Full Circle Center for Integrative Medicine
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Comprehensive New Patient Health History – Adult

Current Date _____/_____/_____

Name _____ Preferred first name/nickname (if different):_____

Date of Birth _____/_____/_____ **Birth Gender:** ❒ male ❒ female **Current Gender:** ❒ male ❒ female

Welcome to the Full Circle Center for Integrative Medicine. This questionnaire has been designed so that we can both review your past medical history and other factors in your life that affect your health. The questionnaire makes it possible for us to be more thorough within the constraints of a brief clinic visit.
It is long and detailed! Some of this information may already be in your medical records, but we are going to ask you to repeat it here to be sure we are getting your complete history. Some questions are very personal - if you do not wish to answer these, please skip over them. You may use an additional sheet of paper if needed. All information collected will be kept strictly confidential. Thank you for your patience.

General Health:.....❒ excellent ❒ good ❒ fair ❒ poor

Reason why/Problem for which I am coming to be seen:_____

If you are well, please let us know what particular preventive concerns you have. If you are not well, please describe the onset of your illness – when was the last time you felt completely well, what was going on in your life at the time the illness started:

_____

_____

_____

What treatments have you tried so far for your problem?

_____

_____

Is there anything in particular that you are hoping for from this visit? Any specific questions you would like answered?

_____

Past Medical Illnesses:

❒ accidents, broken bones, other serious injury
❒ anemia (low blood count) or bleeding problems
❒ lung problems: pneumonia, emphysema, asthma, etc.
❒ heart problems, high blood pressure, heart attack, etc.
❒ allergies (asthma, eczema, hayfever)
❒ cancer, including skin_____(what organ?)
❒ liver or kidney problems
❒ pain: low back pain, headaches, neuropathyetc.

❒ gland problems: diabetes, thyroid trouble, etc.
❒ digestion problems: ulcers, diarrhea, heartburn, etc.
❒ emotional problems: depression, anxiety, hallucinations
❒ high cholesterol or triglycerides
❒ skin disease: eczema, psoriasis, etc.
❒ tuberculosis (or positive skin test)
❒ nervous system: seizures, MS, pinched nerve
❒ sexually transmitted diseases

OTHER (and **dates and details on items checked above**): _____

_____

_____

_____

Your own Birth History: (when you yourself were born)
❒ Term ❒ Premature
❒ Vaginal ❒ Cesarean ❒ Birth Complications:_____
❒ Bottle-fed ❒ Breast fed. How long? _____
Past Surgeries (include approximate dates and types of procedures) or any major **Injuries**: _____

_____

Dental History:
Silver Mercury Fillings ❒ No ❒ Yes: (How many?_____)
❒ Gold Fillings ❒ Root canals ❒ Implants ❒ Other dental issues_____
Travel: Have you ever been in (or are you from): ❒ a foreign country? (Where:_____)
❒ another region of the United States?
Have you done any wilderness camping? ❒ no ❒ Yes: When?_____
Where were you born? _____ Where did you grow up? _____
How long have you lived in Humboldt County?_____
Pregnancy: Have you ever been pregnant?.....❒ yes ❒ no

Number of :	Date(s):	Number of :	Date(s):
Abortions:	_____	C-sections:	_____
Miscarriages :	_____	Premature births:	_____
Live Births:	_____	Stillbirths:	_____

Problems with prior pregnancies(miscarriage, blood sugar, blood pressure, hemorrhage, etc):_____
_____ Any babies over 8 lb? .....❒ yes ❒ no
Did you Breastfeed? ❒ yes ❒ no For how Long?_____ Any issues with breastfeeding? _____
Past diagnostic tests: (list date and results of tests, if known)
❒ Colonoscopy_____ ❒ Pap smear _____ ❒ Mammogram _____ ❒ Eye exam_____
❒ DEXA(bone density)_____ ❒ Heart tests (echo, angiogram, etc.):_____ ❒ Other_____

Immunizations(Mark if ever received, and give approximate date of most recent dose): ❒ Flu shot _____ ❒ Pneumovax _____
❒ Tetanus _____❒ TdaP (tetanus with whooping cough booster)_____ ❒ Shingles vaccine_____ ❒ Hep B series _____
❒ Other _____

Current medications (include prescription drugs, over-the-counter medicines, sleeping pills, aspirin, laxatives, vitamins, herbs, or supplements etc. and indicate dose and how often you take them): _____

_____

_____

_____

_____

PLEASE BRING ALL YOUR BOTTLES TO YOUR VISIT!

