

# METHODIST CENTER FOR INTEGRATIVE MEDICINE

JILL C. CARNAHAN, MD, ABFM, ABHM

9010 North Allen Road

Peoria, IL 61615

Phone: 309-495-8540

Fax: 309-495-8541

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## INTEGRATIVE MEDICAL HISTORY QUESTIONNAIRE

### PART I: PATIENT DEMOGRAPHICS

Date: \_\_\_\_\_ Marital Status: [ ] M [ ] S [ ] W [ ] D [ ] Other  
Patient Name: \_\_\_\_\_ EMAIL: \_\_\_\_\_  
Address: \_\_\_\_\_ Cell phone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home phone: \_\_\_\_\_  
Age: \_\_\_\_\_ Occupation: \_\_\_\_\_ SS#: \_\_\_\_\_ Work phone: \_\_\_\_\_  
Sex: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Birthplace: \_\_\_\_\_  
Spouse/Partner Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Age: \_\_\_\_\_ Phone: \_\_\_\_\_  
Referred by: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Accompanied to office by: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Primary Language \_\_\_\_\_ Secondary Language: \_\_\_\_\_

### Reason for Visit:

#### Problem List:

#1 LIST PROBLEMS/DIAGNOSIS:

#2

#3

#4

#5

### PRESENT PHYSICIANS / CONCURRENT MEDICAL CARE

If you are now being treated for illness or medical problems by another physician or physical or mental health practitioner, please describe each problem and write the name of the physician, health practitioner or medical facility treating you.

Date of last physical examination

#1 - Illness or Medical Problem

Physician(s) and Specialty

Medical Facility (name/address)

#2 - Illness or Medical Problem

Physician(s) and Specialty

Medical Facility (name/address)

## PART 2: TIMELINE OF MEDICAL ILLNESS(ES)

Please provide history for each major problem. Begin with the onset of each problem and indicate doctors' visits, doctors' names, diagnoses, procedures, and results, and whether they were effective or ineffective.

### (1) PROBLEM/DIAGNOSIS (*specify*):

When did the problem begin?	What symptoms were present?
Was there pain? <input type="checkbox"/> Yes <input type="checkbox"/> No Where?	How much pain? ( <i>on scale of 1 to 10 – circle please</i> ) 1    2    3    4    5    6    7    8    9    10
Describe the course or progression of this problem.	
Did anything make problem better?	Did anything make it worse?
What tests/procedures were done?	
When were they done?	Where were they done?
Were you hospitalized for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Where?	If yes, when were you hospitalized, and for how long?
What has happened to the problem since treatment until today?	
What medications or supplements are you taking for this condition?	

### (2) PROBLEM/DIAGNOSIS (*specify*):

When did the problem begin?	What symptoms were present?
Was there pain? <input type="checkbox"/> Yes <input type="checkbox"/> No Where?	How much pain? ( <i>on scale of 1 to 10 – circle please</i> ) 1    2    3    4    5    6    7    8    9    10
Describe the course or progression of this problem.	
Did anything make problem better?	Did anything make it worse?
What tests/procedures were done?	
When were they done?	Where were they done?
Were you hospitalized for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Where?	If yes, when were you hospitalized, and for how long?
What has happened to the problem since treatment until today?	
What medications or supplements are you taking for this condition?	

<b>(3) PROBLEM/DIAGNOSIS (specify):</b>	
When did the problem begin?	What symptoms were present?
Was there pain? <input type="checkbox"/> Yes <input type="checkbox"/> No Where?	How much pain? (on scale of 1 to 10 – circle please) 1   2   3   4   5   6   7   8   9   10
Describe the course or progression of this problem.	
Did anything make problem better?	Did anything make it worse?
What tests/procedures were done?	
When were they done?	Where were they done?
Were you hospitalized for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Where?	If yes, when were you hospitalized, and for how long?
What has happened to the problem since treatment until today?	
What medications or supplements are you taking for this condition?	

<b>(4) PROBLEM/DIAGNOSIS (specify):</b>	
When did the problem begin?	What symptoms were present?
Was there pain? <input type="checkbox"/> Yes <input type="checkbox"/> No Where?	How much pain? (on scale of 1 to 10 – circle please) 1   2   3   4   5   6   7   8   9   10
Describe the course or progression of this problem.	
Did anything make problem better?	Did anything make it worse?
What tests/procedures were done?	
When were they done?	Where were they done?
Were you hospitalized for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Where?	If yes, when were you hospitalized, and for how long?
What has happened to the problem since treatment until today?	
What medications or supplements are you taking for this condition?	

