CHATHAM
CHIROPRACTIC
*A holistic wellness center*
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# What is Functional Medicine?

Functional Medicine determines how and why an illness occurs and restores health by addressing the root causes of the illness. It is a science-based approach that empowers the patient and their practitioner to work together to address the underlying causes of an illness. It involves gathering a detailed history and understanding of each patient's symptoms. After which, testing through bloodwork, urine or stool will be recommended. This will allow a window into each individual's genetic and biochemical makeup and diagnose for certain underlying infectious processes. Based on the results of these tests, the doctor will develop a protocol that will encompass lifestyle modifications, dietary recommendations, vitamins and supplements designed to suit each individual patient's needs to promote their optimal health and wellness.

**Patient information:**

Name: _____ Date Of Birth:_____ Today's Date: _____

Address: _____

Street City State Zip code

Home Phone: ( ) _____ Cell Phone ( ) _____

Email Address _____

Social Security #: _____ □ Male □ Female

Occupation _____

□ Single □ Married □ Divorced □ Widowed

Who may we thank for referring you to us? _____

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## CONSENT AND DISCLAIMER

Dr. Sonal Dalal provides functional medicine to offer an individualized approach to health. The objective of an initial examination is to consider health from a holistic view, with an assessment of physical, mental and emotional condition.

When used correctly under the supervision of a qualified functional provider, this approach to health can be an integral part of preventative care and ailment management.

NOTE: Functional medicine is not intended to be a substitute for allopathic or traditional medicine. Functional medicine is complementary, and the therapy and information offered should not be construed by you, the client, to be a clinical medical diagnosis of any disease or injury. You must consult with your physician for any serious medical condition.

**Please read carefully, initial each statement and sign at the bottom.**

_____I confirm that I have not been advised to refrain from seeking or following conventional medical treatment. I recognize that input from my primary care physician is welcome and encouraged, and the information will be used to augment the functional medicine process.

_____While Dr. Dalal has had extensive training in the functional medicine sciences, I acknowledge that she is not a medical doctor.

_____By signing on as a client with Dr. Dalal I certify that I currently have a primary care provider and that I will notify Dr. Dalal if I withdraw as a patient of such primary care provider.

_____I confirm that any prescription medications I am taking under the care of my primary care provider will not be withdrawn without the prescribing primary care physician's supervision.

_____I understand that though Dr. Dalal may recommend supplements and nutritional plans, no such suggested product or idea should be construed as pharmaceutical prescription or medication.

_____I understand that any recommended supplements may not be FDA approved and Dr. Dalal does not make any assertions or guarantees regarding ingredients, side-effects, or effectiveness.

_____I confirm that I will provide a complete and accurate health history to Dr. Dalal.

_____I fully understand the risks, benefits, and alternatives to functional medicine including how it differs from traditional/allopathic medicine and I consent to the functional treatments offered or recommended to me by Dr. Dalal.

Signature: _____

If patient is under 18 years, parental signature is required

Date:_____

**FINANCIAL RESPONSIBILITY ACKNOWLEDGMENT**

I understand that a block of time has been set aside for my private appointment, and that a 24-hour notification is required if I must cancel. I understand that there is a full charge for appointments canceled less than 24 hours in advance.

I understand that Dr. Sonal Dalal's functional medicine services are cash-pay only. Insurance and health plans are not accepted. As such I am expected to pay the total cost for all services rendered at the time of my visit. I may request a billing statement after payment is remitted.

I understand it is my responsibility to know my own insurance benefits including reimbursement options, exclusions, and any pre-authorization requirements.

I understand that payment is due at the time services are rendered, unless other arrangements have been made prior to the appointment.

I understand that phone consultations will be billed at the usual hourly rate.

I understand that current fees for consultations are as follows, but that there may be changes in the fee structure in the future.

| | | |
|---|---|---|
| Initial Consultation | $200 | 45-minutes |
| Test Result Review (includes 3 follow-up visits) | $600 per test | 60-minutes |

I have read the above financial policies, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that regardless of my insurance company contributions or reimbursement, if any, I assume financial responsibility and will pay all service charges at the time service is rendered.

Signature: _____

If patient is under 18 years, parental signature is required

Date:_____

## THIRD-PARTY PLATFORM CONSENT

As part of receiving functional consultations from Dr. Sonal Dalal, I understand and consent to use of third-party video or phone communication software and platforms, including but not limited to Zoom, FaceTime, etc.