Have you had prolonged or regular use of:

NSAIDs (advil, aleve, motrin aspirin, etc.)?	❒ yes ❒ no	Tylenol (aceteminophen)?	❒ yes ❒ no
Acid blocking drugs (Tagamet, Zantac, Prilosec, etc.)?	❒ yes ❒ no	Steroids(prednisone)?	❒ yes ❒ no
Frequent antibiotics more than 2 times per year?	❒ yes ❒ no	Long-term antibiotics?	❒ yes ❒ no

Allergies:
Do you have drug allergies?....❒ No ❒ Yes What? (list medication and reaction): _____

_____

Do you have any food allergies?....❒ No ❒ Yes What? (list food and reaction):_____

_____

Which of these significantly affect you?
❒ MSG ❒ Aspartame (nutrasweet) ❒ Caffeine ❒ Garlic or onion ❒ Alcohol ❒ Sulfite containing foods (wine, dried fruit, salad bars)
❒ Preservatives (eg sodium benzoate) ❒ Perfumes/colognes ❒ Cigarette smoke ❒ Exhaust fumes ❒ Other:_____

Genetics:
Ethnic heritage (if you are comfortable sharing): ❒ African ❒ Asian ❒ European ❒ Ashkenazi ❒ Native American
❒ Mediterranean ❒ Middle Eastern ❒ Other: _____
Family History:
Are you adopted?.....❒ yes ❒ no
Please list medical history for your family members:

Relationship	Name(s)	Age	Living/Deceased	Medical Problems
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____

Relationship	Name(s)	Age	Living/Deceased	Medical Problems
Brothers				
Sisters				

Is there any history in the family of the following illnesses?
(Include mother(M), father(F), sister(S), brother(B), grandmother (GM), grandfather(GF), aunts(A), uncles(U), cousins(C).)

Heart:	Who?	**Blood:**	Who?	**Neurologic**:	Who?
❒ Heart problems before age 50? ❒ Yes ❒ No		❒ Bleeding or clotting disorder		❒ Alzheimer's	
		❒ Pulmonary Embolism		❒ Migraine	
❒ High cholesterol		**Mental Health/Substance Abuse:**		❒ Epilepsy	
❒ High blood pressure		❒ Alcoholism/drug abuse		❒ Stroke	
❒ Sudden Death		❒ Prescription drug overuse		❒ Multiple Sclerosis	
Hormone:		❒ Attention Deficit Disorder		**Cancer:**	
❒ Diabetes		❒ Depression		❒ Breast cancer	
❒ Thyroid disease		❒ Schizophrenia		❒ Colorectal CA	
❒ Polycystic Ovaries		❒ Smoking tobacco		❒ Pancreatic CA	
Eyes, Ears, Nose, Throat:		**Musculoskeletal:**		❒ Ovarian CA	
❒ Glaucoma		❒ Osteoarthritis		❒ Melanoma	
❒ Hearing loss		❒ Osteoporosis		❒ Prostate cancer	
❒ Visual Loss		❒ Rheumatoid arthritis		❒ Other cancer	
Genetic/Birth:		❒ Other Rheumatologic disorder		**Lung:**	
❒ Birth Defects		**Genitourinary:**		❒ Asthma	
❒ Metabolic disorders		❒ Endometriosis		❒ COPD	
		❒ Polycystic Kidney Disease			

Details of above: _____

Other conditions in your family: _____

Social History and Demographics:

Language you prefer: _____ Second language: _____ Interpreter needed ❒ Yes ❒ No

Marital Status: ❒ Divorced ❒ Married ❒ Partnered ❒ Separated ❒ Single ❒ Widowed

If you are currently married or in a committed relationship, who is your "significant other"? _____

If not, have you ever been married or in a committed relationship?. . . . . ❒ yes ❒ no

Occupation: What is your preferred field of work? _____

Currently ❒ Employed (Employer/job title_____) or ❒ Unemployed? (*last worked* _____)

Work hours per week _____

Health concerns regarding your work: ❒ stress ❒ repetitive motions ❒ heavy lifting ❒ dust, fumes, or loud noises ❒ verbal harrassment or abuse ❒ other _____

Do you like the work you do? ❒ yes ❒ no

Military Service: ❒ No ❒ Yes ❒ Retired

Education highest level completed:.....❒ grade school ❒ high school ❒ trade school ❒ college ❒ other

Are you currently a student, and if so, where?_____

❒ Full-time ❒ Part-time_____

Advance Directive/Living Will: Do you have an Advance directive? ❒ Yes ❒ No (If so, we would like a copy)

If not, are you interested in information about developing one? ❒ Yes ❒ No

Living situation: Are you now or have you recently been homeless? .....❒ yes ❒ no

If not, do you currently live in an apartment? ❒ yes ❒ no house?....❒ yes ❒ no other?.....❒ yes ❒ no

