Thank you for choosing Western Wisconsin Health Roberts Clinic for your functional medicine needs.

Enclosed you will find the paperwork to fill out for your consult and a print out of your scheduled appointments. The provider would appreciate if this paperwork could be dropped off, mailed or faxed back to us prior to your visit so that it can be reviewed.

In order for the provider to give you the best plan of care, we request that you contact any healthcare organization, outside of Allina, to release your healthcare records to Western Wisconsin Health. The types of records that are helpful include recent lab results, imaging results with the reports, recent office visit notes and sleep study results.

Please request the records at least 3 weeks prior to your consult to allow time for processing.

If you have not given us your insurance card or a photo ID it would be appreciated if you could send us front and back copies of each to be scanned into your account. You can email this to patient.access@wwhealth.org.

We encourage you to check with your insurance provider to make sure that our clinic and practitioner are within your health network.

You will need to check in 30 minutes prior to your consult for rooming time with the assistant. If you arrive late or paperwork is not complete your time with the provider will be shorter.

If you have any questions or concerns please feel free to reach out to us.

Patient Access
Western Wisconsin Health Roberts Clinic

Phone: 715-760-3311 FAX: 715-760-3036

# Female Intake Questionnaire

## General Information

Name ______________________ Age _____ Today's Date ______________

Date of Birth ______________ Email ______________________

Address ______________________ City ______________ State ____ Zip ________

Phone (Home) ______________ (Cell) ______________ (Work) ______________

Genetic Background: ☐ African American ☐ Hispanic ☐ Mediterranean ☐ Asian
☐ Native American ☐ Caucasian ☐ Northern European
☐ Other ______________________

When, where and from whom did you last receive medical or health care? ______________________

______________________________________________

Emergency Contact: ______________________ Relationship ______________

Phone (Home) ______________ (Cell) ______________ (Work) ______________

### How did you hear about our practice?

☐ Clinic website ☐ IFM website ☐ Referral from doctor ☐ Social media
☐ Other ______________________
☐ Referral from friend/family member ______________________

## Current Health Concerns

### Please rank current and ongoing health concerns in order of priority

| Describe Problem | Severity | Mild | Moderate | Severe | Prior Treatment/Approach | Success | Excellent | Good | Fair |
|---|---|---|---|---|---|---|---|---|---|
| *Example: Post Nasal Drip* | | *X* | | | *Elimination Diet* | | *X* | | |
| **1.** | | | | | | | | | |
| **2.** | | | | | | | | | |
| **3.** | | | | | | | | | |
| **4.** | | | | | | | | | |
| **5.** | | | | | | | | | |
| **7.** | | | | | | | | | |
| **8.** | | | | | | | | | |
| **9.** | | | | | | | | | |
| **9.** | | | | | | | | | |
| **10.** | | | | | | | | | |

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## Lifestyle Review

### Sleep

How many hours of sleep do you get each night on average?

________________________________________

Do you have problems falling asleep? ☐ Yes ☐ No Staying asleep? ☐ Yes ☐ No

Do you have problems with insomnia? ☐ Yes ☐ No Do you snore? ☐ Yes ☐ No

Do you feel rested upon awakening? ☐ Yes ☐ No

Do you use sleeping aids? ☐ Yes ☐ No

If yes, explain: ________________________________________

Do you have sleep apnea? ☐ Yes ☐ No

If yes, do you use your c-pap? ☐ Yes ☐ No

### Exercise

Current Exercise Program:

| Activity | Type | # of Times Per Week | Time/Duration (Minutes) |
|---|---|---|---|
| Cardio/Aerobic | | | |
| Strength/Resistance | | | |
| Flexibility/Stretching | | | |
| Balance | | | |
| Sports/Leisure (e.g., golf) | | | |
| Other: | | | |

Do you feel motivated to exercise? ☐ Yes ☐ A little ☐ No

Are there any problems that limit exercise? ☐ Yes ☐ No

If yes, explain: ________________________________________

Do you feel unusually fatigued or sore after exercise? ☐ Yes ☐ No

If yes, explain: ________________________________________

## Nutrition

Do you currently follow any of the following special diets or nutritional programs? *(Check all that apply)*

☐ Vegetarian ☐ Vegan ☐ Allergy ☐ Elimination ☐ Low Fat ☐ Low Carb ☐ High Protein
☐ Blood Type ☐ Low sodium ☐ No Dairy ☐ No Wheat ☐ Gluten Free ☐ Soy Free ☐ Corn Free
☐ Other: ________________________________________

Do you have sensitivities to certain foods? ☐ Yes ☐ No
If yes, list food and symptoms: ________________________________________

Do you have an aversion to certain foods? ☐ Yes ☐ No
If yes, explain: ________________________________________

Do you adversely react to: *(Check all that apply)*

☐ Monosodium glutamate (MSG) ☐ Artificial sweeteners ☐ Garlic/onion ☐ Cheese ☐ Citrus foods
☐ Chocolate ☐ Alcohol ☐ Red wine ☐ Sulfite–containing foods (wine, dried fruit, salad bars)
☐ Preservatives ☐ Food colorings ☐ Other food substances: ____________________

Are there any foods that you crave or binge on? ☐ Yes ☐ No
If yes, what foods? ________________________________________

Do you eat 3 meals a day? ☐ Yes ☐ No If no, how many ____________________

Does skipping a meal greatly affect you? ☐ Yes ☐ No

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

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

☐ Fast eater
☐ Eat too much
☐ Late-night eating
☐ Dislike healthy foods
☐ Time constraints
☐ Travel frequently
☐ Eat more than 50% of meals away from home
☐ Healthy foods not readily available
☐ Poor snack choices
☐ Significant other or family members don't like healthy foods
☐ Significant other or family members have special dietary needs
☐ Love to eat
☐ Eat because I have to
☐ Have negative relationship to food
☐ Struggle with eating issues
☐ Emotional eater (eat when sad, lonely, bored, etc.)
☐ Eat too much under stress
☐ Eat too little under stress
☐ Don't care to cook
☐ Confused about nutrition advice

## Diet

Please record what you eat in a typical day:

Breakfast ______________________________

Lunch ______________________________

Dinner ______________________________

Snacks ______________________________

Fluids ______________________________

How many servings do you eat in a typical day of these foods:

Fruits (not juice)______ Vegetables (not including white potatoes) ______
Legumes (beans, peas, etc) ______ Red meat ______ Fish ______
Dairy/Alternatives ______ Nuts & Seeds ______ Fats & Oils ______
Cans of soda (regular or diet) ______ Sweets (candy, cookies, cake, ice cream, etc.) ______

Do you drink caffeinated beverages? ☐ Yes ☐ No If yes, check amounts:

Coffee (cups per day) ☐ 1 ☐ 2-4 ☐ >4 Tea (cups per day) ☐ 1 ☐ 2-4 ☐ >4
Caffeinated sodas—regular or diet (cans per day) ☐ 1 ☐ 2-4 ☐ >4

Do you have adverse reactions to caffeine? ☐ Yes ☐ No
If yes, explain: ______________________________

When you drink caffeine do you feel: ☐ Irritable or wired ☐ Aches or pains

## Smoking

Do you smoke currently? ☐ Yes ☐ No Packs per day: _______ Number of years ______
What type? ☐ Cigarettes ☐ Smokeless ☐ Pipe ☐ Cigar ☐ E-Cig
Have you attempted to quit? ☐ Yes ☐ No
If yes, using what methods: ______________________________

If you smoked previously: Packs per day: ______ Number of years ______
Are you regularly exposed to second-hand smoke? ☐ Yes ☐ No

## Alcohol

How many alcoholic beverages do you drink in a week? *(1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits)*
☐ 1–3 ☐ 4–6 ☐ 7–10 ☐ >10 ☐ None

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

Have you ever had a problem with alcohol? ☐ Yes ☐ No
If yes, when? ______________________________
Explain the problem: ______________________________

Have you ever thought about getting help to control or stop your drinking? ☐ Yes ☐ No

## Other Substances

Are you currently using any recreational drugs? ☐ Yes ☐ No
If yes, type: ______________________________

Have you ever used IV or inhaled recreational drugs? ☐ Yes ☐ No

## Stress

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

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

How much stress do each of the following cause on a daily basis *(Rate on scale of 1-10, 10 being highest)*

Work ____ Family ____ Social ____ Finances ____ Health ____ Other____

Do you use relaxation techniques? ☐ Yes ☐ No

If yes, how often? ______________________________

Which techniques do you use? *(Check all that apply)*

☐ Meditation ☐ Breathing ☐ Tai Chi ☐ Yoga ☐ Prayer ☐ Other: ______________________

Have you ever sought counseling? ☐ Yes ☐ No

Are you currently in therapy? ☐ Yes ☐ No

If yes, describe: ______________________________

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

What are your hobbies or leisure activities?______________________________

## Relationships

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Gay/Lesbian ☐ Long-Term Partner ☐ Widow/er

With whom do you live? (Include children, parents, relatives, friends, pets) ______________________

