Summit
natural wellness center

Welcome to Summit Natural Wellness Center

Congratulations on taking this important step toward improving your health. We are dedicated to providing you personalized health care with an emphasis on science-based natural therapies.

If this is your first visit to a Naturopathic doctor, it is important that you understand our health care philosophy and how we differ from conventional medical practices. If you have not done so already, please review the content of our website (www.snwcenter.com) as it discusses in detail everything you need to know about our center, the doctors and other general information regarding your appointment.

Included in this document, please find our comprehensive Health Questionnaire/Intake form, which we ask that you complete in advance of your initial visit. We ask this because much of the information required on the form is readily available to you at home. Completing the form prior to your appointment will ensure that we have all the information necessary to provide you the best care possible.

Also included in this document is our Informed Consent/Financial Policies form. Please carefully review and sign the document prior to your appointment.

If you have questions or concerns regarding either of the aforementioned forms, please contact us.

Along with the forms, please also remember to bring the following items to your initial appointment.

- Recent Lab Results
- Pathology Report
- Current Medications
- Current Supplements

Also, because of allergies and sensitivities that others may have, please do not wear any perfumes, scented lotions, aftershaves, or other scented products to your appointments.

Once again, we appreciate you having entrusted us with your health care needs, and are excited that you are taking this very important step toward achieving your health goals. We are looking forward to seeing you.

Yours In Health,

Dr. Nicholas Parasson
Dr. Julieann Flynn
Dr. Angela Karvounides

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Informed Consent and Financial Policies

This form provides important information regarding Summit Natural Wellness Center's services and financial policies. Please read it carefully and sign at the bottom indicating you read, understand and agree to its content. Please ask questions if you would like clarification or additional information. A copy of this form is available should you request.

Doctors Parasson and Flynn are graduates of Bastyr University located in Seattle, Washington. Dr. Karvounides is a graduate of University of Bridgeport School of Naturopathic Medicine in Bridgeport, Connecticut. All three doctors are trained and licensed as primary care physicians in states other than Ohio. At this time, the state of Ohio does not license Naturopathic physicians and has not adopted any educational or training standards for Naturopaths or Naturopathic physicians. This statement of credentials is for informational purposes only.

Under Ohio law, a Naturopath or Naturopathic physician may not provide a medical diagnosis, prescribe medical treatments or recommend discontinuance of these treatments. Therefore, our services are not to be misconstrued as directly or indirectly dispensing medical advice for the cure or mitigation of any disease or condition. Nor is it an attempt to diagnose or prescribe, being that Nicholas J. Parasson, N.D., Juliann Flynn, N.D., Angela Karvounides, N.D. and staff are not licensed M.D.s, D.O.s, chiropractors, nurses, dietitians, physical therapists or any other type of licensed practitioner in the state of Ohio. If a client desires a diagnosis or service from one of these licensed practitioners, the client may seek or continue such services at any time.

The client understands that our recommendations and services are primarily that of an educator, consultant or "coach" in regard to the utilization of natural methods for building and maintaining health. The client agrees to hold harmless and waive any claim of present or future liability or negligence against Nicholas Parasson, N.D., Julieann Flynn, N.D., Angela Karvounides, N.D., and / or Summit Natural Wellness Center for recommendations, services rendered or products purchased. The client understands that the recommendations and services rendered by Summit Natural Wellness Center may differ from those usually offered by a conventional medical doctor or other health care provider.

The client is aware that Naturopathic health care is not an exact science and acknowledges that no guarantees have been made as to the results of services and accepts no responsibility for their outcomes.

Confidentiality: All information provided on the health questionnaire/intake form or during office visits is confidential. Information will only be released outside of our center with signed request.

Fees and Payment: Fees for office visits, phone consultations, and email correspondence are based on a rate of $120.00 per hour. Summit Natural Wellness Center requires payment in full at time of service for office visits, phone consultations, email correspondence, supplements and/or products sold. Payment methods include cash, checks, and major credit cards.

Cancellation Policy: Summit Natural Wellness Center requires that cancellations for scheduled appointments be received 24 hours in advance during regular office hours (M-F, 9am-5:30pm). We reserve the right to charge for missed or canceled appointments that do not follow this policy.

I fix my signature to certify that I,

_____
(Print Name)

am voluntarily seeking the services of Nicholas J. Parasson, N.D., Juliann Flynn, N.D., Angela Karvounides, N.D., and / or Summit Natural Wellness Center and have read, understand and agree to the above statements and policies.