Do you have the following where you live? Toilet.....❒ yes ❒ no Stove/place to cook....❒ yes ❒ no

Electricity.....❒ yes ❒ no Tub/shower..... ❒ yes ❒ no Refrigerator.....❒ yes ❒ no

Hot/cold water... ❒ yes ❒ no Phone.....❒ yes ❒ no

Do you feel your current housing is adequate?.....❒ yes ❒ no

Do you feel your home is safe/do you feel safe there? .....❒ yes ❒ no

Do you have smoke detectors? ..... ❒ yes ❒ no

Guns in House:

Are there any weapons in your house? .....❒ yes ❒ no

If there are weapons in the house, are they: ❒ Loaded ❒ Kept locked ❒ Accessible to children

If there are weapons in the house, has everyone in the home been trained in firearm safety? .....❒ yes ❒ no

Family/Companions

Do you live alone? ❒ yes ❒ no

If you live with others (How many? _____), is it crowded? ❒ yes ❒ no

Who do you live with: _____

Do you have any children? ❒ yes ❒ no

If so, please list: Full Name Age Full Name Age

_____ _____ _____ _____

_____ _____ _____ _____

Do any of your children or your partner's children live with someone else? ❒ yes ❒ no

If Yes, please explain: _____

Habits (please indicate if you have ever used and how much you use now):

Caffeine: coffee, tea, soda ❒ yes ❒ no

How many cups per day of: coffee? _____ tea? _____ soda? _____

Do you get a headache or other symptoms if you skip for a day? ❒ yes ❒ no

Tobacco:

Are you exposed to second hand smoke -- at home? ❒ yes ❒ no at work? ❒ yes ❒ no

Do you smoke cigarettes now? ❒ yes ❒ no

in the past? ❒ yes ❒ no

If so, how many packs per day?_____ For how many years?_____ How old were you when you started?_____

Do you use chewing tobacco, snuff, cigars, a pipe, or other forms of tobacco? ❒ yes ❒ no

in the past? ❒ yes ❒ no

If you currently smoke or chew tobacco, have you ever quit before? ❒ yes ❒ no

If yes, for how long? _____ What helped you quit?_____

Would you like help in quitting tobacco now? ❒ yes ❒ no

Alcohol: How often do you drink an alcoholic beverage? *(1 drink = 5 oz wine, 12 oz beer, 1.5 oz spirits)*

Drinks per day_____ Drinks per week_____ How many drinks does it take to make you feel "high"?_____

If you drink, have you ever felt the need to cut down your drinking? ❒ yes ❒ no

felt annoyed by criticism of your drinking? ❒ yes ❒ no

had guilty feelings about your drinking? ❒ yes ❒ no

taken a morning "eye-opener"? ❒ yes ❒ no

When was your last drink? _____

Did you ever drink heavily in the past? ❒ yes ❒ no

Have you ever been unable to remember what you did during a drinking episode? ❒ yes ❒ no

Do you get into arguments or physical fights when you have been drinking? ❒ yes ❒ no

Have you ever been arrested or hospitalized because of drinking? ❒ yes ❒ no

Other: Do you or have you ever used any other recreational **drugs**? ❒ yes ❒ no

❒ marijuana ❒ crack/cocaine ❒ crank/methamphetamines

❒ heroin ❒ downers ❒ MDMA ❒ other _____

Have you ever used drugs through a needle? ❒ yes ❒ no

If you use drugs and/or alcohol, are you interested in quitting? ❒ yes ❒ no

Have you tried to quit? ❒ yes ❒ no

If you quit in the past, how long ago, what helped?_____

Are you concerned about the drinking/drug use of any other members of your family? ❒ yes ❒ no

Other toxic exposures: (current or in the past)

Do you handle or have exposure to chemicals? (examples: glue, paint, bleach, ammonia, pesticides, fertilizers, Cleaning solvents, etc.)?

Past	Current	**Exposures**	Past	Current	
		Mold in bathroom			Mold in cellar, crawlspace, or basement
		Damp cellar or had water in basement			Heavily wooded or damp surroundings
		Pest extermination – inside			Well water
		Pest extermination – outside			Old or crumbling paint (when was house built?_____)
		Chemical use at work or with hobbies			New carpet or other remodeling
		Farm close to house (non-organic)			Feather or down bedding
		Power plant or lines close to house			Landfill/dump
		Industrial plant close to house			Gas or propane stove or heating

Safety: Do you ever ride in a car without wearing a seat belt? ..... ❒ yes ❒ no
Do you use helmets every time when riding bicycles/motorcycles? ..... ❒ yes ❒ no

Diet:

Do you follow a special diet (❒ vegetarian, ❒ vegan, ❒ low salt, ❒ low fat, ❒ diabetic, ❒ Other)..... ❒ yes ❒ no