______________________________

Current occupation: ______________________________

Previous occupations:______________________________

Do you have resources for emotional support? ☐ Yes ☐ ☐ No *(Check all that apply)*

☐ Spouse/Partner ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other:______________

Do you have a religious or spiritual practice? ☐ Yes ☐ No

If yes, what kind? ______________________________

***How well have things been going for you?*** *(Mark on scale of 1–10, or N/A if not applicable)*

| | N/A | Poorly | | | | Fine | | | | | Very Well |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Overall | ☐ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| At school | ☐ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| In your job | ☐ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| In your social life | ☐ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| With close friends | ☐ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| With sex | ☐ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| With your attitude | ☐ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| With your boyfriend/girlfriend | ☐ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| With your children | ☐ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| With your parents | ☐ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| With your spouse | ☐ | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

## History

### Patient's Birth/Childhood History:

Preconception/Mother's General Health: ☐ Tobaccco Use ☐ Alcohol ☐ Drugs ☐ DES

You were born: ☐ Term ☐ Premature ☐ Don't know

Were there any pregnancy or birth complications? ☐ Yes ☐ No

If yes, explain:______________________________________________

You were: ☐ Breast-fed/How long? ________ ☐ Bottle-fed/Type of formula:____________ ☐ Don't know

Age of introduction of: Solid food: _______ Wheat ________ Dairy ________

As a child, were there any foods that were avoided because they gave you symptoms? ☐ Yes ☐ No

If yes, what foods and what symptoms? (Example: milk—gas and diarrhea)

______________________________________________

______________________________________________

Did you eat a lot of sugar or candy as a child? ☐ Yes ☐ No

Secondhand Smoke Exposure? ☐ Yes ☐ No

### Dental History:

*Check if you have any of the following, and provide number if applicable:*

☐ Silver mercury fillings _____ ☐ Gold fillings _____ ☐ Root canals _____ ☐ Implants _____

☐ Caps/Crowns _____ ☐ Tooth pain_____ ☐ Bleeding gums_____ ☐ Gingivitis______

☐ Problems with chewing_____ ☐ Other dental concerns (explain):______

Have you had any mercury fillings removed? ☐ Yes ☐ No If yes, when: ________________________

How many fillings did you have as a kid? _______________

Do you brush regularly? ☐ Yes ☐ No Do you floss regularly? ☐ Yes ☐ No

### Environmental/Detoxification History

Do any of these significantly affect you?

☐ Cigarette smoke ☐ Perfume/colognes ☐ Auto exhaust fumes ☐ Other: ____________________

In your work or home environment are you regularly exposed to: *(Check all that apply)*

☐ Mold ☐ Water leaks ☐ Renovations ☐ Chemicals ☐ Electromagnetic radiation

☐ Damp environments ☐ Carpets or rugs ☐ Old paint ☐ Stagnant or stuffy air ☐ Smokers

☐ Pesticides ☐ Herbicides ☐ Harsh chemicals (solvents, glues, gas, acids, etc) ☐ Cleaning chemicals

☐ Heavy metals (lead, mercury, etc.) ☐ Paints ☐ Airplane travel ☐ Other ____________________

Have you had a significant exposure to any harmful chemicals? ☐ Yes ☐ No

If yes: Chemical name, length of exposure, date:______________________________________

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

If yes, do they live: ☐ Inside ☐ Outside ☐ Both inside and outside

## Women's History

**Obstetric History:** *(Check box and provide number if applicable)*

☐ Pregnancies ______ ☐ Miscarriages ______ ☐ Abortions ______ ☐ Living children ______
☐ Vaginal deliveries______ ☐ Cesarean ______ ☐ Term births ______ ☐ Premature birth______

Birth weight of largest baby__________________ Birth weight of smallest baby _________________

Did you develop any problems in or after pregnancy, for example, toxemia (high blood pressure), diabetes, post-partum depression, issues with breast feeding, etc.? ☐ Yes ☐ No

If yes, please explain ______________________________________________________________

**Menstrual History:**

Age at first period ______ Date of last menstrual period ______________________
Length of cycle ________________________________ Time between cycles ______________________

Cramping? ☐ Yes ☐ No Pain? ☐ Yes ☐ No

Have you ever had premenstrual problems (bloating, breast tenderness, irritability, etc.)? ☐ Yes ☐ No

If yes, please describe:______________________________________________________________

Do you have other problems with your periods (heavy, irregular, spotting, skipping, etc.)? ☐ Yes ☐ No

If yes, please describe:______________________________________________________________

Use of hormonal birth control: ☐ Birth control pills ☐ Patch ☐ Nuva ring
☐ Other____________________________________________________ How Long ______________________

Any problems with hormonal birth control? ☐ Yes ☐ No

If yes, explain ______________________________________________________________________

Use of other contraception? ☐ Yes ☐ No ☐ Condoms ☐ Diaphragm ☐ IUD ☐ Partner vasectomy

Are you in menopause? ☐ Yes ☐ No If yes, age at last period:________________

Was it surgical menopause? ☐ Yes ☐ No If yes, explain surgery:__________________________________

______________________________________________________________________________________

Do you currently have symptomatic problems with menopause? *(Check all that apply)*

☐ Hot flashes ☐ Mood swings ☐ Concentration/memory problems ☐ Headaches ☐ Joint pain
☐ Vaginal dryness ☐ Weight gain ☐ Decreased libido ☐ Loss of control of urine ☐ Palpitations

Are you on hormone replacement therapy? ☐ Yes ☐ No

If yes, for how long and for what reason (hot flashes, osteoporosis prevention, etc.)?___________________

______________________________________________________________________________________

**Other Gynecological Symptoms:** *(Check if applicable)*

☐ Endometriosis ☐ Infertility ☐ Fibrocystic breasts ☐ Vaginal infection ☐ Fibroids
☐ Ovarian cysts ☐ Pelvic inflammatory disease ☐ Reproductive cancer
☐ Sexually transmitted disease (describe) ____________________________________________________

______________________________________________________________________________________

**Gynecological Screening/Procedures:** *(If applicable, provide date)*

Last Pap test: ______________________ ☐ Normal ☐ Abnormal
Last mammogram: _________________ ☐ Normal ☐ Abnormal
Last bone density: _________________ Results: ☐ High ☐ Low ☐ Within Normal Range
Other tests/procedures (list type and dates)___________________________________________________

______________________________________________________________________________________

## Family History:

**Check family members** that have/had any of the following

| | Mother | Father | Brother (s) | Sister (s) | Child | Child | Child | Child | Maternal Grandmother | Maternal Grandfather | Paternal Grandmother | Paternal Grandfather | Other |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Age (if still alive)* | | | | | | | | | | | | | |
| *Age at death (if deceased)* | | | | | | | | | | | | | |
| Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Heart disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hypertension | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Obesity | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Autoimmune disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Arthritis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Kidney disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Thyroid problems | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Seizures/epilepsy | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Psychiatric disorders | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Anxiety | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Depression | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Asthma | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Allergies | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Eczema | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| ADHD | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Autism | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Irritable Bowel Syndrome | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Dementia | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Substance abuse | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Genetic disorders | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other: ____________________ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

*If cancer, type:* _____________________________________

## Medical History: Illnesses/Conditions

**Check YES** = a condition you currently have, **Check PAST** = a condition you've had in the past.

| Gastrointestinal | Yes | Past |
|---|---|---|
| Irritable bowel syndrome | ☐ | ☐ |
| GERD (reflux) | ☐ | ☐ |
| Crohn's disease/ulcerative colitis | ☐ | ☐ |
| Peptic ulcer disease | ☐ | ☐ |
| Celiac disease | ☐ | ☐ |
| Gallstones | ☐ | ☐ |
| Other: | ☐ | ☐ |
| **Respiratory** | | |
| Bronchitis | ☐ | ☐ |
| Asthma | ☐ | ☐ |
| Emphysema | ☐ | ☐ |
| Pneumonia | ☐ | ☐ |
| Sinusitis | ☐ | ☐ |
| Sleep apnea | ☐ | ☐ |
| Other: | ☐ | ☐ |
| **Urinary/Genital** | | |
| Kidney stones | ☐ | ☐ |
| Gout | ☐ | ☐ |
| Interstitial cystitis | ☐ | ☐ |
| Frequent yeast infections | ☐ | ☐ |
| Frequent urinary tract infections | ☐ | ☐ |
| Sexual dysfunction | ☐ | ☐ |
| Sexually transmitted diseases | ☐ | ☐ |
| Other: | ☐ | ☐ |
| **Endocrine/Metabolic** | | |
| Diabetes | ☐ | ☐ |
| Hypothyroidism (low thyroid) | ☐ | ☐ |
| Hyperthyroidism (overactive thyroid) | ☐ | ☐ |
| Polycystic Ovarian Syndrome | ☐ | ☐ |
| Infertility | ☐ | ☐ |
| Metabolic syndrome/insulin resistance | ☐ | ☐ |
| Eating disorder | ☐ | ☐ |
| Hypoglycemia | ☐ | ☐ |
| Other: | ☐ | ☐ |
| **Inflammatory/Immune** | | |
| Rheumatoid arthritis | ☐ | ☐ |
| Chronic fatigue syndrome | ☐ | ☐ |
| Food allergies | ☐ | ☐ |
| Environmental allergies | ☐ | ☐ |
| Multiple chemical sensitivities | ☐ | ☐ |
| Autoimmune disease | ☐ | ☐ |
| Immune deficiency | ☐ | ☐ |
| Mononucleosis | ☐ | ☐ |
| Hepatitis | ☐ | ☐ |
| Other: | ☐ | ☐ |