I further understand that the agencies that certify health technology – the Office of the National Coordinator for Health Information Technology and the National Institute of Standards and Technology – do "not assume the task of certifying software and off-the-shelf products", nor accredit independent agencies to do HIPAA certifications. Additionally, the HITECH Act only provides for testing and certification of Electronic Health Records (EHR) programs and modules.

I understand that while these platforms affirm that they implement the controls needed to secure protected health information (PHI) according to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) Security Rule, Breach Notification Rule, and the applicable parts of the Privacy, Dr. Dalal is not involved in this process and cannot guarantee its efficacy.

I hereby agree to hold Dr. Sonal Dalal harmless from all claims, liabilities, or damages resulting from a third-party platform's breach of privacy or failure to meet any of its security measures.

Signature: _____

If patient is under 18 years, parental signature is required

Date:_____

**Website Privacy & Data Use Disclaimer**

Dr. Sonal Dalal and her employees collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voicemails, and online submissions, that are either required by law or necessary for client onboarding.

Financial and/or medical information that you provide to us in writing, online, on the phone (including information left on voicemails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, sell, or disseminate any information about clients who inquire about or actually receive our services. Such information is considered personal protected information and is confidential. We understand that sharing such information is restricted by law, except as allowed by a signed Release of Information Authorization.

Personal information is only used as is reasonably necessary to provide you with health or counseling services which may require communication between Dr. Dalal and health care providers, pharmacies, insurance companies, and other providers necessary to verify your medical information is accurate and determine the type of services you need.

Dr. Sonal Dalal is compliant with HIPAA regulations. You may contact our office at (973) 635-2290 to learn more about our privacy policy and how we collect, keep, and process your private information in accordance with these laws.

**Website FDA Supplement Disclaimer**

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This Site is not intended to provide diagnosis, treatment or medical advice. Supplements, services, information and other content provided on this Site, including information that may be provided on this Site directly or by linking to third-party websites are provided for informational purposes only. Please consult with a physician or other healthcare professional regarding any medical or health related diagnosis or treatment options.

Information on this Site including any product label or packaging should not be considered as a substitute for advice from a healthcare professional. Dr. Dalal recommends against self-management of health issues. Information on this Site is not comprehensive and does not cover all physical conditions or their treatment. Contact your healthcare professional promptly should you have any health-related questions.

Individuals may react differently to different supplements. You should consult your physician about interactions between medications you are taking and supplements. Comments made on this Site by any employee, officer, or agent of Dr. Dalal are strictly their own personal views made in their own personal capacity and based on their personal experience and should not be understood to apply to any other person.

Contact the manufacturer directly for clarification as to product labeling and packaging details and recommended use.

Dr. Sonal Dalal is not liable for any information provided on this Site with regard to recommendations regarding supplements for any health purposes. Consult with a healthcare professional before starting any diet, supplement or exercise program. Dr. Dalal makes no guarantee or warranty with respect to any supplements or services sold.

Dr. Sonal Dalal is not responsible for any damages for information or services provided.

# FUNCTIONAL MEDICINE INITIAL INTAKE FORM

## GENERAL INFORMATION

Full Name _____

Date of Birth _____ Age _____ Gender ☐ Male ☐ Female

Job Title _____ Nature of Occupation / Business _____

## CONTACT INFORMATION

Address _____
STREET ADDRESS CITY STATE ZIP

Cell Phone _____ Home Phone _____ Work Phone _____

Email Address _____

Emergency Contact Name _____ Emergency Number _____

Emergency Contact Address _____
STREET ADDRESS CITY STATE ZIP

## DOCTOR INFORMATION

Physician's Name _____ Phone Number _____

**Who referred you to us?**

☐ Google _____

☐ Social Media _____

☐ Family Member _____

☐ Friend _____

☐ Other _____

# FUNCTIONAL MEDICINE QUESTIONNAIRE

## ALLERGIES

| MEDICATION | REACTION |
|---|---|
| | |
| | |
| | |

| SUPPLEMENT | REACTION |
|---|---|
| | |
| | |
| | |

| FOOD | REACTION |
|---|---|
| | |
| | |
| | |

## COMPLAINTS & CONCERNS

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

What are your top three areas of concern?

1. 
2. 
3. 

When was the last time you felt well?

Did something trigger your change in health?

What makes you feel worse?

What makes you feel better?

