



Patient Intake Form

Welcome. Our philosophy and approach to medicine is holistic and seeks to understand all factors that may be affecting your health. This intake form will help us to uncover the underlying causes of your health concerns. If any of these questions are difficult for you to answer, please let Dr. Monette know.

Please fill out as much as is possible and mail or bring it to our office at least three days prior to your first visit. If this is not possible, bring in the completed form to your first visit. We look forward to seeing you.

Today's date _____

Name _____

Date of birth _____ Age _____ Sex: Male Female

Occupation _____

Healthcare Providers

Who is your primary care physician? _____
(name) (address)

When was your last physical exam? _____
(month) (year)

Who is your dentist? _____
(name) (address)

When did you last visit the dentist? _____
(month) (year)

Who is your optometrist? _____
(name) (address)

When did you last have your eyesight checked? _____
(month) (year)

Are you currently under the care of a specialist?

1/ _____
(name) (address)

2/ _____
(name) (address)

3/ _____
(name) (address)

Are you currently under the care of an alternative healthcare provider (i.e.: chiropractor, massage therapist)?

1/ _____
(name) (address)

2/ _____
(name) (address)

Have you had any of the following in the last ten years?

Test	When	For what reason ?	Results	Outcome
bone density				
CT scan				
colonoscopy				
EKG				
endoscopy				
MRI				
ultrasound				
x-ray				

Health Concerns

Please list your main health concerns in order of importance.

1/ Describe your condition

When did it start? _____

Has this condition been diagnosed? yes no Diagnosis _____

Are you receiving treatment of any kind for this condition? Please describe: _____

2/ Describe your condition

When did it start? _____

Has this condition been diagnosed? yes no Diagnosis _____

Are you receiving treatment of any kind for this condition? Please describe: _____

3/ Describe your condition

When did it start? _____

Has this condition been diagnosed? yes no Diagnosis _____

Are you receiving treatment of any kind for this condition? Please describe: _____

4/ Describe your condition

When did it start? _____

Has this condition been diagnosed? yes no Diagnosis _____

Are you receiving treatment of any kind for this condition? Please describe: _____

What would you most like to accomplish on your first visit? _____

Past Medical History

Surgeries

Procedure	Year

Hospitalizations

Procedure	Year

Major Injuries

Injury	Year

Date and Location of Last Blood Work _____

Have you received all of your childhood vaccinations? Yes No

Have you received the vaccination for chicken pox? Yes No

Have you received any vaccinations for travel? Yes No

Lifestyle

Relationships single married partnership separated divorced widowed

Live with spouse partner parents children friends alone

Are you sexually active? Yes No If yes, with (check one): male female both

Do you or your partner(s) use contraception? Yes No If so, what type(s)? _____

Are you pregnant? Yes No Trying to get pregnant? Yes No If yes, for how long? _____

Do you have children? Yes No How many? _____

Environmental Exposure

Have you ever been exposed to mold, solvents, lead paint, heavy metals, fumes or other toxic substances at home, at work or when traveling?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever experienced health problems after putting down new carpets, painting, doing renovations or having your lawn sprayed with herbicide?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you sensitive to perfume, gasoline or other vapors?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever lived near a refinery or polluted area?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever lived in a home more than 50 years old?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have mercury dental fillings? How many? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had any dental root canal procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any surgical implants? (medical or cosmetic)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you live near power lines?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Family History

Relative	Age if living	Age if deceased	Ailments
Mother			
Father			
Siblings			
Maternal grandmother			
Maternal grandfather			
Paternal grandmother			
Paternal grandfather			

Has your relative(s) ever had any of the following?

Condition	Check One	Which relative(s)?
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Eczema	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mental Illness Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Thyroid (hypo/hyper)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Review of Systems

Y = presently have
 N = never have had
 P = have had in the past

General	
Chills	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Fever	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Weight Loss	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Fatigue	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Night Sweats	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Frequent Colds	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

Skin	
Rashes	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Eczema	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Acne	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Bruise easily	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Itching	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Lumps	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Dry	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Mole color change	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

Neurological	
Paralysis	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Numbness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Tingling	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Muscle weakness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Loss of memory	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Loss of balance	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

Head	
Headache	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Migraines	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Injury	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

Eyes Ears Nose Throat	
Glasses / contacts	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Vision problems	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Eye pain	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Tearing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Dryness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Cataracts	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Ear pain	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
ringing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Impaired hearing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Ear discharge	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Jaw clicking / pain	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Nosebleeds	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Stiffness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Hay fever	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Sinus problems	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Post nasal drip	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Frequent sore throat	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Sore tongue	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Gum problems	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Teeth problems	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Canker sores	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Hoarseness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Lumps	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Swollen glands	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Goiter	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Neck pain / Stiffness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

Respiratory	
Cough	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Wheezing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Spitting up blood	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Chronic cough	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Pain on breathing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Difficult breathing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Positive TB test	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Shortness of breath	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
at night	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
on exertion	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
lying down	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