| Musculoskeletal | Yes | Past |
|---|---|---|
| Fibromyalgia | ☐ | ☐ |
| Osteoarthritis | ☐ | ☐ |
| Chronic pain | ☐ | ☐ |
| Other: | ☐ | ☐ |
| **Skin** | | |
| Eczema | ☐ | ☐ |
| Psoriasis | ☐ | ☐ |
| Acne | ☐ | ☐ |
| Skin cancer | ☐ | ☐ |
| Other: | ☐ | ☐ |
| **Cardiovascular** | | |
| Angina | ☐ | ☐ |
| Heart attack | ☐ | ☐ |
| Heart failure | ☐ | ☐ |
| Hypertension (high blood pressure) | ☐ | ☐ |
| Stroke | ☐ | ☐ |
| High blood fats (cholesterol, triglycerides) | ☐ | ☐ |
| Rheumatic fever | ☐ | ☐ |
| Arrythmia (irregular heart rate) | ☐ | ☐ |
| Murmur | ☐ | ☐ |
| Mitral valve prolapse | ☐ | ☐ |
| Other: | ☐ | ☐ |
| **Neurologic/Emotional** | | |
| Epilepsy/Seizures | ☐ | ☐ |
| ADD/ADHD | ☐ | ☐ |
| Headaches | ☐ | ☐ |
| Migraines | ☐ | ☐ |
| Depression | ☐ | ☐ |
| Anxiety | ☐ | ☐ |
| Autism | ☐ | ☐ |
| Multiple sclerosis | ☐ | ☐ |
| Parkinson's disease | ☐ | ☐ |
| Dementia | ☐ | ☐ |
| Other: | ☐ | ☐ |
| **Cancer** | | |
| Lung | ☐ | ☐ |
| Breast | ☐ | ☐ |
| Colon | ☐ | ☐ |
| Ovarian | ☐ | ☐ |
| Skin | ☐ | ☐ |
| Other: | ☐ | ☐ |

## **Medical History** *(cont.)*

| Diagnostic Studies | Date | Comments |
| --- | --- | --- |
| Bone density | | |
| CT scan | | |
| Colonoscopy | | |
| Cardiac stress test | | |
| EKG | | |
| MRI | | |
| Upper endoscopy | | |
| Upper GI series | | |
| Chest X-ray | | |
| Other X-rays | | |
| Barium enema | | |
| Other: | | |
| **Injuries** | | |
| Broken bone(s) | | |
| Back injury | | |
| Neck injury | | |
| Head injury | | |
| Other: | | |
| **Surgeries** | | |
| Appendectomy | | |
| Dental | | |
| Gallbladder | | |
| Hernia | | |
| Hysterectomy | | |
| Tonsillectomy | | |
| Joint replacement | | |
| Heart surgery | | |
| Other: | | |
| **Hospitalizations** | **Date** | **Reason** |
| | | |
| | | |
| | | |
| | | |
| | | |

## Symptom Review

**Please check** if these symptoms occur presently or have occurred in the last 6 months

| General | Mild | Moderate | Severe |
|---|---|---|---|
| Cold hands and feet | ☐ | ☐ | ☐ |
| Cold intolerance | ☐ | ☐ | ☐ |
| Daytime sleepiness | ☐ | ☐ | ☐ |
| Difficulty falling asleep | ☐ | ☐ | ☐ |
| Early waking | ☐ | ☐ | ☐ |
| Fatigue | ☐ | ☐ | ☐ |
| Fever | ☐ | ☐ | ☐ |
| Flushing | ☐ | ☐ | ☐ |
| Heat intolerance | ☐ | ☐ | ☐ |
| Night waking | ☐ | ☐ | ☐ |
| Nightmares | ☐ | ☐ | ☐ |
| Can't remember dreams | ☐ | ☐ | ☐ |
| Low body temperature | ☐ | ☐ | ☐ |
| **Head, Eyes, and Ears** | | | |
| Conjunctivitis | ☐ | ☐ | ☐ |
| Distorted sense of smell | ☐ | ☐ | ☐ |
| Distorted taste | ☐ | ☐ | ☐ |
| Ear fullness | ☐ | ☐ | ☐ |
| Ear ringing/buzzing | ☐ | ☐ | ☐ |
| Eye crusting | ☐ | ☐ | ☐ |
| Eye pain | ☐ | ☐ | ☐ |
| Eyelid margin redness | ☐ | ☐ | ☐ |
| Headache | ☐ | ☐ | ☐ |
| Hearing loss | ☐ | ☐ | ☐ |
| Hearing problems | ☐ | ☐ | ☐ |
| Migraine | ☐ | ☐ | ☐ |
| Sensitivity to loud noises | ☐ | ☐ | ☐ |
| Vision problems | ☐ | ☐ | ☐ |
| **Musculoskeletal** | | | |
| Back muscle spasm | ☐ | ☐ | ☐ |
| Calf cramps | ☐ | ☐ | ☐ |
| Chest tightness | ☐ | ☐ | ☐ |
| Foot cramps | ☐ | ☐ | ☐ |
| Joint deformity | ☐ | ☐ | ☐ |
| Joint pain | ☐ | ☐ | ☐ |
| Joint redness | ☐ | ☐ | ☐ |
| Joint stiffness | ☐ | ☐ | ☐ |
| Muscle pain | ☐ | ☐ | ☐ |
| Muscle spasms | ☐ | ☐ | ☐ |
| Muscle stiffness | ☐ | ☐ | ☐ |
| Muscle twitches: | ☐ | ☐ | ☐ |
| Around eyes | ☐ | ☐ | ☐ |
| Arms or legs | ☐ | ☐ | ☐ |
| Muscle weakness | ☐ | ☐ | ☐ |

| Musculoskeletal *(cont.)* | Mild | Moderate | Severe |
|---|---|---|---|
| Neck muscle spasm | ☐ | ☐ | ☐ |
| Tendonitis | ☐ | ☐ | ☐ |
| Tension headache | ☐ | ☐ | ☐ |
| TMJ problems | ☐ | ☐ | ☐ |
| **Mood/Nerves** | | | |
| Agoraphobia | ☐ | ☐ | ☐ |
| Anxiety | ☐ | ☐ | ☐ |
| Auditory hallucinations | ☐ | ☐ | ☐ |
| Blackouts | ☐ | ☐ | ☐ |
| Depression | ☐ | ☐ | ☐ |
| Difficulty: | ☐ | ☐ | ☐ |
| Concentrating | ☐ | ☐ | ☐ |
| With balance | ☐ | ☐ | ☐ |
| With thinking | ☐ | ☐ | ☐ |
| With judgment | ☐ | ☐ | ☐ |
| With speech | ☐ | ☐ | ☐ |
| With memory | ☐ | ☐ | ☐ |
| Dizziness (spinning) | ☐ | ☐ | ☐ |
| Fainting | ☐ | ☐ | ☐ |
| Fearfulness | ☐ | ☐ | ☐ |
| Irritability | ☐ | ☐ | ☐ |
| Light-headedness | ☐ | ☐ | ☐ |
| Numbness | ☐ | ☐ | ☐ |
| Other phobias | ☐ | ☐ | ☐ |
| Panic attacks | ☐ | ☐ | ☐ |
| Paranoia | ☐ | ☐ | ☐ |
| Seizures | ☐ | ☐ | ☐ |
| Suicidal thoughts | ☐ | ☐ | ☐ |
| Tingling | ☐ | ☐ | ☐ |
| Tremor/trembling | ☐ | ☐ | ☐ |
| Visual hallucinations | ☐ | ☐ | ☐ |
| **Cardiovascular** | | | |
| Angina/chest pain | ☐ | ☐ | ☐ |
| Breathlessness | ☐ | ☐ | ☐ |
| Heart attack | ☐ | ☐ | ☐ |
| Heart murmur | ☐ | ☐ | ☐ |
| High blood pressure | ☐ | ☐ | ☐ |
| Irregular pulse | ☐ | ☐ | ☐ |
| Mitral valve prolapse | ☐ | ☐ | ☐ |
| Palpitations | ☐ | ☐ | ☐ |
| Phlebitis | ☐ | ☐ | ☐ |
| Swollen ankles/feet | ☐ | ☐ | ☐ |
| Varicose veins | ☐ | ☐ | ☐ |