### PAST MEDICAL HISTORY

Please **circle** any illnesses or medical problems you have now or have had in the past and indicate the year each started. If this has occurred within the last 3 years, add an asterisk (\*).

ILLNESS	YEAR	ILLNESS	YEAR	ILLNESS	YEAR
Measles	_____	Diabetes	_____	HIV /AIDS	_____
Mumps	_____	Heart disease	_____	Food allergies	_____
Diphtheria	_____	Heart attack	_____	Kidney disease	_____
Pertussus	_____	Stroke	_____	Bladder infections	_____
Polio	_____	Thyroid disease	_____	Arthritis	_____
Meningitis	_____	Gallbladder disease	_____	Back pain	_____
Influenza	_____	Inflammatory bowel disease	_____	headaches	_____
Chicken Pox	_____	Hemorrhoids	_____	Anemia	_____
Chlamydia	_____	Jaundice/liver disease	_____	Seizures	_____
Gonorrhea	_____	Depression	_____	Epilepsy	_____
Hepatitis	_____	Anxiety/panic attacks	_____	Fainting/dizziness	_____
Tuberculosis	_____	Insomnia/sleep disorder	_____	Lung disease	_____
Asthma	_____	Swelling/edema	_____	OTHER	_____
Allergies	_____	Arthritis/joint pain	_____		_____
Eczema	_____	Muscle disease	_____		_____
Hives	_____	Cancer (which type?)	_____		_____

### HOSPITALIZATIONS / SURGERIES

List all times (and reasons) you have been hospitalized, operated on, or severely injured.

Date	Hospital admissions, procedures (what & why) for all illnesses, injuries	Doctor & Medical Facility

Have you ever had any surgical procedures that were recommended, but not completed?

No    Yes

If yes, Please explain:

\_\_\_\_\_

### PART 3: RECENT DIAGNOSTIC TESTS

Type of test	Date (s)	Reason	Results	Medical Facility
Xrays				
Mammogram				
EKG				
Echocardiogram				
CT scan				
MRI				
Other:				

## PART 4: PRESENT AND PAST SYMPTOMS

### CURRENT SYMPTOMS

Please mark with an (X) any illnesses or medical problems you have, or have had,  
within the past year.

SYMPTOMS	(X)	DATE STARTED	SYMPTOMS	(X)	DATE STARTED
Frequent or severe headaches			Spots before eyes		
Fainting spells			Frequent eye infections		
Dizziness on change of position			Eye pain		
Unconscious spells			Change in vision		
Blurred vision			Eyeglasses needed		
Earaches			Recurrent head colds		
Discharge from ears			Sinus trouble		
Ringing in ears			Hay fever/allergies		
Decrease in hearing			Persistent body odor		
Recurrent nose bleeds			Recurrent sore throats		
Strange taste or loss in taste			Recurrent mouth sores		
Persistent hoarseness			Soreness/bleeding gums		
Difficulty swallowing			Dentures?		
Swollen lymph nodes			Pain in arms or legs		
Chest pain			Restless legs		
Chest pain			Palpitations/fluttering of heart		
Coughing up blood			High blood pressure		
Frequent cough			Swelling of hands, feet or ankles		
Frequent sinus infections			Leg cramps while walking or reclining?		
Wake up nights, short of breath			At what time of day?		
How many bed pillows at night?			Varicose veins		
Shortness of breath when:			Nausea or vomiting		
- Walking several blocks			Vomiting blood		
- Ascending flight of stairs			Avoiding any foods? (list)		
- Lying down or reclining			What kinds?		
Cold or discolored lips/fingers			Avoiding spices? (list)		
Recurrent stomach pain			Rectal pain with bowel movement		
Belching or heartburn			Blood in bowel movement		
Appetite: Good, Fair, or Poor			Full bladder feeling but little urination		
Abdominal cramping/pain			Urinate less than usual		
Change in bowel movement?			Lose urine on coughing, sneezing or laughing		
Color of bowel movement (describe)			Discharge from penis/vagina		
Blood in stool?			Blood in urine?		
Pain on urinating			Tingling or weakness of hands or feet		
Getting up at night to urinate			Redness or heat in joints		
How many times?			Muscle spasms		
Urinating frequently			Dry skin		
Difficulty starting urination			Easy bruising		
Recurrent backaches or pain			Inability to tolerate heat		
Joint pain			Inability to tolerate cold		
Swelling of any joints			Change in hair texture/hair loss		
Loss or change in sensation of hands or feet			Change in skin texture		
Tremor/shaking of extremities			Skin rashes		
Swollen neck or throat			Difficulty concentrating		
Hot flashes/night sweats			Poor memory		
Fatigue without obvious reason			Depressed mood		
Brittleness of nails			Anxiety		