_____
(Signature)

_____
(Date)

Check here if you want to OPT OUT of our monthly naturopathic newsletter. ☐

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Patient Intake and Health History Questionnaire

Naturopathic health care requires the practitioner to have a **complete** picture of the patient physically, mentally and emotionally. For us to fully evaluate your health, please fill out this intake form and questionnaire to the best of your ability. The more information provided, the better we can serve your needs.

All information provided on this intake form or during office visits is confidential. Information will only be released with your written and signed request. Your time, thoroughness and honesty will greatly aid us in assessing your needs and restoring your health. Consider copying this form for your records.

Personal Profile

Date _____

Name _____

Gender ☐ Male ☐ Female

Date of Birth _____ / _____ / _____ Age _____

Height _____ Current Weight _____ Goal Weight _____

If current weight differs from goal weight, how long has it been since you were at your goal weight? _____

Address _____

City/State _____ Zip Code _____

Phone: Home (_____) _____ Work (_____) _____ Cell (_____) _____

Which phone numbers may we use to leave messages? ☐ Home ☐ Work ☐ Cell ☐ None

E-mail _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partnership

Live with: ☐ Spouse ☐ Partner ☐ Parents ☐ Children ☐ Friends ☐ Pets ☐ Alone

Occupation _____ Hours per week _____

☐ Retired ☐ Student ☐ Stay-home parent ☐ Unemployed

Employer _____

Ethnicity _____

Emergency Contact _____ Phone (_____) _____

Insurance Provider _____

How did you hear about Summit Natural Wellness Center? _____

r061410

Medical Information

Please bring copies of **current** (within past 2 years) medical reports and laboratory tests to your appointment.

Primary Care Provider_____

Date of last medical or health care visit _____ Reason for that visit_____

Type of health care provider seen (MD, DO, chiropractor, ND, etc.)_____

Date of last physical exam _____ Date of last laboratory testing _____

Blood Type (if known) _____

Have you ever contracted an illness while traveling outside the country or shortly upon your return? ☐ Yes ☐ No.

If so, describe. _____

For Males Only

Date of last testicular exam _____ Results_____

Date of last digital rectal exam (prostate exam) _____ Results_____

Date of last prostate specific antigen (PSA) blood test _____ Results _____

Are you sexually active? ☐ Yes ☐ No. Current form of contraception _____

Are there any questions/concerns regarding your sex life or intimacy you wish to discuss? _____

_____

For Females Only

Date of last OB/GYN exam _____

Last PAP _____ Results _____

Have you ever had an abnormal PAP? ☐ Yes ☐ No. If Yes, describe. _____

Date of last mammogram _____ Results_____

Date of last manual breast exam (performed by physician) _____ Results_____

How do you wipe after urinating? ☐ Front-to-back. ☐ Back-to-front.

How do you wipe after bowel movement? ☐ Front-to-back. ☐ Back-to-front.

Are you sexually active? ☐ Yes ☐ No. Current form of contraception _____

Have you ever used birth control pills? ☐ Yes ☐ No. If Yes, for how long _____ Type _____

Side effects of birth control pills, if any _____

Have you ever used an IUD? ☐ Yes ☐ No. If Yes, for how long? Type of IUD _____

Age of first menstruation _____

Did you have a difficult time during puberty (i.e., physically, emotionally)? ☐ Yes ☐ No.

If Yes, explain _____

If you experience PMS (Premenstrual Syndrome), please check the following symptoms that apply:

PMT-A
- ☐ Nervous tension
- ☐ Irritability
- ☐ Mood changes
- ☐ Anxiety
- ☐ Insomnia

PMT-D
- ☐ Depression
- ☐ Forgetful
- ☐ Crying
- ☐ Confusion

PMT-C
- ☐ Headache
- ☐ Cravings for sweets
- ☐ Increased appetite
- ☐ Heart pounding
- ☐ Dizziness or faint
- ☐ Fatigue

PMT-H
- ☐ Weight gain
- ☐ Bloating
- ☐ Swelling of extremities
- ☐ Breast tenderness
- ☐ Cramping

Periods occur every _____ days (e.g., 28 days) Do you ever skip periods? ☐ Yes ☐ No.

Are your periods consistent (occur the same time each month)? ☐ Yes ☐ No.

Date of last period: _____

Periods usually last _____ days on average (e.g., 5 days). Quantity of flow: ☐ Light ☐ Moderate ☐ Heavy

Number of tampons and/or pads used per day: _____ tampons _____ pads

Quality of menstrual blood: ☐ Dark red ☐ Bright red ☐ Large clots Describe: _____

Are you currently pregnant? ☐ Yes ☐ No.