*Please list the top three current and ongoing problems in order of priority:*

| DESCRIBE PROBLEM | MILD | MODERATE | SEVERE |
|---|---|---|---|
| Ex. Headaches | | X | |
| | | | |
| | | | |
| | | | |

| PRIOR TREATMENT / THERAPEUTIC APPROACH | EXCELLENT | GOOD | FAIR |
|---|---|---|---|
| Ex. Elimination Diet | X | | |
| | | | |
| | | | |
| | | | |

## MEDICAL HISTORY – DISEASES / DIAGNOSES / CONDITIONS

*Check the box next to the conditions you have and provide date of onset.*

### GASTROINTESTINAL

- ☐ Irritable Bowel Syndrome _____
- ☐ Inflammatory Bowel Disease _____
- ☐ Crohn s Disease _____
- ☐ Ulcerative Colitis _____
- ☐ Gastritis or Peptic Ulcer Disease _____
- ☐ GERD (reflux) _____
- ☐ Celiac Disease _____
- ☐ Constipation _____
- ☐ Loose Stools _____
- ☐ Bloating _____
- ☐ Flatulence (gas) _____
- ☐ Other _____

### CARDIOVASCULAR

- ☐ Heart Attack _____
- ☐ Other Heart Disease _____
- ☐ Stroke _____
- ☐ Elevated Cholesterol Arrythmia _____
- ☐ (irregular heart rate) _____
- ☐ Other _____
- ☐ Hypertension (high blood pressure) _____
- ☐ Rheumatic Fever _____
- ☐ Mitral Valve Prolapse _____

## METABOLIC / ENDOCRINE

- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes
- ☐ Hypoglycemia
- ☐ Insulin Resistance / Pre-Diabetes
- ☐ Hypothyroidism (low thyroid)
- ☐ Hyperthyroidism (overactive thyroid)
- ☐ Polycystic Ovarian Syndrome (PCOS)
- ☐ Infertility
- ☐ Other
- ☐ Frequent Weight Fluctuations
- ☐ Bulimia
- ☐ Anorexia
- ☐ Binge Eating Disorder
- ☐ Night Eating Syndrome
- ☐ Eating Disorder (non-specific)

## CANCER

- ☐ Lung Cancer
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Other
- ☐ Ovarian Cancer
- ☐ Prostate Cancer
- ☐ Skin Cancer

## GENITOURINARY

- ☐ Kidney Stones
- ☐ Gout
- ☐ Interstitial Cystitis
- ☐ Frequent Urinary Tract Infections
- ☐ Other
- ☐ Frequent Yeast Infections
- ☐ Erectile and/or Sexual Dysfunction

## MUSCULOSKELETAL / PAIN

- ☐ Osteoarthritis
- ☐ Fibromyalgia
- ☐ Other
- ☐ Chronic Pain

## INFLAMMATORY / IMMUNE

- ☐ Chronic Fatigue Syndrome
- ☐ Autoimmune Disease
- ☐ Rheumatoid Arthritis
- ☐ Lupus SLE
- ☐ Immune Deficiency Disease
- ☐ Herpes-Genital
- ☐ Other
- ☐ Severe Infection Disease
- ☐ Food Allergies
- ☐ Poor Immune Function
- ☐ Environmental Allergies
- ☐ Multiple Chemical Sensitivities
- ☐ Latex Allergy

## RESPIRATORY DISEASES

- ☐ Asthma Chronic _____
- ☐ Sinusitis _____
- ☐ Bronchitis _____
- ☐ Emphysema _____
- ☐ Pneumonia _____
- ☐ Tuberculosis _____
- ☐ Sleep Apnea _____

## SKIN DISEASES

- ☐ Eczema _____
- ☐ Psoriasis _____
- ☐ Acne _____
- ☐ Other _____
- ☐ Melanoma _____
- ☐ Skin Cancer _____

## NEUROLOGIC / MOOD

- ☐ Depression _____
- ☐ Anxiety _____
- ☐ Bipolar Disorder _____
- ☐ Headaches _____
- ☐ Migraines _____
- ☐ ADD/ADHD _____
- ☐ Autism _____
- ☐ Other _____
- ☐ Mild Cognitive Impairment _____
- ☐ Memory Problems _____
- ☐ Parkinson's Disease _____
- ☐ Multiple Sclerosis _____
- ☐ ALS _____
- ☐ Seizures _____