<b>IMMUNIZATIONS / VACCINATIONS</b>							
	<b>Check [X] any you received</b>	<b>X</b>	<b>When?</b>	<b>Boosters</b>	<b>X</b>	<b>When?</b>	<b>Describe any adverse reactions</b>
	Smallpox			Within past 7 years?			
	DPT						
	Diphtheria						
	<b>Check [X] any you received</b>	<b>X</b>	<b>When?</b>	<b>Boosters</b>	<b>X</b>	<b>When?</b>	<b>Describe any adverse reactions</b>
	Pertussis						
	Tetanus			Tetanus booster?			
	Measles						
	Mumps						
	Rubella						
	Polio			Within past 2 years?			
	Hepatitis						
	Influenza (flu)			Your last Flu shot?			
	Pneumovax						
	Other (specify)						
Have you been out of the country in the last 2 years? [ ]No [ ]Yes When: _____ Where: _____							
Tuberculin (TB) skin test? When: _____ Positive[ ] Negative[ ]							
<b>ALLERGIES, SENSITIVITIES &amp; INTOLERANCES</b>							
<b>List anything that you are allergic to such as specific foods, medications, dust, chemicals, etc., and indicate how each affects you (e.g., congestion, headache, hives, difficulty breathing, dizzy, etc.)</b>							
	<i>Allergic, Sensitive, Intolerant to:</i>			<i>Effect:</i>			
	Do you live with a pet? No[ ] Yes[ ] Any reactions? No[ ] Yes[ ]						
	What kind of pet(s)? _____ How many? _____ How long? _____						
	To consider environmental/chemical exposures, list relevant jobs you have held.						
<b>WEIGHT HISTORY</b>							
Your present weight?				Your weight 1 year ago?		Your weight 5 years ago?	
Your MAXIMUM adult weight?				When?		What do you consider ideal weight?	
Your MINIMUM adult weight?				When?			
Any circumstances surrounding extremes of weight?							

### VISION AND DENTAL HISTORY

VISION / EYESIGHT		DENTAL	
Date of last eye examination		Date of last dental examination	
Date of last new eyeglasses or contacts		Date of last dental x-rays	
Do you require eyeglasses?	[ ]yes [ ]no	Do you have silver fillings?	[ ]yes [ ]no
How many years?                      How old were you?		How old were you?	
Are you [ ]nearsighted [ ]Farsighted		Do you have dental implants?	[ ]yes [ ]no
Other (explain)		How old were you?	
Do you have cataracts?	[ ]yes [ ]no	Do you have dentures?	[ ]yes [ ]no
How old were you?		How many years?	
Do you wear contact lenses?	[ ]yes [ ]no		
Soft lens[ ]      Hard lens[ ]			

### FAMILY HEALTH HISTORY

		Relationship				Relationship	
Heart condition				Cancer			
Heart attack				Epilepsy			
High blood pressure				Seizure disorder			
Stroke				Nervous breakdown			
Bleeding disorder				Mental disorder			
Tuberculosis				Alcoholism/Drug Addiction			
Diabetes				Suicide/Attempted Suicide			
Immediate Family	Age	Present health	Deceased ?	Age at death	Year of death	Cause of death	
Father							
Mother							
Brother[ ]    Sister[ ]							
Brother[ ]    Sister[ ]							
Brother[ ]    Sister[ ]							
Brother[ ]    Sister[ ]							
Brother[ ]    Sister[ ]							
Brother[ ]    Sister[ ]							
Brother[ ]    Sister[ ]							
Brother[ ]    Sister[ ]							
Husband/Wife							
Children, and their Names	Age	Present health	Deceased ?	Age at death	Year of death	Cause of death	
1							
2							
3							
4							
5							
6							

## PART 5: FOR WOMEN ONLY

### Menstrual History

Age and year periods began (onset of menarche) \_\_\_\_\_

Date of LMP (last menstrual period) \_\_\_\_\_

How many days from start of one period to start of next? \_\_\_\_\_

How many days does your period last? \_\_\_\_\_

Is your cycle regular?  yes  no

Do you pass any clots? \_\_\_\_\_

Is the flow heavy \_\_\_\_\_, medium \_\_\_\_\_, or light \_\_\_\_\_?