## Symptom Review *(cont.)*

**Please check** if these symptoms occur presently or have occurred in the last 6 months

| Urinary | Mild | Moderate | Severe |
|---|---|---|---|
| Bed wetting | ☐ | ☐ | ☐ |
| Hesitancy | ☐ | ☐ | ☐ |
| Infection | ☐ | ☐ | ☐ |
| Kidney disease | ☐ | ☐ | ☐ |
| Kidney stone | ☐ | ☐ | ☐ |
| Leaking/incontinence | ☐ | ☐ | ☐ |
| Pain/burning | ☐ | ☐ | ☐ |
| Urgency | ☐ | ☐ | ☐ |
| **Digestion** | | | |
| Anal spasms | ☐ | ☐ | ☐ |
| Bad teeth | ☐ | ☐ | ☐ |
| Bleeding gums | ☐ | ☐ | ☐ |
| Bloating of: | ☐ | ☐ | ☐ |
| Lower abdomen | ☐ | ☐ | ☐ |
| Whole abdomen | ☐ | ☐ | ☐ |
| Bloating after meals | ☐ | ☐ | ☐ |
| Blood in stools | ☐ | ☐ | ☐ |
| Burping | ☐ | ☐ | ☐ |
| Canker sores | ☐ | ☐ | ☐ |
| Cold sores | ☐ | ☐ | ☐ |
| Constipation | ☐ | ☐ | ☐ |
| Cracking at corner of lips | ☐ | ☐ | ☐ |
| Dentures w/poor chewing | ☐ | ☐ | ☐ |
| Diarrhea | ☐ | ☐ | ☐ |
| Difficulty swallowing | ☐ | ☐ | ☐ |
| Dry mouth | ☐ | ☐ | ☐ |
| Farting | ☐ | ☐ | ☐ |
| Fissures | ☐ | ☐ | ☐ |
| Foods "repeat" (reflux) | ☐ | ☐ | ☐ |
| Heartburn | ☐ | ☐ | ☐ |
| Hemorrhoids | ☐ | ☐ | ☐ |
| Intolerance to: | ☐ | ☐ | ☐ |
| Lactose | ☐ | ☐ | ☐ |
| All dairy products | ☐ | ☐ | ☐ |
| Gluten (wheat) | ☐ | ☐ | ☐ |
| Corn | ☐ | ☐ | ☐ |
| Eggs | ☐ | ☐ | ☐ |
| Fatty foods | ☐ | ☐ | ☐ |
| Yeast | ☐ | ☐ | ☐ |
| Liver disease/jaundice | ☐ | ☐ | ☐ |
| (yellow eyes or skin) | | | |
| Lower abdominal pain | ☐ | ☐ | ☐ |
| Mucus in stools | ☐ | ☐ | ☐ |

| Digestion *(cont.)* | Mild | Moderate | Severe |
|---|---|---|---|
| Nausea | ☐ | ☐ | ☐ |
| Periodontal disease | ☐ | ☐ | ☐ |
| Sore tongue | ☐ | ☐ | ☐ |
| Strong stool odor | ☐ | ☐ | ☐ |
| Undigested food in stools | ☐ | ☐ | ☐ |
| Upper abdominal pain | ☐ | ☐ | ☐ |
| Vomiting | ☐ | ☐ | ☐ |
| **Eating** | | | |
| Binge eating | ☐ | ☐ | ☐ |
| Bulimia | ☐ | ☐ | ☐ |
| Can't gain weight | ☐ | ☐ | ☐ |
| Can't lose weight | ☐ | ☐ | ☐ |
| Carbohydrate craving | ☐ | ☐ | ☐ |
| Carbohydrate intolerance | ☐ | ☐ | ☐ |
| Poor appetite | ☐ | ☐ | ☐ |
| Salt cravings | ☐ | ☐ | ☐ |
| Frequent dieting | ☐ | ☐ | ☐ |
| Sweet cravings | ☐ | ☐ | ☐ |
| Caffeine dependency | ☐ | ☐ | ☐ |
| **Respiratory** | | | |
| Bad breath | ☐ | ☐ | ☐ |
| Bad odor in nose | ☐ | ☐ | ☐ |
| Cough – dry | ☐ | ☐ | ☐ |
| Cough – productive | ☐ | ☐ | ☐ |
| Hayfever: | ☐ | ☐ | ☐ |
| Spring | ☐ | ☐ | ☐ |
| Summer | ☐ | ☐ | ☐ |
| Fall | ☐ | ☐ | ☐ |
| Change of season | ☐ | ☐ | ☐ |
| Hoarseness | ☐ | ☐ | ☐ |
| Nasal stuffiness | ☐ | ☐ | ☐ |
| Nose bleeds | ☐ | ☐ | ☐ |
| Post nasal drip | ☐ | ☐ | ☐ |
| Sinus fullness | ☐ | ☐ | ☐ |
| Sinus infection | ☐ | ☐ | ☐ |
| Snoring | ☐ | ☐ | ☐ |
| Sore throat | ☐ | ☐ | ☐ |
| Wheezing | ☐ | ☐ | ☐ |
| Winter stuffiness | ☐ | ☐ | ☐ |

## Symptom Review *(cont.)*

**Please check** if these symptoms occur presently or have occurred in the last 6 months

| Nails | Mild | Moderate | Severe |
|---|---|---|---|
| Bitten | ☐ | ☐ | ☐ |
| Brittle | ☐ | ☐ | ☐ |
| Curve up | ☐ | ☐ | ☐ |
| Frayed | ☐ | ☐ | ☐ |
| Fungus – fingers | ☐ | ☐ | ☐ |
| Fungus – toes | ☐ | ☐ | ☐ |
| Pitting | ☐ | ☐ | ☐ |
| Ragged cuticles | ☐ | ☐ | ☐ |
| Ridges | ☐ | ☐ | ☐ |
| Soft | ☐ | ☐ | ☐ |
| Thickening of: | ☐ | ☐ | ☐ |
| Finger nails | ☐ | ☐ | ☐ |
| Toenails | ☐ | ☐ | ☐ |
| White spots/lines | ☐ | ☐ | ☐ |
| **Lymph Nodes** | | | |
| Enlarged/neck | ☐ | ☐ | ☐ |
| Tender/neck | ☐ | ☐ | ☐ |
| Other enlarged/tender | ☐ | ☐ | ☐ |
| lymph nodes | | | |
| **Skin, Dryness of** | | | |
| Eyes | ☐ | ☐ | ☐ |
| Feet | ☐ | ☐ | ☐ |
| Any cracking? | ☐ | ☐ | ☐ |
| Any peeling? | ☐ | ☐ | ☐ |
| Hair | ☐ | ☐ | ☐ |
| And unmanageable? | ☐ | ☐ | ☐ |
| Hands | ☐ | ☐ | ☐ |
| Any cracking? | ☐ | ☐ | ☐ |
| Any peeling? | ☐ | ☐ | ☐ |
| Mouth/throat | ☐ | ☐ | ☐ |
| Scalp | ☐ | ☐ | ☐ |
| Any dandruff? | ☐ | ☐ | ☐ |
| Skin in general | ☐ | ☐ | ☐ |
| **Skin Problems** | | | |
| Acne on back | ☐ | ☐ | ☐ |
| Acne on chest | ☐ | ☐ | ☐ |
| Acne on face | ☐ | ☐ | ☐ |
| Acne on shoulders | ☐ | ☐ | ☐ |
| Athlete's foot | ☐ | ☐ | ☐ |
| Bumps on back of upper arms | ☐ | ☐ | ☐ |
| Cellulite | ☐ | ☐ | ☐ |
| Dark circles under eyes | ☐ | ☐ | ☐ |

| Skin Problems *(cont.)* | Mild | Moderate | Severe |
|---|---|---|---|
| Ears get red | ☐ | ☐ | ☐ |
| Easy bruising | ☐ | ☐ | ☐ |
| Eczema | ☐ | ☐ | ☐ |
| Herpes – genital | ☐ | ☐ | ☐ |
| Hives | ☐ | ☐ | ☐ |
| Jock itch | ☐ | ☐ | ☐ |
| Lackluster skin | ☐ | ☐ | ☐ |
| Moles w color/size change | ☐ | ☐ | ☐ |
| Oily skin | ☐ | ☐ | ☐ |
| Pale skin | ☐ | ☐ | ☐ |
| Patchy dullness | ☐ | ☐ | ☐ |
| Psoriasis | ☐ | ☐ | ☐ |
| Rash | ☐ | ☐ | ☐ |
| Red face | ☐ | ☐ | ☐ |
| Sensitive to bites | ☐ | ☐ | ☐ |
| Sensitive to poison ivy/oak | ☐ | ☐ | ☐ |
| Shingles | ☐ | ☐ | ☐ |
| Skin cancer | ☐ | ☐ | ☐ |
| Skin darkening | ☐ | ☐ | ☐ |
| Strong body odor | ☐ | ☐ | ☐ |
| Thick calluses | ☐ | ☐ | ☐ |
| Vitiligo | ☐ | ☐ | ☐ |
| **Itching Skin** | | | |
| Anus | ☐ | ☐ | ☐ |
| Arms | ☐ | ☐ | ☐ |
| Ear canals | ☐ | ☐ | ☐ |
| Eyes | ☐ | ☐ | ☐ |
| Feet | ☐ | ☐ | ☐ |
| Hands | ☐ | ☐ | ☐ |
| Legs | ☐ | ☐ | ☐ |
| Nipples | ☐ | ☐ | ☐ |
| Nose | ☐ | ☐ | ☐ |
| Genitals | ☐ | ☐ | ☐ |
| Roof of mouth | ☐ | ☐ | ☐ |
| Scalp | ☐ | ☐ | ☐ |
| Skin in general | ☐ | ☐ | ☐ |
| Throat | ☐ | ☐ | ☐ |