Pregnancies (include current) _____ # Births _____ # Miscarriages _____ # Abortions _____

Any complications of pregnancy? ☐ Yes ☐ No. If Yes, please explain _____

History of breastfeeding? ☐ Yes ☐ No. If any problems with breastfeeding, please explain _____

_____

Are there any questions/concerns regarding your sex life or intimacy you wish to discuss? _____

_____

Have you reached: ☐ Peri-menopause ☐ Menopause ☐ Post-menopause?

Have you or are you taking hormone replacement therapy? ☐ Yes ☐ No. Duration of use _____

Type of hormone replacement therapy _____ Dose _____ (i.e., milligrams per day)

Have you had a hysterectomy? ☐ Yes ☐ No. If Yes: ☐ Partial. ☐ Complete.

Childhood/Adolescence History

How was your health as a child? ☐ Excellent ☐ Good (typical illnesses) ☐ Chronically Ill

Were you troubled by : ☐ Acne ☐ Allergies ☐ Asthma

☐ Eczema ☐ Fatigue ☐ Chronic Bronchitis ☐ Chronic Ear Infections

☐ Chronic Sore Throats ☐ Stomach Problems ☐ Other Chronic Infections: _____

☐ Depression ☐ Learning/Behavioral Problems ☐ Other: _____

List all medication(s) used for an extended period of time (e.g., antibiotics, cortisone, etc.)? _____

_____

Were you overweight as a child/adolescent? ☐ Yes ☐ No.

How would you describe your experience of childhood/adolescence: ☐ Happy/Secure ☐ Lonely

☐ Stressed/Pressured ☐ Deprived of Love/Affection ☐ Abused: ☐ Verbally ☐ Physically ☐ Sexually

Any significant childhood/adolescent injuries/illnesses/traumatic events? _____

_____

Present Health Concerns

Please list your health concerns. Begin with the most important. If you prefer, list these in chronological flow chart form, or write a brief chronological history of your concerns on a separate page. If you choose the latter be sure to include all the information listed below (i.e., when did it start, diagnosis (if any), treatments, etc.).

1

Health Concern	
Medical diagnosis	
Doctor	
When did it start?	
Frequency (check one)	☐ Daily ☐ Weekly ☐ Monthly
Severity	LEAST < 1 2 3 4 5 6 7 8 9 10 > WORST
Setting *(e.g., time of day, associated with meals, environment in which it occurs, during which activities?)*	
Any contributing factors or events that preceded onset of condition *(e.g., change in diet/lifestyle, stress, traumatic events, surgeries, drug reactions, travel, acute illness, accident, major dental work, home/work renovations, new home/work, etc.)*	
Factors that make condition better	
Factors that make condition worse	
Associated symptoms *(e.g., "When I get a headache [main concern] my eyes get blurry [associated symptom].")*	
Treatments or therapy received for this condition	
Result of treatments or therapy	

2

Health Concern	
Medical diagnosis	
Doctor	
When did it start?	
Frequency (check one)	☐ Daily ☐ Weekly ☐ Monthly
Severity	LEAST < 1 2 3 4 5 6 7 8 9 10 > WORST
Setting *(e.g., time of day, associated with meals, environment in which it occurs, during which activities?)*	
Any contributing factors or events that preceded onset of condition *(e.g., change in diet/lifestyle, stress, traumatic events, surgeries, drug reactions, travel, acute illness, accident, major dental work, home/work renovations, new home/work, etc.)*	
Factors that make condition better	
Factors that make condition worse	
Associated symptoms *(e.g., "When I get a headache [main concern] my eyes get blurry [associated symptom].")*	
Treatments or therapy received for this condition	
Result of treatments or therapy	

Present Health Concerns (continued)

3

Health Concern	
Medical diagnosis	
Doctor	
When did it start?	
Frequency (check one)	☐ Daily ☐ Weekly ☐ Monthly
Severity (circle one)	LEAST < 1 2 3 4 5 6 7 8 9 10 > WORST
Setting *(e.g.,time of day, associated with meals, environment in which it occurs, during which activities?)*	
Any contributing factors or events that preceded onset of condition *(e.g., change in diet/lifestyle, stress, traumatic events, surgeries, drug reactions, travel, acute illness, accident, major dental work, home/work renovations, new home/work, etc.)*	
Factors that make condition better	
Factors that make condition worse	
Associated symptoms *(e.g., "When I get a headache [main concern] my eyes get blurry [associated symptom].")*	
Treatments or therapy received for this condition	
Result of treatments or therapy	