How many pads \_\_\_\_\_, tampons \_\_\_\_\_ used on heavy days?

Do you have cramps BEFORE period?  yes  no

DURING period?  yes  no

Any change in breast size?  yes  no

Do you examine your breasts?  yes  no

Do you experience tender breasts?  yes  no If so, when? \_\_\_\_\_

Nipple discharge?  yes  no If so, what color? \_\_\_\_\_

Date of last mammogram and findings \_\_\_\_\_

Age and year of menopause \_\_\_\_\_

Do you have hot flashes?  yes  no

Ever taken estrogen or hormone replacements (HRT)?  yes  no

Age and year at time of estrogen/HRT \_\_\_\_\_

Date of last pelvic/gynecological exam and result of exam \_\_\_\_\_

Date of last pap test and result of test \_\_\_\_\_

Do you experience itching or burning of vaginal area?  yes  no

Do you experience discharge from vagina?  yes  no

If so, Amount: \_\_\_\_\_ Color: \_\_\_\_\_ When began? \_\_\_\_\_

### Birth Control Methods

Have you used Pills?  yes  no

Have you used an IUD?  yes  no

If so, what type? \_\_\_\_\_

Describe any problems with pills or IUD \_\_\_\_\_

### Pregnancies

Have you ever been pregnant?  yes  no

How old were you during pregnancies? \_\_\_\_\_

Describe any complications with pregnancies/deliveries: \_\_\_\_\_

Did you breastfeed?  yes  no If so, how long? \_\_\_\_\_

Number of miscarriages		Any medical complications?
Number of stillbirths		Reason give
Number of premature births		Reason given:
Number of Cesarean sections		Reason given:
Number of abortions?		Reason:

## PART 6: PERSONAL HYGIENE & LIFE STYLE

How often do you brush your teeth?		Do you use enemas?	<input type="checkbox"/> ]yes <input type="checkbox"/> ]no
How many minutes each time?		What kind and for what purpose?	
Do you use fluoridated toothpaste?	<input type="checkbox"/> ]yes <input type="checkbox"/> ]no	Do you use vaginal douches?	<input type="checkbox"/> ]yes <input type="checkbox"/> ]no
What type of dental floss do you use? waxed <input type="checkbox"/> unwaxed <input type="checkbox"/> none <input type="checkbox"/>		What kind and for what purpose?	
How often do you use dental floss?		Do you take saunas or steam baths?	<input type="checkbox"/> ]yes <input type="checkbox"/> ]no
Do you use antiseptic mouthwash?	<input type="checkbox"/> ]yes <input type="checkbox"/> ]no	Are you right-handed?	<input type="checkbox"/> ]yes <input type="checkbox"/> ]no
Do you use deodorants?	<input type="checkbox"/> ]yes <input type="checkbox"/> ]no	Left-handed?	<input type="checkbox"/> ]yes <input type="checkbox"/> ]no
Do you use antiperspirant	<input type="checkbox"/> ]yes <input type="checkbox"/> ]no	Ambidextrous?	<input type="checkbox"/> ]yes <input type="checkbox"/> ]no

### SMOKING / ALCOHOL / DRUG HISTORY

SMOKING		ALCOHOL	
Do you smoke?	<input type="checkbox"/> ]yes <input type="checkbox"/> ]no	How many drinks do you normally have?	
How many years?		Beer	_____ per day / week / month
Have you ever smoked?	<input type="checkbox"/> ]yes <input type="checkbox"/> ]no	Wine	_____ per day / week / month
How many years?		Hard liquor	_____ per day / week / month
Stopped when?		Have you ever had a problem with alcohol?	<input type="checkbox"/> ]yes <input type="checkbox"/> ]no
Cigarettes, packs/day		Where were you treated?	<input type="checkbox"/> ]yes <input type="checkbox"/> ]no
How many Cigars/day?			
How many Pipes/day?		DRUG USE	
Co-workers smoke?	<input type="checkbox"/> ]yes <input type="checkbox"/> ]no	Have you ever used drugs?	<input type="checkbox"/> ]yes <input type="checkbox"/> ]no
How many years?		Have you ever smoked marijuana?	<input type="checkbox"/> ]yes <input type="checkbox"/> ]no
How many hours/day?		Have you ever used "hard" drugs?	<input type="checkbox"/> ]yes <input type="checkbox"/> ]no
Anyone smoke at home?	<input type="checkbox"/> ]yes <input type="checkbox"/> ]no	Which drugs?	
How many hours/day?		How many years?	
Do you drink alcohol?	<input type="checkbox"/> ]yes <input type="checkbox"/> ]no	Were you ever treated for drug use?	<input type="checkbox"/> ]yes <input type="checkbox"/> ]no
How many years?		Where were you treated?	