Cardiovascular	
Palpitations	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Chest pain	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Heart Disease	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Murmur	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
High blood pressure	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Low blood pressure	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Poor circulation	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Leg cramps	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Swelling of feet	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Varicose veins	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Hemorrhoids	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Cold hands	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Cold feet	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

Gastrointestinal	
Nausea	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Vomiting	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Diarrhea	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Constipation	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Bloating	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Heartburn	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Ulcer	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Belching / Gas	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Trouble Swallowing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Change in thirst	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Blood in stool	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Undigested food in stool	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Itching around rectum	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Jaundice	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Liver Disease	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Gallbladder Disease	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
How many bowel movements per day? _____	
Is this a change?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Have you ever travelled to a third world country? If so, for how long? _____	

Musculoskeletal	
Joint pain	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Joint stiffness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Weakness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Muscle spasms	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Muscle cramps	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Broken bones	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Sciatica	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

Endocrine	
25 pounds change in weight	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Sluggish after eating	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Generally feel hot	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Generally feel cold	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Low blood sugar	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Mental sluggishness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Recently lost or gained weight	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you awake feeling rested?	<input type="checkbox"/> Y <input type="checkbox"/> N

Immune	
Chronic infections	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Frequent antibiotics	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Frequent colds/flu	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Cold sores	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Swollen glands or lymph nodes	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Slow wound healing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Frequent sore throat	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Shingles	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Has there ever been an event or sickness that you have never fully recovered from? <input type="checkbox"/> Y <input type="checkbox"/> N	
Explain.	_____ _____ _____

Mental Emotional	
Abuse	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Anxiety / Nervousness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Depression	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Mood swings	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Mental illness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Panic attacks	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Phobias	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Prolonged sadness or grief	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
What was the most stressful event in your life?	_____ _____
Is it still affecting you?	<input type="checkbox"/> Y <input type="checkbox"/> N

Urinary	
Pain on urination	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Increased frequency	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Frequent infections	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Inability to hold urine	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Awaken to urinate	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Strain to urinate	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Kidney stones	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

Rate your energy level between 1 and 10 (1=extreme fatigue, 10=most energetic) _____

Rate your stress level between 1 and 10 (1=less stress, 10=extremely stressed) _____

At what time of the day is your energy the best? _____
the worst? _____

How many hours of sleep do you get a night? _____

Male only

Male Reproductive Health					
Hernia	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Testicular pain	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Low sex drive	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Discharge or sores	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Sexual difficulties	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Prostate condition	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Testicular mass	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Impotence	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P		

When was your last prostate exam? _____

Female only

Female Reproductive Health					
Discharge	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Sexual difficulties	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Pain during intercourse	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Itching	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Sores, growths, lumps	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Low sex drive	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Vaginal dryness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Odor	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Abortions	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Use tampons	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Abdominal pain midcycle	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Miscarriages	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

When was your last pap smear? _____ Normal: Yes No

Age of first menses? _____

Age of last menses (if applicable)? _____ Menopause symptoms? _____

How long is your monthly cycle (in days)? _____

How many days is your menses? _____

Female Breast Health					
Nipple discharge	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Tenderness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Dry skin on nipple	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Breast lump	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Fibrocystic breasts	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Puckering of skin	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

Do you perform monthly self breast exams? Yes No

When was your last breast exam? _____

Do you have regular mammograms? Yes No

Premenstrual / Menstrual symptoms					
Pain cramping	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Light flow	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Water retention	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Cravings	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Mood swings	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Breast tenderness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Bleeding between periods	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Low back ache	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Heavy flow	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Clotting	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Missed periods	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

Personal

Have you ever been a smoker? Yes No If so, how many packs per day? _____

How long have you smoked? _____

Are you exposed to secondhand smoke? _____

How often do you drink alcohol and how much at one time? _____

Do you use recreational drugs? Yes No How often? _____

How often do you exercise? _____

What kind of exercise do you do? _____

How much time do you spend outdoors per week? _____

What do you do to relax? _____

Describe your supportive network _____

Do you have a spiritual practice? _____

What behaviors or habits do you engage in regularly to support your health? _____

What behaviors or habits do you engage in regularly that are destructive to your health? _____

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health?

Diet

How many meals do you eat daily? _____

How much water do you drink daily? _____ What type of water do you drink? _____

How many sodas, coffees and teas do you drink per week? _____

How many times per week do you eat dairy products? _____

How many times per week do you eat red meat? _____

How many times per week do you eat fish? _____

How many times per day do you eat fruit? _____

How many times per day do you eat vegetables? _____

Do you eat organic food? Yes No How often do you eat out? _____

What foods do you crave? _____

Do you have dietary restrictions? _____

Are you satisfied with your current diet? Yes No

What is your current weight? _____

What is your ideal weight? _____

Thank you for taking the time to fill out this form. We look forward to seeing you.

Signature _____

Date _____