4

Health Concern	
Medical diagnosis	
Doctor	
When did it start?	
Frequency (check one)	☐ Daily ☐ Weekly ☐ Monthly
Severity (circle one)	LEAST < 1 2 3 4 5 6 7 8 9 10 > WORST
Setting *(e.g.,time of day, associated with meals, environment in which it occurs, during which activities?)*	
Any contributing factors or events that preceded onset of condition *(e.g., change in diet/lifestyle, stress, traumatic events, surgeries, drug reactions, travel, acute illness, accident, major dental work, home/work renovations, new home/work, etc.)*	
Factors that make condition better	
Factors that make condition worse	
Associated symptoms *(e.g., "When I get a headache [main concern] my eyes get blurry [associated symptom].")*	
Treatments or therapy received for this condition	
Result of treatments or therapy	

Medications

List prescription and over-the-counter drugs you are currently taking or have previously taken for extended periods of time (greater than one month). Please bring your medications to your appointment.

Drug Name	Reason for Taking	Dose (mg/day)	Date Started	Date Discontinued	Side Effects

Please list allergies to medications. _____

_____

_____

Immunizations (if known):

☐ Polio ☐ Rubella ☐ Flu Vaccine ☐ Tetanus ☐ Measles ☐ Diphtheria

☐ Smallpox ☐ Mumps ☐ Hepatitis B ☐ Pertussis ☐ Other:_____

Nutritional Supplements

Examples: Vitamins, minerals, herbal & homeopathic remedies.

For evaluation of content and quality please bring supplements to your appointment.

Name/Type	Reason for Taking	Dose	Date Started	Results/Benefits

Hospitalizations, Surgeries & Outpatient Procedures

Type	Date	Reason for Procedure/Admission	Outcome/Results

Major Accidents & Traumatic Events

Examples: car accident, serious shock, nervous breakdown, divorce, death of loved one.

Type	Age	Duration	Complete Recovery? (yes/no)	Treatment (include medications)

Family History

Use the key below to identify family members and their associated health conditions.
Please list type where parentheses are present.

M: Mother **F:** Father **S:** Sister **B:** Brother **G:** Grandparent **A:** Aunt **U:** Uncle **C:** Child

Condition	Relative	Condition	Relative
Allergies		Eczema	
Alcoholism		Epilepsy	
Anemia		Gout	
Alzheimer's		Heart Disease	
Arthritis (Rheumatoid)		High Blood Pressure	
Arthritis (Osteo)		High Cholesterol	
Asthma		Kidney Disease	
Bleeding Disorder		Lupus	
Cancer ( )		Mental Disorder	
Cancer ( )		Nervous System Disease	
Celiac Disease		Obesity	
Crohns Disease		Stroke	
Colitis		Thyroid (Hypo/Hyper)	
Depression		Other ( )	
Diabetes Type 1		Other ( )	
Diabetes Type 2		Other ( )	

Deceased Relatives

Please provide age at death and cause of death if known.

Relative	Age	Cause of Death
Mother		
Father		
Grandfather (maternal)		
Grandmother (maternal)		
Grandfather (paternal)		
Grandmother (paternal)		
Sister(s)		
Brother(s)		

Personal Habits

Substance Use

	Tobacco	Alcohol	Caffeine	Drugs
Currently Use				
Previously Used				
Never Used				
How much/many per day/week/month				
Specify Type: (cigarettes/cigars/ pipe/chewing tobacco; beer/wine/ spirits; tea/coffee/espresso/soft drinks/ energy drinks/ weight loss products;cocaine/marijuana/ heroin/ ecstasy)				
Duration of use (month/years)				
Date Quit				

Exercise (complete this section only if you exercise regularly.)

Type of exercise (biking, walking, yoga, jogging, weights, swimming)	**How long per session** (minutes, hours)	**Frequency** (daily, weekly)	**How long have you been doing this specific activity** (weeks, months, years)

Sleep

Hours per night _____

Do have trouble falling asleep? ☐ Yes ☐ No. If Yes, what keeps you up? _____

Do you have trouble staying asleep? ☐ Yes ☐ No. If Yes, how many times do you wake per night and is there a consistent time that you wake throughout the night? _____

Do you snore excessively or experience sleep apnea? ☐ Yes ☐ No.

Do you have any recurring dreams? ☐ Yes ☐ No. If Yes, please describe: _____

_____

Do you wake refreshed? ☐ Yes ☐ No.