### EXERCISE HISTORY

Are you now more or less capable physically than you were at age 17-18?  ]More  ]Same  ]Less  
 Do you have time for exercise?  ]No  ]Yes      Could you make time for exercise?  ]No  ]Yes

**Put a check mark alongside activities in which you do or did engage.**

Activity		Activity	
Jog	<input type="checkbox"/> ]Now <input type="checkbox"/> ]Past <input type="checkbox"/> ]Daily <input type="checkbox"/> ]Weekly <input type="checkbox"/> ]Monthly	Isometrics	<input type="checkbox"/> ]Now <input type="checkbox"/> ]Past <input type="checkbox"/> ]Daily <input type="checkbox"/> ]Weekly <input type="checkbox"/> ]Monthly
Run	<input type="checkbox"/> ]Now <input type="checkbox"/> ]Past <input type="checkbox"/> ]Daily <input type="checkbox"/> ]Weekly <input type="checkbox"/> ]Monthly	Bicycling	<input type="checkbox"/> ]Now <input type="checkbox"/> ]Past <input type="checkbox"/> ]Daily <input type="checkbox"/> ]Weekly <input type="checkbox"/> ]Monthly
Swim	<input type="checkbox"/> ]Now <input type="checkbox"/> ]Past <input type="checkbox"/> ]Daily <input type="checkbox"/> ]Weekly <input type="checkbox"/> ]Monthly	Garden	<input type="checkbox"/> ]Now <input type="checkbox"/> ]Past <input type="checkbox"/> ]Daily <input type="checkbox"/> ]Weekly <input type="checkbox"/> ]Monthly
Lift Weights	<input type="checkbox"/> ]Now <input type="checkbox"/> ]Past <input type="checkbox"/> ]Daily <input type="checkbox"/> ]Weekly <input type="checkbox"/> ]Monthly	Breath Exercises	<input type="checkbox"/> ]Now <input type="checkbox"/> ]Past <input type="checkbox"/> ]Daily <input type="checkbox"/> ]Weekly <input type="checkbox"/> ]Monthly
Walk	<input type="checkbox"/> ]Now <input type="checkbox"/> ]Past <input type="checkbox"/> ]Daily <input type="checkbox"/> ]Weekly <input type="checkbox"/> ]Monthly	Martial Arts	<input type="checkbox"/> ]Now <input type="checkbox"/> ]Past <input type="checkbox"/> ]Daily <input type="checkbox"/> ]Weekly <input type="checkbox"/> ]Monthly
Dance	<input type="checkbox"/> ]Now <input type="checkbox"/> ]Past <input type="checkbox"/> ]Daily <input type="checkbox"/> ]Weekly <input type="checkbox"/> ]Monthly	OTHER (specify)	

**ENVIRONMENT**

Check any of the following that create stress for you at work or home

<input type="checkbox"/> Chemicals	<input type="checkbox"/> Spring	<input type="checkbox"/> Summer
<input type="checkbox"/> Pollution	<input type="checkbox"/> Fall	
<input type="checkbox"/> Exhaust	<input type="checkbox"/> Winter	
<input type="checkbox"/> Poor Air Ventilation	<input type="checkbox"/> Cold	
<input type="checkbox"/> Lighting	<input type="checkbox"/> Heat	
<input type="checkbox"/> Lack of Sunshine	<input type="checkbox"/> Noise	
<input type="checkbox"/> Lunar Cycles	<input type="checkbox"/> Deadlines	
<input type="checkbox"/> High Humidity	<input type="checkbox"/> Pressure to perform	
<input type="checkbox"/> Dampness	<input type="checkbox"/> Relationship with Co-workers	
<input type="checkbox"/> Season Change	<input type="checkbox"/> Relationship with household members	
Do you adapt well to change? <input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> Other (specify):	

**SLEEP PATTERN**

How many sleep hours do you need?
Describe how you fall asleep:
Do you have trouble falling asleep? <input type="checkbox"/> yes <input type="checkbox"/> no
If you awaken during the night, how often?
When you awaken at night, do you have trouble falling back to sleep? <input type="checkbox"/> yes <input type="checkbox"/> no
Are your sleep habits routine? <input type="checkbox"/> yes <input type="checkbox"/> no
Do you have trouble waking up in the morning? <input type="checkbox"/> yes <input type="checkbox"/> no
What time of day are you most awake and alert? From _____ To _____

**DAILY ACTIVITIES**

Describe how your "typical" day usually unfolds from morning to night with approximate times.