## INJURIES

*Check box if yes:* ☐ Back Injury ☐ Head Injury ☐ Neck Injury ☐ Broken Bones

## SURGERIES

*Check box if yes and provide date of surgery:*

- ☐ Appendectomy _____
- ☐ Hysterectomy +/– Ovaries Gall _____
- ☐ Bladder _____
- ☐ Hernia _____
- ☐ Tonsillectomy _____
- ☐ Dental Surgery _____
- ☐ Joint Replacement: Knee / Hip _____
- ☐ Other
- ☐ Spinal Surgery _____
- ☐ Heart Surgery: Bypass Valve _____
- ☐ Angioplasty or Stent _____
- ☐ Pacemaker _____

## HOSPITALIZATIONS

| DATE | REASON |
|---|---|
| | |
| | |
| | |
| | |

☐ NONE

## GYNECOLOGIC HISTORY (for women only)

### OBSTETRIC HISTORY

*Check box if yes and provide number:*

☐ Pregnancies _____ ☐ Baby Over 8 Pounds _____ ☐ Abortion _____

☐ Miscarriage _____ ☐ Living Children _____ ☐ Toxemia

☐ Vaginal Deliveries _____ ☐ Breastfeeding ☐ Postpartum Depression

☐ Caesarean _____ For how long? _____ ☐ Gestational Diabetes

### MENSTRUAL HISTORY

Age at First Period _____ Menses Frequency _____ Length _____

Pain ☐ Yes ☐ No Clotting ☐ Yes ☐ No Has your period ever skipped? ☐ Yes ☐ No

Last Menstrual Period _____

Do you use contraception? ☐ Yes ☐ No

Contraception Type: ☐ Condom ☐ Diaphragm ☐ IUD ☐ Partner Vasectomy

Hormonal Contraception: ☐ Birth Control ☐ Pills ☐ Patch ☐ Nuva Ring

How long? _____

## WOMEN'S DISORDERS / HORMONAL IMBALANCES (for women only)

☐ Fibrocystic ☐ Breasts ☐ Endometriosis ☐ Fibroids Infertility

☐ Painful Periods ☐ Heavy Periods ☐ PMS

Last PAP Test _____ ☐ Normal ☐ Abnormal

Are you in menopause? ☐ Yes ☐ No Age at menopause _____

☐ Hot Flashes ☐ Mood Swings ☐ Concentration / Memory Problems ☐ Vaginal Dryness

☐ Decreased Libido ☐ Heavy Bleeding ☐ Joint Pains ☐ Weight Gain ☐ Headaches

☐ Palpitations ☐ Loss of Control of Urine

Use of hormone replacement therapy ☐ Yes ☐ No How long? _____

## MEN'S HISTORY (for men only)

☐ Prostate Enlargement ☐ Difficulty Obtaining an Erection ☐ Difficulty Maintaining an Erection

☐ Prostate Infection ☐ Loss of Control of Urine

☐ Change in Libido ☐ Nocturia (urination at night) How many times a night? _____

☐ Impotence ☐ Urgency / Hesitancy / Change in Urinary Stream

## GI HISTORY

Foreign Travel ☐ Yes ☐ No Where? _____

Wilderness Camping ☐ Yes ☐ No Where? _____

Have you ever had severe: ☐ Gastroenteritis ☐ Diarrhea

Do you feel like you digest your food well? ☐ Yes ☐ No

Do you feel bloated after meals? ☐ Yes ☐ No

## DENTAL HISTORY

☐ Silver Mercury Fillings How many? _____ ☐ Tooth Pain

☐ Gold Fillings ☐ Bleeding Gums

☐ Root Canals How many? _____ ☐ Gingivitis

☐ Implants How many? _____ ☐ Problems with Chewing

Do you floss regularly? ☐ Yes ☐ No

## MEDICATIONS

### CURRENT MEDICATIONS

| MEDICATION | DOSE | FREQUENCY | START DATE (mm/yy) | REASON FOR USE |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

### PREVIOUS MEDICATIONS (Last 5 Years)

| MEDICATION | DOSE | FREQUENCY | START DATE (mm/yy) | REASON FOR USE |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**NUTRITIONAL SUPPLEMENTS (Vitamins / Minerals / Herbs / Homeopathy)**

| SUPPLEMENT & BRAND | DOSE | FREQUENCY | START DATE (mm/yy) | REASON FOR USE |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