## Symptom Review *(cont.)*

**Please check** if these symptoms occur presently or have occurred in the last 6 months

| Female Reproductive | Mild | Moderate | Severe |
|---|---|---|---|
| Breast cysts | ☐ | ☐ | ☐ |
| Breast lumps | ☐ | ☐ | ☐ |
| Breast tenderness | ☐ | ☐ | ☐ |
| Ovarian cyst | ☐ | ☐ | ☐ |
| Poor libido (sex drive) | ☐ | ☐ | ☐ |
| Endometriosis | ☐ | ☐ | ☐ |
| Fibroids | ☐ | ☐ | ☐ |
| Infertility | ☐ | ☐ | ☐ |
| Vaginal discharge | ☐ | ☐ | ☐ |
| Vaginal odor | ☐ | ☐ | ☐ |
| Vaginal itch | ☐ | ☐ | ☐ |
| Vaginal pain | ☐ | ☐ | ☐ |
| Premenstrual: | ☐ | ☐ | ☐ |
| Bloating | ☐ | ☐ | ☐ |
| Breast tenderness | ☐ | ☐ | ☐ |
| Carbohydrate craving | ☐ | ☐ | ☐ |
| Chocolate craving | ☐ | ☐ | ☐ |
| Constipation | ☐ | ☐ | ☐ |
| Decreased sleep | ☐ | ☐ | ☐ |
| Diarrhea | ☐ | ☐ | ☐ |
| Fatigue | ☐ | ☐ | ☐ |
| Increased sleep | ☐ | ☐ | ☐ |
| Irritability | ☐ | ☐ | ☐ |
| Menstrual: | ☐ | ☐ | ☐ |
| Cramps | ☐ | ☐ | ☐ |
| Heavy periods | ☐ | ☐ | ☐ |
| Irregular periods | ☐ | ☐ | ☐ |
| No periods | ☐ | ☐ | ☐ |
| Scanty periods | ☐ | ☐ | ☐ |
| Spotting between | ☐ | ☐ | ☐ |

## Medications/Supplements

### Current medications (include prescription and over-the-counter)

| Medication | Dosage | Start Date (mo/yr) | Reason for Use |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

### Nutritional supplements (vitamins/minerals/herbs etc.)

| Name and Brand | Dosage | Start Date (mo/yr) | Reason for Use |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Allergies

| Name of Medication/Supplement/Food: | Reaction: |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

## Readiness Assessment and Health Goals

### Readiness Assessment

***Rate on a scale of 5 (very willing) to 1 (not willing):***

In order to improve your health, how willing are you to:

| | | | | | |
|---|---|---|---|---|---|
| Significantly modify your diet | ☐ 5 | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 |
| Take several nutritional supplements each day | ☐ 5 | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 |
| Keep a record of everything you eat each day | ☐ 5 | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 |
| Modify your lifestyle (e.g., work demands, sleep habits) | ☐ 5 | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 |
| Practice a relaxation technique | ☐ 5 | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 |
| Engage in regular exercise | ☐ 5 | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 |

***Rate on a scale of 5 (very confident) to 1 (not confident at all):***

How confident are you of your ability to organize and follow through on the above health-related activities? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to follow through? ______________________________

______________________________________________________________

***Rate on a scale of 5 (very supportive) to 1 (very unsupportive):***

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

***Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact):***

How much ongoing support (e.g., telephone consults, email correspondence) from our professional staff would be helpful to you as you implement your personal health program? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Have medications or supplements ever caused unusual side effects or problems? ☐ Yes ☐ No

If yes, describe: ______________________________________________

Have you used any of these regularly or for a long time:

NSAIDs (Advil, Aleve, etc.), Motrin, Aspirin? ☐ Yes ☐ No Tylenol (acetaminophen)? ☐ Yes ☐ No

Acid-blocking drugs (Zantac, Prilosec, Nexium, etc.)? ☐ Yes ☐ No

### How many times have you taken antibiotics?

| | < 5 | > 5 | Reason for Use |
|---|---|---|---|
| Infancy/Childhood | | | |
| Teen | | | |
| Adulthood | | | |

Have you ever taken long term antibiotics? ☐ Yes ☐ No

If yes, explain: ______________________________________________

### How often have you taken oral steroids (e.g., cortisone, prednisone, etc.)?

| | < 5 | > 5 | Reason for Use |
|---|---|---|---|
| Infancy/Childhood | | | |
| Teen | | | |
| Adulthood | | | |

## Health Goals

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

______________________________

______________________________

When was the last time you felt well? ______________________________

______________________________

______________________________

Did something trigger your change in health? ______________________________

______________________________

______________________________

What makes you feel better? ______________________________

______________________________

______________________________

What makes you feel worse? ______________________________

______________________________

______________________________

How does your condition affect you? ______________________________

______________________________

______________________________

What do you think is happening and why? ______________________________

______________________________

______________________________

What do you feel needs to happen for you to get better? ______________________________

______________________________

______________________________

# Toxin Exposure Questionnaire

Patient Name________________________________________ Date______________

**Please check the best response for each of the following questions. Your provider will discuss your answers with you.**

| FOOD & WATER | YES | SOMETIMES | IN THE PAST | NO |
|---|---|---|---|---|
| **1.** Do you consume conventionally-farmed (non-organic) or genetically-modified fruits and vegetables? | ☐ | ☐ | ☐ | ☐ |
| **2.** Do you consume conventionally-raised (non-organic) animal products (i.e., meat, poultry, dairy, eggs) | ☐ | ☐ | ☐ | ☐ |
| **3.** Do you consume canned or farmed fish and seafood? | ☐ | ☐ | ☐ | ☐ |
| **4.** Do you consume processed foods (i.e., foods with added artificial colors, flavors, preservatives, or sweeteners), deep-fried, or fast foods? | ☐ | ☐ | ☐ | ☐ |
| **5.** Do you drink water from a well, spring, or cistern, or from plumbing pipes or fixtures installed before 1986? | ☐ | ☐ | ☐ | ☐ |
| **6.** Do you drink sodas, juices, or other beverages with natural or refined sweeteners (i.e., high-fructose corn syrup, cane sugar, agave nectar, Stevia, undiluted fruit juice, etc.) or artificial sweeteners (i.e., NutraSweet/Equal/aspartame, Sweet'N Low/saccharine, Splenda/sucralose, Sunett/Sweet One/acesulfame K, neotame)? | ☐ | ☐ | ☐ | ☐ |

| HOME & WORK ENVIRONMENT | YES | SOMETIMES | IN THE PAST | NO |
|---|---|---|---|---|
| **1.** Do you live in an apartment or home built before 1978, or in a mobile home, boat, or RV? | ☐ | ☐ | ☐ | ☐ |
| **2.** Does your home or workplace contain new construction materials or furniture (i.e., paint, laminate flooring, particle board, new carpeting, bedding, furniture, etc.)? | ☐ | ☐ | ☐ | ☐ |
| **3.** Does your home or workplace show signs of mold or water damage (i.e., cracking paint, ceiling leaks, decaying insulation or foam, visible mold, or damp windows, basement, or crawlspaces, etc.)? | ☐ | ☐ | ☐ | ☐ |
| **4.** Are you exposed to toxic substances (i.e., treated lumber, lead paint, paint chips or dust, broken mercury thermometers or fluorescent bulbs, etc.) at home or work? | ☐ | ☐ | ☐ | ☐ |
| **5.** Are you exposed to conventional cleaning chemicals, disinfectants, hand sanitizers, air fresheners, scented candles, or other scented products at home or work? | ☐ | ☐ | ☐ | ☐ |
| **6.** Do you live or work near an industrial pollution source (i.e., highway, factory, incinerator, gas station, power plant, etc.)? | ☐ | ☐ | ☐ | ☐ |
| **7.** Do you live or work near a source of electromagnetic radiation (i.e., cell phone tower, high-voltage power lines, or other known source)? | ☐ | ☐ | ☐ | ☐ |
| **8.** Do you live or work in an agricultural area or another type of area where you are exposed to herbicides, pesticides, or fungicides? | ☐ | ☐ | ☐ | ☐ |
| **9.** Do you have wood-burning, propane, or gas stoves or appliances at home or work? | ☐ | ☐ | ☐ | ☐ |
| **10.** Do you live or work in a sealed building with recirculated air? | ☐ | ☐ | ☐ | ☐ |


