do you consume regularly?

- |                                        |                                                      |                                                       |
|----------------------------------------|------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> soda          | <input type="checkbox"/> alcohol                     | <input type="checkbox"/> dairy (milk, cheese, yogurt) |
| <input type="checkbox"/> diet soda     | <input type="checkbox"/> gluten (wheat, rye, barley) | <input type="checkbox"/> coffee                       |
| <input type="checkbox"/> refined sugar | <input type="checkbox"/> fast food                   |                                                       |

18. Are you currently on a special diet?

- |                                                         |                                             |                                                  |
|---------------------------------------------------------|---------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> autoimmune paleo (AIP)         | <input type="checkbox"/> vegan              | <input type="checkbox"/> gluten-free             |
| <input type="checkbox"/> SCD/GAPS                       | <input type="checkbox"/> paleo              | <input type="checkbox"/> ketogenic diet          |
| <input type="checkbox"/> dairy restricted or dairy-free | <input type="checkbox"/> blood type         | <input type="checkbox"/> intermittent fasting    |
| <input type="checkbox"/> vegetarian                     | <input type="checkbox"/> raw                | <input type="checkbox"/> Other (please describe) |
|                                                         | <input type="checkbox"/> refined sugar-free |                                                  |

19. What percentage of your meals are home-cooked?

- |                             |                             |                             |                             |                              |
|-----------------------------|-----------------------------|-----------------------------|-----------------------------|------------------------------|
| <input type="checkbox"/> 10 | <input type="checkbox"/> 30 | <input type="checkbox"/> 50 | <input type="checkbox"/> 70 | <input type="checkbox"/> 90  |
| <input type="checkbox"/> 20 | <input type="checkbox"/> 40 | <input type="checkbox"/> 60 | <input type="checkbox"/> 80 | <input type="checkbox"/> 100 |

20. Are there any foods that you avoid because of the way they make you feel?

If yes, please name the food and the symptom:

21. Do you have symptoms immediately after eating like bloating, gas, sneezing or hives?

Do you have any known food allergies or sensitivities? If so, please explain:

22. Are you aware of any delayed symptoms after eating certain foods such as fatigue, muscle aches, sinus congestion, etc? If so, please explain:

23. Are there foods that you crave? If so, please explain:

24. Describe your diet at the onset of your health concerns:

25. Do you have any known food allergies or sensitivities?

26. Is there anything else we should know about your current diet, history or relationship to food?

## Intestinal Status

27. Bowel movement frequency

- 1-3 times per day
- more than 3 times per day
- not regularly every day

28. Bowel movement consistency

- soft & well formed
- diarrhea
- loose but not watery
- often float
- thin, long or narrow
- alternating between hard and loose
- difficult to pass
- small and hard

29. Bowel movement color

- medium brown
- blood is visible
- chalky colored
- very dark or black
- variable
- greasy, shiny
- greenish
- yellow, light brown

30. Do you experience intestinal gas? If so, please explain if it is excessive, occasional, odorous, etc:

31. Have you ever had food poisoning? If yes, please describe in detail, including 1) Where were you  
2) What did you treat it with and 3) If you feel like you fully recovered from it:

## Potential Health Hazards

32. To your knowledge, have you been exposed to any chemicals or toxic metals (lead, mercury, arsenic, aluminum)?

33. Do odors affect you?

34. Are you or have you been exposed to second-hand smoke?

35. Are you currently or have you been exposed to mold? (If so, what is/was the source of the exposure and for how long have you been/were you exposed to mold, if known?)

36. Have you used or abused alcohol, drugs, meds, tobacco or caffeine? Do you still?

## Oral Health History

37. How long since you last visited the dentist? What was the reason for that visit?

38. In the past 12 months has a dentist or hygienist talked to you about your oral health, blood sugar or other health concerns? (Explain.)

39. What is your current oral and dental regimen? (Please note whether this regimen is once or twice daily or occasionally and what kind of toothpaste you use.)

40. Do you have any mercury amalgams? (If no, were they removed? If so, how?)

41. Have you had any root canals? (If yes, how many and when?)

42. Do you have any concerns about your oral or dental health? (gums bleed after flossing, receding gums)

43. Is there anything else about your current oral or dental health or health history that you'd like us to know?

## Sleep History

44. Are you satisfied with your sleep?

45. Do you stay awake all day without dozing?

46. Are you asleep (or trying to sleep) between 2:00 a.m. and 4:00 a.m.?

47. Do you fall asleep in less than 30 minutes?

48. Do you sleep between 6 and 8 hours per night?

49. Is there anything else you would like us to know about your sleep?

## Reproductive Hormone History

*If you do not have female reproductive organs please skip to question 57.*

50. How old were you when you first got your period?

51. How are/were your menses? Do/did you have PMS? Painful periods? If so, explain.

52. In the second half of your cycle do you experience any symptoms of breast tenderness, water retention or irritability?

53. Have you experienced any yeast infections or urinary tract infections? Are they regular?

54. Have you/do you still take birth control pills: If so, please list length of time and type.

55. Have you had any problems with conception or pregnancy?

56. Are you taking any hormone replacement therapy or hormonal supportive herbs? If so, please list again here.

### Mental Health Status

57. How are your moods in general? Do you experience more anxiety, depression or anger than you would like?

58. On a scale of 1-10, one being the worst and 10 being the best, describe your usual level of energy.

59. At what point in your life did you feel best? Why?

## Other

60. Do you think family and friends will be supportive of you making health and lifestyle changes to improve your quality of life? Explain, if no.

61. Who in your family or on your health care team will be most supportive of you making dietary change?

62. What role does spirituality play in your life?

63. Please describe any other information you think would be useful in helping to address your health concern(s):