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

Describe: _____

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ☐ Yes ☐ No

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

Have you had prolonged or regular use of Acid Blockers (Tagamet, Zantac, Prilosec, etc.)? ☐ Yes ☐ No

Frequent antibiotics? (>2 times / year) ☐ Yes ☐ No

Long-term antibiotics? ☐ Yes ☐ No

Use of steroids (prednisone, nasal allergy inhalers) in the past? ☐ Yes ☐ No

Use of oral contraceptives? ☐ Yes ☐ No

## NUTRITION HISTORY

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

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

Describe: _____

Do you currently follow a special diet or nutritional program? ☐ Yes ☐ No

Check all that apply:

☐ Low Fat ☐ Low Carbohydrate ☐ High Protein ☐ Low Sodium ☐ Diabetic

☐ No Dairy ☐ No Wheat ☐ No Gluten ☐ Vegetarian ☐ Vegan

Specific Program for Weight Loss / Maintenance Type: _____

Other: _____

Height (feet / inches) _____ Current Weight _____

Usual Weight Range (+/- 5 lbs) _____ Desired Weight Range (+/- 5 lbs) _____

Highest Adult Weight _____ Lowest Adult Weight _____

Weight Fluctuations (>10 lbs) ☐ Yes ☐ No Body Fat % _____

How often do you weigh yourself? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Do you avoid any particular foods? ☐ Yes ☐ No

If yes, types and reason: _____

_____

Do you grocery shop? ☐ Yes ☐ No If no, who does the shopping? _____

Do you read food labels? ☐ Yes ☐ No

Do you cook? ☐ Yes ☐ No If no, who does the cooking? _____

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

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

☐ Fast eater ☐ Erratic eating pattern ☐ Eat too much

☐ Late night eating ☐ Dislike healthy food ☐ Time constraints

☐ Travel frequently ☐ Love to eat ☐ Don't care to cook

☐ Struggle with eating issues ☐ Eat too much under stress ☐ Eat too little under stress

☐ Do not plan meals or menus ☐ Reliance on convenience items ☐ Eating in the middle of the night

☐ Non-availability of healthy foods ☐ Confused about nutrition advice ☐ Negative relationship with food

☐ Eat more than 50% of meals away from home ☐ Emotional eater (eat when sad, lonely, depressed, bored)

☐ Significant other or family members don't like healthy foods

☐ Significant other or family members have special dietary needs or food preferences

## SMOKING

Currently Smoking? ☐ Yes ☐ No How many years? _____ Packs per day? _____

Attempts to quit: _____

Previous Smoking? ☐ Yes ☐ No How many years? _____ Packs per day? _____

Second-hand Smoke Exposure? ☐ Yes ☐ No

## ALCOHOL INTAKE

How many drinks currently per week? *1 drink = 5 oz. Wine, 12 oz. Beer, 1.5 oz Spirits*

☐ None (skip to "Other Substances") ☐ 1–3 ☐ 4–6 ☐ 7–10 ☐ > 10

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

Have you ever been told you should cut down your alcohol intake? ☐ Yes ☐ No

Do you ever feel guilty about your alcohol consumption? ☐ Yes ☐ No

Do you notice a tolerance to alcohol (can you "hold" more than others)? ☐ Yes ☐ No

Have you ever been unable to remember what you did during a drinking ☐ Yes ☐ No

episode? Do you get into arguments or physical fights when you have been ☐ Yes ☐ No

drinking? Have you ever been arrested or hospitalized because of drinking? ☐ Yes ☐ No

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

## OTHER SUBSTANCES

Caffeine Intake? ☐ Yes ☐ No

*Coffee Cups / Day* ☐ 1 ☐ 2–4 ☐ > 4 *Tea Cups / Day* ☐ 1 ☐ 2–4 ☐ > 4

Caffeinated Sodas or Diet Sodas Intake? ☐ Yes ☐ No

*12-oz. Can or Bottle / Day* ☐ 1 ☐ 2–4 ☐ > 4

Are you currently using any recreational drugs (marijuana, ecstasy, etc.)? ☐ Yes ☐ No

Type _____

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

## EXERCISE

*Current Exercise Program: (List type of activity, number of sessions per week, and duration)*

| ACTIVITY | TYPE | FREQUENCY PER WEEK | DURATION IN MINUTES |
|---|---|---|---|
| Stretching | | | |
| Cardio / Aerobics | | | |
| Strength | | | |
| Other | | | |
| Sports or Leisure Activities (golf, tennis, rollerblading, etc.) | | | |