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| TRAVEL & RECREATION | YES | SOMETIMES | IN THE PAST | NO |
|---|---|---|---|---|
| **1.** Do you frequent parks, golf courses, or other outdoor or recreational areas treated with herbicides, pesticides, or fungicides? | ☐ | ☐ | ☐ | ☐ |
| **2.** Do you travel by air? | ☐ | ☐ | ☐ | ☐ |
| **3.** Do you run or bike to work along busy streets? | ☐ | ☐ | ☐ | ☐ |
| **4.** Do you get sick while camping, hiking, or traveling (foreign or domestic)? | ☐ | ☐ | ☐ | ☐ |
| **5.** Are you exposed to toxic chemicals as a result of a hobby (i.e., paints, photo-developing chemicals, epoxy adhesives, glues, varnishes, etc.)? | ☐ | ☐ | ☐ | ☐ |

| MEDICAL & PERSONAL CARE | YES | SOMETIMES | IN THE PAST | NO |
|---|---|---|---|---|
| **1.** Are you sensitive to personal care products like lotions, moisturizers, toners, shampoos, conditioners, shaving creams, and soaps? | ☐ | ☐ | ☐ | ☐ |
| **2.** Are you sensitive to smoke, perfumes, fragrances, cleaning products, gasoline, or other fumes? | ☐ | ☐ | ☐ | ☐ |
| **3.** Do you smoke, or are you often exposed to second-hand smoke? | ☐ | ☐ | ☐ | ☐ |
| **4.** Do you have a history of heavy use of alcohol, or recreational or prescription drugs? | ☐ | ☐ | ☐ | ☐ |
| **5.** Do you have any unusual reactions to anesthesia or to prescription or over-the-counter medications? | ☐ | ☐ | ☐ | ☐ |
| **6.** Do you have root canals, extracted teeth, "silver" fillings, crowns, dental sealants, dentures, retainers, aligning trays, braces, mouth guards, dental implants, etc.? | ☐ | ☐ | ☐ | ☐ |
| **7.** Do you have food reactions, sensitivities, or intolerances? Do you have environmental allergies? | ☐ | ☐ | ☐ | ☐ |
| **8.** Do you have any artificial materials in your body (implants, pins, joints, etc.)? | ☐ | ☐ | ☐ | ☐ |
| **9.** Do you lead a high-stress lifestyle, or have you experienced a stressful or traumatic event? | ☐ | ☐ | ☐ | ☐ |

**Note:** For more information on the questions included here, please see the **Toxin Exposure Questionnaire—Bibliography** in IFM's Clinical Practice Toolkit.

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# Adverse Childhood Experience (ACE) Questionnaire
## Finding your ACE Score ra hbr 10 24 06

**While you were growing up, during your first 18 years of life:**

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   **or**
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 ________

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   **or**
   **Ever** hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 ________

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   **or**
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 ________

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   **or**
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 ________

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   **or**
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 ________

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 ________

7. Was your mother or stepmother:
   **Often** pushed, grabbed, slapped, or had something thrown at her?
   **or**
   **Sometimes or often** kicked, bitten, hit with a fist, or hit with something hard?
   **or**
   **Ever** repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 ________

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 ________

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 ________

10. Did a household member go to prison?
    Yes No If yes enter 1 ________

**Now add up your "Yes" answers: _______ This is your ACE Score**

# Biotoxin Illness Symptom Cluster Score Sheet

| Symptom | |
|---|---|
| Fatigue | ☐ |

| Symptom | |
|---|---|
| Concentration problems | ☐ |

| Symptom | |
|---|---|
| Memory | ☐ |
| Problem finding words | ☐ |

| Symptom | |
|---|---|
| Unusual skin sensations, tingling | ☐ |

| Symptom | |
|---|---|
| Weakness | ☐ |
| Achiness | ☐ |
| Headaches | ☐ |
| Difficult new knowledge assimilation | ☐ |
| Light sensitivity | ☐ |

| Symptom | |
|---|---|
| Shortness of breath | ☐ |
| Sinus congestion | ☐ |

| Symptom | |
|---|---|
| Nasal drainage | ☐ |

| Symptom | |
|---|---|
| Joint pain | ☐ |
| Morning stiffness | ☐ |
| Muscle cramps | ☐ |

| Symptom | |
|---|---|
| Cough | ☐ |
| Increased thirst | ☐ |
| Confusion | ☐ |

| Symptom | |
|---|---|
| Appetite swings | ☐ |
| Body temperature dysregulation | ☐ |
| Urinary frequency / urgency | ☐ |

| Symptom | |
|---|---|
| Red eyes | ☐ |
| Blurred vision | ☐ |
| Excessive sweating or nights sweats | ☐ |
| Mood swings | ☐ |
| Unusual pain - especially sharp stabbing “icepick” pain | ☐ |

| Symptom | |
|---|---|
| Abdominal tenderness or pain | ☐ |
| Diarrhea / loose stools | ☐ |
| Numbness | ☐ |

| Symptom | |
|---|---|
| Eyes tearing up | ☐ |
| Disorientation | ☐ |
| Metallic taste in mouth | ☐ |

| Symptom | |
|---|---|
| Vertigo | ☐ |
| Static electric shocks | ☐ |

One point per big box

**Total Score** ______________________

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# Candida Screening Questionnaire

Answering these questions and adding up the scores will help you and your clinician decide if yeast may be contributing to your health problems.

For each section read the directions and score as indicated. Total your score and record it at the end of the section. Add the totals for each section to get your Grand Total Score.

## Section A: History

For each "yes" answer, circle the point score for that question. Add up the total score and record it at the end of this section.

| | SECTION A: HISTORY | | Point Score |
|---|---|---|---|
| 1 | Have you taken tetracyclines (Sumycin, Panmycino, Vibramycin, Minocin, etc.) or other antibiotics for acne for one month (or longer)? | | 35 |
| 2 | Have you, at any time in your life, taken other "broad spectrum" antibiotics* for respiratory, urinary, or other infections (for two months or longer, or in shorter courses four or more times in a one-year period)? | | 35 |
| 3 | Have you taken a broad spectrum antibiotic drug*, even a single course? | | 6 |
| 4 | Have you, at any time in your life, been bothered by persistent prostatitis, vaginitis, or other problems affecting your reproductive organs? | | 25 |
| 5 | Have you been pregnant? | *One time?* | 3 |
| | | *Two or more times?* | 5 |
| 6 | Have you taken birth control pills? | *For six months to two years?* | 8 |
| | | *For more than two years?* | 15 |
| 7 | Have you taken prednisone, decadron or other cortisone-type drugs? | *For two weeks or less?* | 6 |
| | | *For more than two weeks?* | 15 |
| 8 | Does exposure to perfumes, insecticides, fabric shop odors, and other chemicals provoke symptoms? | *Mild symptoms?* | 5 |
| | | *Moderate to severe symptoms?* | 20 |
| 9 | Are your symptoms worse on damp, muggy days or in moldy places? | | 20 |
| 10 | Have you had athlete's foot, ringworm, "jock itch," or other chronic fungus infections of the skin or nails? | *Mild to moderate?* | 10 |
| | | *Severe or persistent?* | 20 |
| 11 | Do you crave sugar? | | 10 |
| 12 | Do you crave breads? | | 10 |
| 13 | Do you crave alcoholic beverages? | | 10 |
| 14 | Does tobacco smoke really bother you? | | 10 |
| | | Section A Total | ______ |

*Including Keflex, ampicillin, amoxicillin, Ceclor, Bactrim, and Septra. Such antibiotics kill off "good germs" while they're killing off those which cause infection.