What time do you go to bed? _____ What time do you rise in the morning? _____

Recreation & Relaxation

How much time per day do you spend watching television? _____

How much time per day do you spend on computers? _____

How much time per day do you spend outdoors? _____

What are your interests and hobbies? _____

Do you have a lot of clutter in your life (i.e. home and/or work)? ☐ Yes ☐ No.

What do you do for relaxation? _____

Do you consider yourself a "relaxed" individual? ☐ Yes ☐ No.

Social History

What are the major sources of happiness in your life? _____

Are you presently happy with your life? ☐ Yes ☐ No. Why or why not? _____

_____

What are the major sources of stress in your life? _____

Stress level (rate on scale of 1-10, 1=lowest stress, 10=severe, chronic stress) _____

How do you cope with stress? _____

How important is religion or spirituality in your life? _____

Do you have a good support network (friends, family, pets)? ☐ Yes ☐ No.

Are you fulfilled by your work? ☐ Yes ☐ No. If No, why not? _____

Do you have short and long-term goals for your life? ☐ Yes ☐ No.

Do you take regular vacations? ☐ Yes ☐ No. If Yes, how often and how long (per year)? _____

Is there a noticeable change in your health while on vacation? ☐ Yes ☐ No. Describe. _____

_____

Environmental History

Where do you live (e.g., house, apartment)? _____

Where do you work or go to school? _____

Has the air quality in your home, place of work or school been a concern to you or others? ☐ Yes ☐ No.

If yes, explain: _____

What kind of shampoo do you use? _____

Are you exposed to any harsh chemicals at work or at home? ☐ Yes ☐ No.

If yes, explain: _____

Does your work or home environment have any visible mold present? ☐ Yes ☐ No.

What is the source of your drinking water? ☐ Distilled ☐ Filtered ☐ Spring ☐ Tap/City ☐ Well

Allergies

Do you suffer from allergies? ☐ Yes ☐ No. If Yes, to what (e.g., pollens, grasses, dust, animals, food)? _____

_____

Have you ever experienced an anaphylaxis reaction (i.e., severe allergic reaction requiring medical attention)?

☐ Yes ☐ No. If Yes, to what? _____

Have you had allergy testing? ☐ Yes ☐ No. If Yes, what type of testing (e.g., blood, skin scratch test)? _____

Results _____

Diet

List any specific foods or beverages you exclude from your diet and why? _____

_____

How many meals do you generally eat each day? _____

Have you "yo-yo" dieted in the past? ☐ Yes ☐ No. Explain. _____

_____

How often do you eat out or eat take-out food? _____

Do you crave any specific foods or beverages (e.g., sweets, chocolate, salty snack foods, bread, soda)? ☐ Yes ☐ No.

If Yes, which foods or beverages?_____

Are there specific foods that you feel you can't live without? ☐ Yes ☐ No. If Yes, which ones? _____

_____

List any foods/beverages that do not agree with you? _____

How do those foods/beverages not agree with you _____

What type of oil do you use for cooking/baking?_____

How much water do you drink on a typical day? _____

2-Day Diet Assessment

Please list all **foods** and **beverages** consumed in the last two days.

	Day 1	Day 2
Breakfast		
Morning Snack		
Lunch		
Afternoon Snack		
Dinner		
Dessert		
Evening Snack		

General Diet Assessment

Please check the appropriate boxes, (daily, weekly, monthly or never), to help us assess your diet.

Food Category	Daily	Weekly	Monthly	Never
Baked sweet goods (cakes, cookies, muffins, pastries, pies)				
Deep-fried foods/Harmful fats (french fries, fried chicken/fish, chips, donuts, margarine)				
Candy				
Chocolate				
Soda				
Juice/Sweetened beverages/Sports drinks				
Hot/Cold cereal (specify type _____)				
Bread/Bagels/Rolls (specify type _____)				
Pizza				
Rice				
Potatoes				
Milk				
Cheese				
Yogurt				
Butter				
Ice cream				
Fruits				
Vegetables				
Eggs				
Fish				
Chicken/Turkey				
Red meat (steak, pork, bacon, sausage, hamburgers, hot dogs)				
Beans/Legumes				
Soy (tofu, tempeh, miso, soy milk, edamame)				
Nuts/Seeds				
White/Brown sugar, Honey				
Artificial sweeteners (Aspartame, Nutrasweet, Equal, Splenda)				
Other:				

Review of Systems

From the list below, CHECK (✔) "**C**" for an illness or symptom you are **currently** experiencing, or "**P**" for an illness or symptom you've experienced in the **past**. Otherwise, leave blank.