Rate your level of motivation for including exercise in your life? List problems that limit activity: ☐ Low ☐ Medium ☐ High

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

If yes, please describe:

## PSYCHOSOCIAL

| | |
|---|---|
| Do you feel significantly less vital than you did a year ago? | ☐ Yes ☐ No |
| Are you happy? | ☐ Yes ☐ No |
| Do you feel your life has meaning and purpose? | ☐ Yes ☐ No |
| Do you believe stress is presently reducing the quality of your life? | ☐ Yes ☐ No |
| Do you like the work you do? | ☐ Yes ☐ No |
| Have you ever experienced major losses in your life? | ☐ Yes ☐ No |
| Do you spend the majority of your time and money to fulfill responsibilities and obligations? | ☐ Yes ☐ No |
| Would you describe your experience as a child in your family as happy and secure? | ☐ Yes ☐ No |

## STRESS / COPING

| | |
|---|---|
| Have you ever sought counseling? | ☐ Yes ☐ No |
| Are you currently in therapy? | ☐ Yes ☐ No |

Describe: _____

| | |
|---|---|
| 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 |

**Daily Stressors: Rate on a scale of 1–10**

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

Do you practice meditation or relaxation techniques? If yes, how often? _____ ☐ Yes ☐ No

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

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

## SLEEP / REST

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

Do you have trouble falling asleep? ☐ Yes ☐ No

Do you feel rested upon awakening? ☐ Yes ☐ No

Do you have problems with insomnia? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No

Do you use sleeping aids? ☐ Yes ☐ No

Explain: _____

## ROLES / RELATIONSHIPS

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Long-term Partnership ☐ Widow

# of Children _____ Age of Each Child _____

Who else is living in household? _____

Under what circumstances? *(ex: my mother – dementia)* _____

_____

Resources for emotional support?

Check all that apply: ☐ Spouse ☐ Family ☐ Friends ☐ Religious / Spiritual

☐ Pets ☐ Other _____

| HOW WELL HAVE THINGS BEEN GOING FOR YOU? | VERY WELL | FINE | POORLY | DOES NOT APPLY |
|---|---|---|---|---|
| Overall in your life | | | | |
| At school | | | | |
| In your job | | | | |
| In your social life | | | | |
| With your friends | | | | |
| With sex | | | | |
| With your spouse / significant other | | | | |
| With your children | | | | |
| With your parents | | | | |
| With having a positive attitude | | | | |

## ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

Do you have known adverse food reactions or sensitivities? ☐ Yes ☐ No

If yes, describe symptoms: _____

Do you have any food allergies or sensitivities? ☐ Yes ☐ No

If yes, list all: _____

Do you have an adverse reaction to caffeine? ☐ Yes ☐ No

When you drink caffeine, do you feel: ☐ Irritable or Wired ☐ Aches and Pains

Do you adversely react to any of the following?

☐ Monosodium Glutamate (MSG) ☐ Aspartame (NutraSweet) ☐ Caffeine ☐ Garlic

☐ Onion ☐ Cheese ☐ Citrus Foods ☐ Chocolate ☐ Alcohol ☐ Red Wine

☐ Sulfite Containing Foods (wine, dried fruit, salad bars) ☐ Preservatives (ex. sodium benzoate)

☐ Cigarette Smoke ☐ Perfumes/Colognes ☐ Auto Exhaust Fumes ☐ Other _____

In your work or home environment, are you exposed to:

☐ Chemicals ☐ Electromagnetic Radiation ☐ Mold

Do you have a known history of significant exposure to any harmful chemicals such as the following:

☐ Herbicides ☐ Insecticides (frequent visits of exterminator) ☐ Pesticides

☐ Organic Solvents ☐ Heavy Metals ☐ Other _____

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

Do you or have you lived or worked in a damp or moldy environment? ☐ Yes ☐ No

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

## 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:

| | | | | | |
|---|---|---|---|---|---|
| Modify your diet | ☐ 5 | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 |
| Take several nutritional supplements each day | ☐ 5 | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 |
| Modify your lifestyle (e.g., routines, sleep habits) | ☐ 5 | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 |
| Practice a relaxation technique | ☐ 5 | ☐ 4 | ☐ 3 | ☐ 2 | ☐ 1 |

Comments _____

_____

_____

***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 |

Comments _____

_____

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***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 |

Comments _____

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CLEAR FORM