(A.M.) Morning:
(P.M.) Afternoon:
Evening (5:00 - 7:00):
(P.M.) Night:
Weekend:

**FOR MEN AND WOMEN  
- SEXUAL PATTERNS -**

What is your attitude towards sex?
Do you have any questions or concerns about sex?
Is your present sex life satisfactory? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any pain or discomfort with sexual intercourse? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:
How many partners have you had in the past ten years?
What is the frequency of your present sexual activity?
Do you practice birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe what type:
Do you have any questions about birth control?
If you have used any form of birth control, please indicate how long. IUD: _____ Diaphragm: _____ Foam: _____ Condoms: _____ Pill: _____ Other: _____
Do you find your present method satisfactory for your experience of sex? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you find your present method satisfactory for your health? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any problems with or questions about venereal disease? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had a sexually transmitted disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:

## PART 7: STRESS & SATISFACTION

<b>STRESS RATING SCALE</b>							
Check (X) stresses you have or have had. If experienced within the last 3 years, add a check mark (√).							
SCORE	X	√	LIFE EVENT / SITUATION	SCORE	X	√	LIFE EVENT / SITUATION
100			Death of spouse	29			Trouble with in-laws
75			Divorce	28			Outstanding personal achievement
65			Separation from spouse or relationship	26			Began new work or stopped working
65			Incarceration	26			Began or ended school
65			Death of close family member	25			Change in living conditions
55			Personal injury or illness	24			Revision of personal habits
50			Marriage	23			Trouble with boss
47			Fired from job	20			Change in work hours or conditions
45			Marital or similar reconciliation	20			Change in residence
44			Retirement	20			Change in schools
44			Change in health of family member	19			Change in recreation
40			Pregnancy	19			Change in religious activities
39			Sex difficulties	18			Change in social activities
39			Addition to family	17			Mortgage/loan less than \$10,000
39			Business readjustment	16			Change in sleeping habits
38			Change in financial state	15			Change in eating habits
37			Death of close friend	15			Change in family get-togethers
36			Change to different line of work	13			Stressful experience of holidays
35			Change in argument style with spouse				Abortion (Yourself, if female) (Your spouse or girlfriend, if male)
31			Mortgage over \$10,000				
30			Foreclosure of mortgage or loan				
29			Change in responsibilities at work				
29			Son or daughter leaving home				
			Other, specify (assign your own number)				Other, specify (assign your own number)

<b>PERSONAL STRESS CONCERNS</b>	
	Is there anything about your present behavior that you would like to change? If so, what?
	Are there situations in your life currently causing problems, or ones you would like to change?
	Do you use stress reduction techniques [ ] YES [ ] NO If so, describe:
	What do you do for enjoyment or relaxation?
<b>STRESS RESPONSE</b>	
	How are you handling your feelings about illness and treatment?
	<b>Number from 1 (your most probable response) to 6 (your least probable response).</b>
	Keep your feelings to yourself.
	Maintain a calm appearance to those around you.
	You would discuss your feelings openly and constructively.
	Question the validity of what you were told.
	You would become depressed and experience feelings of hopelessness.
	Get angry and upset.

<b>EMPLOYMENT &amp; EDUCATION</b>		
Do you enjoy your work and daily activities?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel a personal responsibility for your work?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you in the right work, fulfilled by your place in life?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does your work provide you with the necessities of life?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you get self-satisfaction out of your work?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If no, what motivates you to work?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you made significant occupational changes in the last 10 years? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, describe them briefly:		
Please indicate the highest level of education completed: _____		
<b>PRIORITIES</b>		
Number the following with <b>1</b> as the most important to you, ending with <b>8</b> as the least important. Then indicate how satisfied you are with each of these aspects of your life. <i>Scale from (0) very dissatisfied to (3) very satisfied.</i>		
Order of Importance	Scale 1-3	
		Vitality and performance
		Associations / relationships (family, friends)
		Appearance
		Longevity
		Libido (sexual drive)
		Solace (freedom from pain)
		Security / Safety (physical and emotional)
		Recognition / Acknowledgment for your work
<b>PART 8: LIFE PATTERN &amp; PERSONAL PERSPECTIVE</b>		
<b>Section I: Life Events &amp; Life Context</b>		
<b>FAMILY LIFE:</b>		
Give an impression of the atmosphere of the home in which you grew up. Include: compatibility between parents, between parents and children, attitudes toward education, type of discipline, etc.:		
<b><u>Briefly describe any major life events or crises during:</u></b>		
Childhood:		
Adolescence:		
Early childhood:		
Recent years:		

**RELATIONSHIPS – A**

Who are the most important people in your life?