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### Section B: Major Symptoms

For each of your symptoms, circle the appropriate figure in the point score column. Add up the total score and record it at the end of this section.

| SECTION B: MAJOR SYMPTOMS | Point Score | | |
|---|---|---|---|
| | *Occasional and/or Mild* | *Frequent and/or Moderately Severe* | *Very Frequent and/or Very Severe or Disabling* |
| **1** Fatigue or lethargy | 3 | 6 | 9 |
| **2** Feeling of being "drained" | 3 | 6 | 9 |
| **3** Poor memory | 3 | 6 | 9 |
| **4** Depression | 3 | 6 | 9 |
| **5** Feeling "spacey" or "unreal" | 3 | 6 | 9 |
| **6** Inability to make decisions | 3 | 6 | 9 |
| **7** Numbness, burning, or tingling | 3 | 6 | 9 |
| **8** Muscle aches or weakness | 3 | 6 | 9 |
| **9** Pain and/or swelling in joints | 3 | 6 | 9 |
| **10** Abdominal pain | 3 | 6 | 9 |
| **11** Constipation | 3 | 6 | 9 |
| **12** Diarrhea | 3 | 6 | 9 |
| **13** Bloating, belching, or intestinal gas | 3 | 6 | 9 |
| **14** Troublesome vaginal burning, itching, or discharge | 3 | 6 | 9 |
| **15** Persistent vaginal burning or itching | 3 | 6 | 9 |
| **16** Prostatitis | 3 | 6 | 9 |
| **17** Impotence | 3 | 6 | 9 |
| **18** Loss of sexual desire or feeling | 3 | 6 | 9 |
| **19** Endometriosis or infertility | 3 | 6 | 9 |
| **20** Cramps and/or other menstrual irregularities | 3 | 6 | 9 |
| **21** Premenstrual tension | 3 | 6 | 9 |
| **22** Attacks of anxiety or crying | 3 | 6 | 9 |
| **23** Cold hands or feet and/or chilliness | 3 | 6 | 9 |
| **24** Shaking or irritable when hungry | 3 | 6 | 9 |
| | | **Section B Total** | ________ |

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### Section C: Other Symptoms*

For each of your symptoms, circle the appropriate figure in the point score column. Add up the total score and record it at the end of this section.

| SECTION C: OTHER SYMPTOMS | Point Score | | |
|---|---|---|---|
| | *Occasional and/or Mild* | *Frequent and/or Moderately Severe* | *Very Frequent and/or Very Severe or Disabling* |
| **1** Drowsiness | 1 | 2 | 3 |
| **2** Irritability or jitteriness | 1 | 2 | 3 |
| **3** Uncoordination | 1 | 2 | 3 |
| **4** Inability to concentrate | 1 | 2 | 3 |
| **5** Frequent mood swings | 1 | 2 | 3 |
| **6** Headache | 1 | 2 | 3 |
| **7** Dizziness/loss of balance | 1 | 2 | 3 |
| **8** Pressure above ears, feeling of head swelling | 1 | 2 | 3 |
| **9** Tendency to bruise easily | 1 | 2 | 3 |
| **10** Chronic rashes or itching | 1 | 2 | 3 |
| **13** Numbness, tingling | 1 | 2 | 3 |
| **13** Indigestion or heartburn | 1 | 2 | 3 |
| **14** Food sensitivity or intolerance | 1 | 2 | 3 |
| **14** Mucus in stools | 1 | 2 | 3 |
| **15** Rectal itching | 1 | 2 | 3 |
| **16** Dry mouth or throat | 1 | 2 | 3 |
| **17** Rash or blisters in mouth | 1 | 2 | 3 |
| **18** Bad breath | 1 | 2 | 3 |
| **19** Foot, body, or hair odor not relieved by washing | 1 | 2 | 3 |
| **20** Nasal congestion or postnasal drip | 1 | 2 | 3 |
| **21** Nasal itching | 1 | 2 | 3 |
| **22** Sore throat | 1 | 2 | 3 |
| **23** Laryngitis, loss of voice | 1 | 2 | 3 |
| **24** Cough or recurrent bronchitis | 1 | 2 | 3 |
| **25** Pain or tightness in chest | 1 | 2 | 3 |

*While the symptoms in this section commonly occur in people with yeast-connected illness, they are also found in other individuals

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| SECTION C: OTHER SYMPTOMS | Point Score | | |
|---|---|---|---|
| | *Occasional and/or Mild* | *Frequent and/ or Moderately Severe* | *Very Frequent and/or Very Severe or Disabling* |
| **26** Wheezing or shortness of breath | 1 | 2 | 3 |
| **27** Urgency or urinary frequency | 1 | 2 | 3 |
| **28** Burning on urination | 1 | 2 | 3 |
| **29** Spots in front of eyes or erratic vision | 1 | 2 | 3 |
| **30** Burning or tearing of eyes | 1 | 2 | 3 |
| **31** Recurrent infections or fluid in ears | 1 | 2 | 3 |
| **32** Ear pain or deafness | 1 | 2 | 3 |
| | | **Section C Total** | ________ |

**Section A Total Score** ____________

**Section B Total Score** ____________

**Section C Total Score** ____________

**Grand Total Score** ____________

The Grand Total Score will help you and your clinician decide if your health problems are yeast connected. Scores in women will run higher as seven items in the questionnaire apply exclusively to women, while only two apply exclusively to men.

| Men | Women | Interpretation |
|---|---|---|
| 40 or below | 60 or below | Yeast is less apt to cause health problems |
| 41-90 | 61-121 | Yeast-connected health problems are possibly present |
| 91-140 | 121-180 | Yeast-connected health problems are probably present |
| 141 or higher | 181 or higher | Yeast-connected health problems are almost certainly present |

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# Crista Mold Questionnaire

Date Taken

CHECK **ALL SYMPTOMS** EXPERIENCED IN THE **PAST 3-6 MONTHS**

## CATEGORY 1

- ☐ Brain fog
- ☐ Feel tired all the time
- ☐ Frequent runny nose
- ☐ Blow your nose often
- ☐ Sneezing
- ☐ Sinusitis
- ☐ Post-nasal drip
- ☐ Nose bleeds
- ☐ Swollen glands
- ☐ Shortness of breath
- ☐ Frequent yawning or sighing
- ☐ Heart palpitations
- ☐ Headaches
- ☐ Hay fever
- ☐ Eye irritation
- ☐ Blurry vision
- ☐ Frequent change in vision
- ☐ Allergies
- ☐ Dark circles under eyes
- ☐ Sensitivity to sunlight
- ☐ Nervousness/can't settle
- ☐ Low mood or depressed
- ☐ Feeling overwhelmed
- ☐ Episodic/chronic dry cough
- ☐ Irritated lungs
- ☐ Blood-streaked mucous
- ☐ Nasal polyps
- ☐ Coated tongue
- ☐ Sores in the mouth
- ☐ Bumps on back of throat
- ☐ Thrush
- ☐ Sore or itchy ear canals
- ☐ Ringing in the ears
- ☐ Bothered by loud noises
- ☐ Skin rash
- ☐ Burning or itchy skin
- ☐ Easy bruising
- ☐ Spider veins
- ☐ Bothered by tags and seams on clothing
- ☐ Anemia
- ☐ Protruding veins on limbs
- ☐ Lower extremity edema
- ☐ Clear your throat often
- ☐ Sore throat
- ☐ Frequent colds
- ☐ Delayed recovery from colds
- ☐ Exhausted from exercise
- ☐ Frequent static shocks
- ☐ Increased thirst
- ☐ Trouble sleeping
- ☐ Feeling of internal vibration
- ☐ Dizziness
- ☐ Vertigo
- ☐ Drunken feeling
- ☐ Frequent urination
- ☐ Yeast infection
- ☐ Change in appetite
- ☐ Intestinal gas
- ☐ Nausea
- ☐ Feeling bloated
- ☐ Constipation
- ☐ Crave sweets
- ☐ Crave alcohol

TOTAL **CATEGORY 1** BOXES MARKED: _______

0-4 boxes marked = Score 0
5-9 boxes marked = Score 1
10-15 boxes marked = Score 2
16+ boxes marked = Score 3

CATEGORY **1** SCORE _______

## CATEGORY 2

- ☐ Wheezing
- ☐ Asthma
- ☐ Burning lungs
- ☐ Recurrent respiratory infections
- ☐ Migraine
- ☐ Allergies aren't well controlled by medication
- ☐ Voice sounds nasally
- ☐ Plugged or clogged ears
- ☐ Chronic sinusitis
- ☐ Vomiting
- ☐ Alternating constipation/ diarrhea
- ☐ Diarrhea
- ☐ Irritable bowel
- ☐ Food sensitivities
- ☐ Chemical sensitivities
- ☐ Abnormal reaction to antibiotics
- ☐ Epstein-Barr virus
- ☐ Recurrent yeast infections
- ☐ Bacterial vaginosis
- ☐ Recurrent athlete's foot, jock itch, or toenail fungus
- ☐ Peeling/sloughing skin
- ☐ Episodes of fast heart rate
- ☐ Chest pain
- ☐ Raynaud's syndrome
- ☐ Non-obstructive sleep apnea
- ☐ Difficulty thinking clearly
- ☐ Disorientation
- ☐ Balance Issues
- ☐ Slow reflexes
- ☐ Incoordination
- ☐ Numbness or tingling
- ☐ Nerve pains
- ☐ Unexplained menstrual changes
- ☐ Overactive bladder
- ☐ Bladder infection
- ☐ React to musty spaces

TOTAL **CATEGORY 2** BOXES MARKED: _______

0-2 boxes marked = Score 0
3-5 boxes marked = Score 1
6-9 boxes marked = Score 2
10+ boxes marked = Score 3