General	C	P
Weight gain		
Difficulty losing weight		
Central abdominal weight gain ('apple-shape' fat distribution/elevated waist-to-hip circumference)		
Weight loss		
Poor appetite		
Increased appetite		
Feel worse after eating		
Feel cold most of time		
Cold hands and feet		
Feel hot most of time		
Excessive or unexplained sweating		
Night sweats		
Inadequate perspiration		
Fatigue		
Tired upon rising		
Fever		
Flu-like symptoms		
Excessive urination		
Excessive thirst		
Light-headedness		
Dizziness		
Restlessness		
Fainting		
Chemical sensitivity/Fume intolerance		
Chronic antibiotic/Oral contraceptive/steroid use		
Alcohol intolerance		
Body odor		
Symptoms worse on damp days or moldy places		
Congenital disease		
Other:		

Childhood	C	P
Measles (Rubeola)		
German Measles (Rubella)		
Chicken Pox		
Mononucleosis		
Mumps		
Scarlet Fever		
Whooping Cough		
Polio		
Reye's Syndrome		
Other:		

Travel-Related Illness	C	P
Typhoid		
Cholera		
Malaria		
Food Poisoning		
Worms/Parasites		
Traveler's diarrhea		
Dysentery		
Other:		

Skin, Hair and Nails	C	P
Acne		
Rosacea		
Boils		
Ringworm		
Fungus (Athlete's Foot, Jock Itch)		
Yeast infection		
Scabies		
Shingles		
Eczema		
Keloids		
Psoriasis		
Warts		
Hives		
Ulcers (any part of body)		
Vitiligo		
Skin cancer		
Rash		
Itching		
Dry skin		
Oily skin		
Bumps on back of arms		
Skin tags		
Flushing/ Hot Flashes		
Depigmentation		
Light or dark patches on skin		
Bronzing (tanned appearance) of skin without exposure to sunlight		
Dry, coarse hair		
Decrease in body, facial or head hair		
Increase in body or facial hair		
Weak, peeling and cracked fingernails		
Rigid fingernails		
White spots on nails		
Ridges on nails		
Other:		
Cancer Type:		

Dental / Oral	C	P
Dental caries (fillings) How many? _____		
Root canals		
Tooth extractions (Wisdom, Other)		

Gingivitis		
Periodontitis		
Dentures		
Canker sores (recurrent)		
Ulcerations in mouth		
White spots in mouth		
Thrush (oral yeast infection)		
Temporomandibular Joint Disorders (TMJ)		
Change/loss of taste		
Burning sensation in mouth/nose/throat		
Metallic taste		
Red tongue		
Thick white coating on tongue		
Thick yellow coating on tongue		
Swollen tongue		
Receding gums		
Bleeding gums		
Dark pigmentation on gums		
Cracked corners of mouth		
Grinding teeth		
Enlarged tonsils		
Bad breath		
Other:		

Gastrointestinal	C	P
Colitis		
Irritable Bowel Syndrome (IBS)		
Crohn's Disease		
Celiac Disease		
Diverticulitis/-osis		
Hiatal Hernia		
Constipation (infrequent/incomplete bowel movements)		
Diarrhea		
Gastroesophageal Reflux Disease (GERD)/ Heartburn		
Hemorrhoids		

Stomach/Duodenal ulcers (Peptic ulcers)		
Appendicitis		
Pernicious Anemia		
Colon polyps		
Gall Bladder Disease		
Pancreatic Disease		
Hepatitis (viral, alcoholic)		
Other liver diseases		
Less than one bowel movement per day		
Greater than three bowel movements per day		
Reliance on laxatives		
Trouble swallowing		
Nausea/Vomiting		
Vomiting blood		
Abdominal pain		
Intestinal cramping		
Pain under right rib cage		
Anal itching		
Rectal bleeding		
Yellowing of skin		
Frequent belching		
Frequent flatulence		
Bloating		
Indigestion		
Mucus in stool		
Blood in stool		
Dark brown/black stool		
Yellow/green/grey stool		
Greasy, fatty stools (stools float)		
Other:		

Musculoskeletal Disorders & Connective Tissue	C	P
Rheumatoid Arthritis		
Osteoarthritis		
Fibromyalgia		
Lupus		
Vasculitis		