Name	Relationship

**RELATIONSHIPS – B**

Describe your marriage(s) or long term relationships:

Describe your divorce(s) or separations:

Describe your present relationship:

**RELATIONSHIPS – C**

How many children are in the family in which you were raised?

Where do you fit in the birth order? You were # \_\_\_\_\_ child out of \_\_\_\_\_ children

Mark the box next to the words that describe your childhood (and add others that might apply)  
 happy  good  fair  unhappy  terribly depressing  verbally abusive  physically abusive  other \_\_\_\_\_

**RELATIONSHIPS – D**

Describe the quality of your relationships with people in general (include co-workers):

Describe the quality of your relationships with your family and in-laws:

**RELATIONSHIPS – E**

Indicate by number(s) which of the following words or phrases best describe these people:

<b>Father</b>	1 - Warm and affectionate	7 - Fearful and anxious, distrustful
	2 - Trusting	8 - Irate and angry
<b>Mother</b>	3 - Perfectionist and driven	9 - Self-reliant
	4 - Selfish	10 - Hungry for approval and recognition
<b>Other (guardian)</b>	5 - Selfless and always doing for others	11 - Needing to be with people
	6 - Insecure	12 - Uncomfortable with intimacy
		13 - Very concerned about personal health and well-being
<b>YOU</b>		

<b>Section III: Health Beliefs</b>
What are your expectations from this visit?
Would you like to discuss the religious or spiritual implications of your healthcare?
Do your religious or spiritual beliefs impact your treatment decisions? [ ]Yes [ ]No
In what ways do you intend to participate in increasing your healthcare?
What do you believe is your role in treating your illness?

## PART 9: DIETARY PATTERNS

<b>EATING HABITS - Section 1</b>									
Where were you born?	Country	State/Province	City						
What was the general geographic climate?									
		NO	YES		NO	YES		NO	YES
<b>Infant/ Childhood Diet</b>	Breast fed			American			Vegetarian		
	Bottle fed			Macrobiotic			Other (explain):		
Explain, if you indicated Other:									
					NO	YES		NO	YES
<b>Adult Diet</b>				American			Vegetarian		
				Macrobiotic			Other (explain):		
Explain, if you indicated Other:									
					NO	YES		NO	YES
<b>Present Diet</b>				American			Vegetarian		
				Macrobiotic			Other (explain):		
Explain, if you indicated Other:									
Was your childhood diet similar to your present one?								NO	YES
How many meals do you now eat per day?									
Describe your dining atmosphere:									
What % of your meals are eaten at home?				What % are eaten out?					
What % of the food you eat is raw?				What % is cooked?					
What energy source do you use for cooking? Gas[ ] Electric[ ] Microwave[ ]									
Describe your present appetite:									
What foods or mixtures do you avoid and why do you avoid them?									
What are your favorite flavors? Sweet[ ] Salty[ ] Sour[ ] Bitter[ ] Pungent[ ] Spicy[ ]									
<b>When you have intense food cravings, which foods (or types of foods) do you usually crave?</b>									
Most intense craving									
Sometimes crave									
Least intense craving									
<b>What did you eat and drink yesterday?</b>									
<b>Breakfast</b>	<b>Lunch</b>	<b>Dinner</b>	<b>Snacks</b>	<b>Beverages</b>					

### EATING HABITS – Section 2

		USUALLY	RARELY
1	Do you experience hunger?		
2	Do you eat at a slow to moderate speed?		
3	Do you chew your food well?		
4	Do you stop eating before you feel really full?		
5	Do you enjoy the taste of food?		
6	Do you take responsibility for your physical, mental, and emotional well-being?		
7	Do you feel somewhat guilty if you overeat?		
8	Are you knowledgeable about the nutritional value of food and calorie levels?		
9	Do you take time to rest or meditate before sitting down to eat?		
10	Is it difficult for you to avoid eating when you think about food?		
11	Are you distracted from daily activities by thinking about food?		
12	Do you turn to eating when you become frustrated with work or family?		
13	Do you eat while standing?		
14	Do you eat while reading or watching television?		
15	Do you "space out" on food, eating large quantities of food without realizing it?		