CATEGORY **2** SCORE _______

Continue to Category 3


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CHECK **ALL SYMPTOMS** EXPERIENCED IN THE **PAST 3-6 MONTHS**

## CATEGORY **3**

- ☐ Daily use of sinus spray, sinus prescription, or Neti pot
- ☐ Sinus surgery at any time in your life
- ☐ Chronic inflammatory response syndrome (CIRS)
- ☐ MARCoNS
- ☐ Peanut allergy
- ☐ Chronic fatigue syndrome
- ☐ Difficulty walking
- ☐ Dysautonomia
- ☐ Postural Tachycardia Syndrome (PoTS)
- ☐ Hearing loss
- ☐ Confusion
- ☐ Dementia
- ☐ Memory loss
- ☐ Tremors
- ☐ Sarcoidosis
- ☐ Asthma that's difficult to control with medication
- ☐ Idiopathic pneumonitis
- ☐ Lung scarring or nodules
- ☐ Respiratory distress
- ☐ Aspergillosis
- ☐ Arrhythmia
- ☐ Coagulation abnormalities
- ☐ Atriovenous abnormalities
- ☐ Churg Strauss Syndrome
- ☐ Histamine intolerance
- ☐ Erythema nodosum
- ☐ Eosinophilic esophagitis
- ☐ Ulcer
- ☐ Non-celiac intestinal disease
- ☐ Blood in stool
- ☐ Cyclical vomiting syndrome
- ☐ Liver pain or swelling
- ☐ Fatty liver
- ☐ Non-alcoholic steatohepatitis (NASH)
- ☐ Interstitial cystitis
- ☐ Kidney pain or swelling
- ☐ Kidney disease
- ☐ Nephritis
- ☐ Chronic pelvic pain
- ☐ Infertility
- ☐ Hepatocellular carcinoma
- ☐ Previous or current cancer diagnosis
- ☐ Mast cell activation syndrome (MCAS)
- ☐ Exposure to water-damaged building any time in your life
- ☐ Exposure to mold
- ☐ Positive Shoemaker tests

TOTAL **CATEGORY 3** BOXES MARKED: ________

Score 1 for each box marked
Boxes marked and score will
be the same for this category

CATEGORY **3** SCORE ________

Continue to Results

## TOTAL MOLD RISK **RESULTS**

Gather your Category scores
from the 3 previous categories

**CATEGORY 1** SCORE: ________ +
**CATEGORY 2** SCORE: ________ +
**CATEGORY 3** SCORE: ________ = **TOTAL MOLD RISK** ________

TOTAL MOLD RISK
## RESULTS

**0-4 = Not Likely Mold Sickness**
**5-9 = Possible Mold Sickness**
**10+ = Probable Mold or Biotoxin Sickness**

**OTHER THINGS TO CONSIDER:**

- LYME DISEASE, MSIDS, TICK-BORNE COINFECTIONS (USE HORROWITZ MSIDS-LYME QUESTIONNAIRE)
- OTHER ENVIRONMENTAL TOXINS (IE: MERCURY, LEAD, PM2.5, GLYPHOSATE, PESTICIDES, VOCs)
- INTESTINAL PARASITES, CHRONIC VIRAL SYNDROMES, OR OTHER STEALTH INFECTIONS
- FOOD SENSITIVITIES
- CVIDS OR IMMUNODEFICIENCY SYNDROMES

This tool is intended as a clinical information aid, and is not intended to diagnose or treat disease. Symptoms listed have been reported in mold illness patients. Not all symptoms have been proven in studies.


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# Horowitz/MSIDS 38 Point Symptom Checklist

Print your name: ____________ Date: ________ Male: ___ Female: ___ Age: ___

**This is a questionnaire to determine the probability of your having Lyme disease and other tick borne disorders.**

Think about how you have been feeling over the previous month and how often you have been bothered by the following:

## Section 1

| | Frequency | | | |
|---|---|---|---|---|
| | **never** | **sometimes** | **most of the time** | **all of the time** |
| Unexplained fevers, sweats, chills, or flushing | 0 | 1 | 2 | 3 |
| Unexplained weight change...loss or gain | 0 | 1 | 2 | 3 |
| Fatigue, tiredness | 0 | 1 | 2 | 3 |
| Unexplained hair loss | 0 | 1 | 2 | 3 |
| Swollen glands | 0 | 1 | 2 | 3 |
| Sore throat | 0 | 1 | 2 | 3 |
| Testicular pain/pelvic pain | 0 | 1 | 2 | 3 |
| Unexplained menstrual irregularity | 0 | 1 | 2 | 3 |
| Unexplained breast milk production, breast pain | 0 | 1 | 2 | 3 |
| Irritable bladder or bladder dysfunction | 0 | 1 | 2 | 3 |
| Sexual dysfunction/loss of libido | 0 | 1 | 2 | 3 |
| Upset stomach | 0 | 1 | 2 | 3 |
| Change in bowel function (constipation or diarrhea) | 0 | 1 | 2 | 3 |
| Chest pain or rib soreness | 0 | 1 | 2 | 3 |
| Shortness of breath/cough | 0 | 1 | 2 | 3 |
| Heart palpitations, pulse skips, heart block | 0 | 1 | 2 | 3 |
| History of heart murmur or valve prolapse | 0 | 1 | 2 | 3 |
| Joint pain or swelling | 0 | 1 | 2 | 3 |
| Stiffness of the neck or back | 0 | 1 | 2 | 3 |
| Muscle pain or cramps | 0 | 1 | 2 | 3 |
| Twitching of the face or other muscles | 0 | 1 | 2 | 3 |
| Headaches | 0 | 1 | 2 | 3 |
| Neck cracks or neck stiffness | 0 | 1 | 2 | 3 |
| Tingling, numbness, burning or stabbing sensations | 0 | 1 | 2 | 3 |
| Facial paralysis (bells palsy) | 0 | 1 | 2 | 3 |
| Eyes/vision – double, blurry | 0 | 1 | 2 | 3 |
| Ears/hearing – buzzing, ringing, ear pain | 0 | 1 | 2 | 3 |
| Increased motion sickness, vertigo | 0 | 1 | 2 | 3 |
| Lightheadedness, poor balance, difficulty walking | 0 | 1 | 2 | 3 |
| Tremors | 0 | 1 | 2 | 3 |
| Confusion, difficulty thinking | 0 | 1 | 2 | 3 |
| Difficulty with concentration or reading | 0 | 1 | 2 | 3 |
| Forgetfulness, poor short term memory | 0 | 1 | 2 | 3 |

| | | | | |
|---|---|---|---|---|
| Disorientation; getting lost, going to wrong places | 0 | 1 | 2 | 3 |
| Difficulty with speech or writing | 0 | 1 | 2 | 3 |
| Mood swings, irritability, depression | 0 | 1 | 2 | 3 |
| Disturbed sleep – too much, too little, early awake | 0 | 1 | 2 | 3 |
| Exaggerated symptoms or worse hangover from alcohol | 0 | 1 | 2 | 3 |

Please add up your totals from each column, then add up the 4 column totals: _______________ This is your first score.

**Score from Section 1:** ____________

## Section 2

**Now, please check off each incident you can answer yes to with the following questions:**

| | | |
|---|---|---|
| 1. You have had a tick bite with no rash or flu-like symptoms. | _____ | 3 points |
| 2. You have had a tick bite, an Erythema migrans or undefined rash, followed by flu-like symptoms. | _____ | 5 points |
| 3. You live in what is considered a Lyme endemic area. | _____ | 2 points |
| 4. You have a family member diagnosed with Lyme and/or tick borne infections. | _____ | 1 points |
| 5. You experience migratory muscle pain. | _____ | 4 points |
| 6. You experience migratory joint pain. | _____ | 4 points |
| 7. You experience tingling/burning/numbness that migrates and/or comes and goes. | _____ | 4 points |
| 8. You have received a prior diagnosis of Chronic Fatigue Syndrome or Fibromyalgia. | _____ | 3 points |
| 9. You have received a prior diagnosis of a non specific autoimmune disorder (Lupus, MS, Rheumatoid Arthritis). | _____ | 3 points |
| 10. You have had a positive Lyme test (ELISA, Western Blot, PCR). | _____ | 5 points |

**Please add your points from Section 2 _____ + Score from Section 1 _____ = _____ (This is your Ongoing Score)**

## Section 3

1. Thinking about your overall physical health, for how many days during the past 30 days was your physical health not good? _____ Days

2. Thinking about your overall mental health, for how many days during the past 30 days was your mental health not good? _____ Days

0 – 5 days = 1 point | 6 – 12 days = 2 points | 13 – 20 days = 3 points | 21 – 30 days = 4 points

**Please add your points from Section 3 _____ + Ongoing Score _____ = _____**

## Section 4

**Lastly, if on the first Section you rated a '3' for ALL of the following:**

Fatigue **|** Forgetfulness, poor short term memory **|** Joint pain or Swelling **|** Tingling, numbness, burning or stabbing sensations **|** Disturbed sleep – Too Much, Too Little, Early Awake

Please give yourself a 5 and add it to the final score after Section 3 = _______ (This is your **FINAL SCORE**)

O**NLY GIVE YOURSELF THESE 5 POINTS IF YOU RATED "3" for ALL OF THESE SYMPTOMS.**

**FINAL SCORING:**

Now please take your final score and compare it to the scale used by Dr. Horowitz

**0 – 20** Tick Borne Illness not likely | **21-45** Tick Borne Illness possible | **46 and above** Tick Borne Illness highly likely