Systemic Sclerosis		
Sjogren's Disease		
Ankylosing Spondylitis		
Reiter's Syndrome		
Rheumatic Fever		
Gout		
Sciatica		
Osteopenia		
Osteoporosis		
Bursitis/ Tendonitis		
Carpal Tunnel Syndrome		
Injuries		
Muscle cramps		
Muscle pain		
Muscle weakness		
Muscle spasms		
Muscle tension		
Back pain		
Neck pain		
Joint pain or stiffness (fingers, wrist, shoulder, hip, knee, etc.)		
Swollen joints		
Red/Hot joints		
Loss of joint movement		
Bone pain		
Other:		

Respiratory	C	P
Asthma		
Emphysema		
Chronic Bronchitis		
Pneumonia		
Pleurisy		
Tuberculosis		
Dry cough		
Productive cough		
Persistent cough		
Coughing up blood or sputum		

Shortness of breath/ Trouble breathing— in general		
Shortness of breath/ Trouble breathing—at rest		
Shortness of breath/ Trouble breathing— on exertion		
Shortness of breath/ Trouble breathing— lying down		
Frequent sighing (air hunger)		
Rapid breathing		
Wheezing		
Other:		

Eyes, Ears, Nose & Throat	**C**	**P**
Blindness		
Glaucoma		
Cataracts		
Diabetic Retinopathy		
Macular Degeneration		
Papilledema		
Ear infection		
Vertigo		
Meniere's Disease		
Sinusitis		
Tonsillitis		
Strept throat		
Impaired vision		
Blurry vision		
Eye "Floaters"		
Poor night vision		
Eye pain		
Itchy/Watery eyes		
Red eyes		
Dry eyes		
Dark circles under eyes		
Swollen eyelids		
Suborbital swelling		
Denny's lines (lines in lower eyelid(s))		

Xanthomas (yellow/white skin tags on eyelids)		
Light sensitivity		
Double vision		
Wear glasses/Contacts		
Laser surgery		
Pressure above ears/ feeling of head swelling		
Impaired hearing		
Ringing in ears		
Earache		
Ear pressure		
Red ears		
Itchy ears		
Earlobe crease (diagonal)		
Sensitivity to noise		
Horizontal crease on nose in children		
Disturbance of smell		
Nose bleeds		
Nasal polyps		
Nasal congestion		
Excessive sneezing		
Sore throat		
Hoarseness of voice		
Frequent need to clear throat		
Other:		

Urinary	**C**	**P**
Urinary tract infections/ Cystitis		
Interstitial Cystitis		
Urinary incontinence		
Kidney Failure/Disorder		
Kidney stones		
Cloudy urine		
Dark yellow urine		
Increased frequency of urination (more than 8 times per day)		
Frequency at night		
Pain/Burning on urination		

Hesitancy		
Urgency to urinate		
Inability to urinate		
Reduced stream/Dribbling		
Blood in urine		
Bed-wetting		
Other:		

Endocrine Disorders/ Metabolic	**C**	**P**
Cushing's Disease		
Addison's Disease		
Hypothyroidism		
Hyperthyroidism		
Diabetes Type 1 (or juvenile-onset DM)		
Diabetes Type 2 (or adult-onset DM)		
Hypoglycemia (low blood sugar)		
Crave sweets, caffeine, alcohol		
Crave salt		
Lightheaded upon standing		
Shakiness when hungry		
Feel worse after exercise		
Feel worse when skip meals		
Nervous exhaustion		
Unable to relax		
Difficulty coping with stress		
Feel overwhelmed		
Mass/Nodules in neck		
Other:		

Cardiovascular Disorders	**C**	**P**
High blood pressure		
Low blood pressure		
High cholesterol/ Triglycerides)		
Atherosclerosis		

Heart attack		
Cardiomyopathy		
Arrhythmias		
Valvular diseases (Aortic Valve /Mitral Valve)		
Endocarditis		
Aneurysms		
Murmurs		
Venous Thrombosis		
Varicose veins		
Spider veins		
Stroke		
Raynaud's Disease		
Palpitations		
Chest pressure/ chest tightness		
Chest pain (Angina)— in general		
Chest pain (Angina)— at rest		
Chest pain (Angina)— on exertion		
Chest pain (Angina)— lying down		
Chest pain (Angina)— after eating		
Chest pain (Angina)— with movement		
Swelling in ankles		
Water retention		
Rapid/Irregular pulse		
Skipped beats		
Numbness/tingling in arms/legs		
Leg pain when walking		
Other:		

Hematological Disorders	**C**	**P**
Platelet disorders		
Anemia		
Low white blood cell count		
High white blood cell count		
Blood clotting disorder		
Spleen disorders		
Iron overload (Hemochromatosis)		
Easy bruising		
Difficulty stopping bleeding		
Bleeding from unusual places		
Other:		