### PRESENT EATING HABITS – Section 3

Enter how much or how often you eat or drink each item listed: per day (Dy), per week (Wk), or per month (Mo):												
	Dy	Wk	Mo		Dy	Wk	Mo		Dy	Wk	Mo	
<b>DAIRY</b>				<b>FRUIT</b>				<b>LIQUIDS, BEVERAGES</b>				
Milk				Fresh				Water:				
Cheese				Frozen				City				
Yogurt				Dried				Well				
Ice Cream				Canned				Spring				
Ice Milk								Distilled				
								Sodas (non-colas)				
								Herbal Tea				
								Decaf Coffee				
<b>EGGS</b>				<b>VEGETABLES</b>				<b>CAFFEINATED BEVERAGES</b>				
				Fresh				Coffee (with caffeine)				
				Raw, or Salad				Tea (regular)				
<b>MEAT</b>				Frozen				Cola, Diet Cola				
Beef , Burgers				Sprouts				Chocolate				
Lamb				Juices								
Pork/Bacon/Ham				Canned								
Hot Dogs				<b>LEGUMES</b>				<b>CONDIMENTS</b>				
Cold Cuts				Tofu, Tempeh				Salt				
Veal				Beans, Peas				Salt Substitute				
Chicken				Lentils, Others				Salty Foods				
Turkey				Nuts, Seeds				Pickles, Olives				
Fish				Nut Butters				Pepper				
Shellfish				Seed Butters				Spices				
								Herbs				
<b>FATS</b>				<b>GRAINS</b>				<b>ALCOHOL</b>				
Butter				<b>Whole Grains:</b>				Beer				
Margarine				Brown Rice				Wine				
Cream				Pasta, whole gr				Distilled Spirits				
Vegetable Oil				Oatmeal								
Fried Foods				Whole Wheat, Bulgur								
Fat Substitute				Flour, Whole Wheat								
Other				Bread, Whole Grain								

PRESENT EATING HABITS – Section 3 (continued)												
Enter how much or how often you eat or drink each item listed: per day (Dy), per week (Wk), or per month (Mo):												
	Dy	Wk	Mo		Dy	Wk	Mo		Dy	Wk	Mo	
SWEETS			Refined Grains:					SUPPLEMENTS				
Sugar				White Rice				Bran				
Sugar Substitute				White Flour Products				Wheat Germ				
Honey				Breakfast Cereal				Yeast				
Chocolate				Pasta				Lecithin				
Candy				Other				Protein Powder				
Desserts												
Jams, Jellies												
EATING PATTERN PROFILES - Section 4												
<b>X</b>	<b>Indicate with an "X" which of the following describes you.</b>											
<b>A</b>	Almost complete disinterest in food. Eat only when physically hungry and then only to survive. Eat what is put before you with <u>no aesthetic interest</u> . Generally have no problem with being overweight; instead, often underweight.											
<b>B</b>	Similar to A in terms of general disinterest but tend to be picky in terms of "likes" and "dislikes," resistant to change. Possible overweight problems because of unbalanced nature of diet or significant problems of underweight for the same reason.											
<b>C</b>	Moderate interest in food, but food seen chiefly as means of satisfying biological need. Eat <u>moderate quantities</u> with no compulsion to "clean the plate." Rarely eat between meals or binge to excess. Tend to maintain ideal weight and rarely gain or lose.											
<b>D</b>	Substantial interest in food, but with good control. Selective, capable of leaving food on plates, snack intelligently, eclectic in food tastes. Reasonable knowledge of food, some cooking skills, selective eating out. Tendency to gain weight, but able to diet off quickly before significant accumulation occurs. Rarely underweight.											
<b>E</b>	Passionate interest in food, with a degree of control but borderline. Still concerned with quality; experimental with new food. Tend to snack and eat pre-bedtime. Require constant dietary control because weight loss often followed by rapid weight gain.											
<b>F</b>	Compulsive eater with obsessive attention to food. Any food cue produces desire to eat, often unselectively. Recognize difference between "quality" and "junk food," but will eat both. Frequent "hungers" and intense feelings of deprivation. Crave specific foods such as potato chips, pastry, candy, chocolate, ice cream, packaged baked goods. Capable of constant eating, though physiologically satiated. Significant weight gain with feelings of guilt, producing further compulsive eating. Self-loathing in terms of physical appearance.											
<b>G</b>	Generally either bulimic or massively obese with capacity for food bingeing and/or bulimic pattern of binge/induced vomit. Appetite control mechanism inoperative. To date, not able to succeed in weight management regardless of program.											
<b>H</b>	If more than one of the above statements describes you, please explain:											