Neurological Disorders	**C**	**P**
Headaches (Migraine/ Tension)		
Chronic pain		
Vertigo		
Seizure/Convulsion disorders		
Alzheimer's/Dementia		
Sleep disorders (Insomnia, Sleep Apnea)		
Multiple Sclerosis		
Muscular Dystrophy		
Meningitis		
Parkinson's Disease		
ALS (Lou-Gehrig's disease)		
Paralysis		
Numbness/Tingling		
Temporary loss of sensation		
Lack of strength		
Loss of balance		
Incoordination		
Tremor (shaking, trembling)		
Other:		

Sexually Transmitted Diseases	**C**	**P**
Gonorrhea		
Chlamydia		
Syphilis		
HIV		
Herpes (Type 1/ Type 2)		
Hepatitis B		
Human Papillovirus (HPV)/ Genital warts		
Other:		

Immune	**C**	**P**
Chronic Fatigue Syndrome		
Allergies (Environmental/ Pet/Food)		
Candida (Yeast Infection)		
Organ transplantation		
Environmental illness/ Chemical sensitivity		
Painful lymph nodes		
Wounds heal slowly		
Swollen glands		
Increased vulnerability to infections (e.g., colds)		
Takes longer than usual to recover from colds/flu		
Other:		

Psychological / Behavioral / Cognitive	**C**	**P**
Attention Deficit/ Hyperactivity Disorder		
Autism		
Anxiety		
Panic attacks		
Eating disorder (Bulimia, Anorexia, Compulsive Eating)		
Schizophrenia		
Obsessive thoughts/ behaviors		
Bipolar Disorder (Manic-depression)		
Depression		
Seasonal Affective Disorder/Winter blues		
Post-traumatic Stress Disorder		
Cravings for or addictions to alcohol, caffeine, drugs, tobacco, work, food or sex (please circle)		
Have you ever been in psychotherapy or counseling		

Restlessness		
Excessive worry		
Crying spells/Weeping		
Irritability		
Negative attitude		
Despair/Hopelessness		
Have to please others excessively		
Lack of drive/motivation		
Trouble expressing emotions		
Suicidal thoughts		
Loneliness, isolated, lacking meaningful connections to people or pets		
Rarely touch or get touched by others		
Keep repeating negative patterns or choices that harm you or others		
Feel like a victim		
Mood swings		
Poor memory/Forgetful		
Mental confusion		
Decreased focus/ concentration		
Nervousness		
Hyperactive		
Excessive anger/rage		
Aggressive/ Criminal behavior		
"Brain fog"		
Low self-esteem/ Self-worth		
Learning disabilities		
Phobias (Type:_____)		

Crave comfort/reward		
Very sensitive to emotional or physical pain		
Other:		

Male Reproduction	**C**	**P**
Prostatitis		
Benign Prostatic Hyperplasia		
Erectile dysfunction		
Testicular swelling		
Testicular lumps/nodules		
Testicular pain		
Discharge from penis		
Infertility		
Painful erection		
Difficulty achieving/ maintenance of erection		
Difficulty/Premature ejaculation		
Genital eruptions		
Genital itching		
Lack of sexual desire		
Other:		

Female Reproduction	**C**	**P**
Multiple pregnancies		
PMS (Premenstrual Syndrome)		
Endometriosis		
Uterine fibroids		
Ovarian cysts		
Polycystic Ovarian Syndrome (PCOS)		
Vaginitis (recurrent)		

Infertility		
Fibrocystic breast disease		
Uterine prolapse		
Gestational diabetes		
Preeclampsia (toxemia of pregnancy)		
Ectoptic (Tubal) pregnancy		
Vaginal Candidiasis (yeast infection)		
Post-partum depression		
Water retention		
Menstrual cramps		
Lumps in breast(s)		
Nipple discharge		
Breast pain		
Pelvic pain		
Discharge from vagina		
Vaginal itching/burning		
Genital eruptions		
Painful intercourse		
Lack of sexual desire		
Excessive bleeding during menses		
Excessive pain during menses		
Bleeding/Spotting between periods		
Absent/Skipped periods		
Small amount/scanty bleeding during periods		
Hot flashes/Flushing		
Vaginal dryness		
Other:		

Thank you for taking time to fill out this questionnaire. Please remember to bring your nutritional supplements/medications and **copies** of your laboratory tests/medical reports to your appointment.