Please describe:_____

How many times a week do you eat red meat? _____
How many meals do you eat out every week? ❒ 0-1 ❒ 2-3 ❒ 4-5 ❒ more than 5
How many servings of fruit or vegetables do you eat every day ? ❒ 0-1 ❒ 2-3 ❒ 4-5 ❒ more than 5
Has your weight ever been a problem for you? ..... ❒ yes ❒ no
Have you had weight fluctuations of more than 10 lb? ..... ❒ yes ❒ no
What methods have you used to lose/gain weight? _____

_____

Please list what you ate and drank yesterday, with approximate amounts: *(if that was not a typical day, list your last usual day)*

Breakfast	Lunch	Dinner	Snacks

Do you do your grocery shopping and food preparation? ❒ yes ❒ no If not, who does this:_____

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

- ❒ Fast eater
- ❒ Late night eating
- ❒ Eat more than 50% of meals away from home
- ❒ Do not plan meals or menus
- ❒ Eat because I have to
- ❒ Eat too much under stress
- ❒ Confused about nutrition advice
- ❒ Erratic eating pattern
- ❒ Dislike healthy food
- ❒ Travel frequently
- ❒ Poor snack choices
- ❒ Have a negative relationship to food
- ❒ Eat too little under stress
- ❒ Emotional eater (eat when sad, lonely, depressed, bored)
- ❒ Eat too much
- ❒ Time constraints
- ❒ Reliance on convenience items
- ❒ Love to eat
- ❒ Struggle with eating issues
- ❒ Don't care to cook
- ❒ Significant other/family members don't like healthy foods
- ❒ Significant other or family members have special dietary needs or food preferences

The most important thing I would like to change about how I eat to improve my health is: _____

How much water or uncaffeinated, unsweetened tea do you drink daily? _____
Is your water generally: ❒ Well ❒ Tap ❒ Bottled
❒ Filtered ❒ Unfiltered

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

Activity	**Type**	**Frequency per week**	**Duration in Minutes**
Stretching			
Cardio/Aerobics, Zumba			
Strength (Resistance/weights)			
Other (Yoga, Pilates, Tai chi/ Qi Gong, etc.)			
Sports or leisure activities (golf, tennis, hiking, etc.)			

Rate your level of motivation for including exercise in your life: ❒ low ❒ medium ❒ high

List problems that limit activity: _____

Do you feel unusually fatigued or ill after exercise? ❒ no ❒ yes – please describe _____

Do you usually sweat when exercising? ❒ no ❒ yes

Sexual History:

Have you had sex in the last month?..... ❒ yes ❒ no
3 months?..... ❒ yes ❒ no
1 year?..... ❒ yes ❒ no
Are you satisfied with your sex life?..... ❒ yes ❒ no
Do you have or have you ever had sex with:..... ❒ men ❒ women ❒ both
How many people have you had sex with in the last year?..... ❒1 ❒ 2-3 ❒ more than 3
" " in your lifetime? _____
What do you use for birth control/safe(r) sex? _____
Do you want to discuss safe sex, AIDS, or other sexual issues with the doctor? ..... ❒ yes ❒ no
Has anyone ever sexually abused or raped you as a child or an adult?..... ❒ yes ❒ no
If so, are you comfortable describing the event(s) to your provider? ..... ❒ yes ❒ no
If so, have you had some counseling or other help with this? ..... ❒ yes ❒ no
Do you feel this still affects you?..... ❒ yes ❒ no

Stress:

Are there currently any major stressors in your life? ..... ❒ yes ❒ no
If so, what are they?_____

_____

Have you experienced major losses in your life?..... ❒ yes ❒ no

If so, what sort?_____
Do you feel your life has meaning and purpose? ..... ❒ yes ❒ no
Are you currently providing care for a disabled or elderly family member? ..... ❒ yes ❒ no
Do you have concerns about your children or your relationship with them?..... ❒ yes ❒ no
Are you afraid of your own temper or that of anyone else in your family?..... ❒ yes ❒ no
Do you have problems with getting angry frequently or at little things? ..... ❒ yes ❒ no
Do you sometimes feel out of control? ..... ❒ yes ❒ no
Do you sometimes feel you are no good or you can't do anything right?..... ❒ yes ❒ no
Have you ever thought about or tried to commit suicide?..... ❒ yes ❒ no
Have you or anyone on your block been shot or mugged in the last year? ..... ❒ yes ❒ no
Is there any history of violence in your family?..... ❒ yes ❒ no
Has anyone close to you ever physically hit you or hurt you?..... ❒ yes ❒ no
Do you feel unsafe in your current relationship?..... ❒ yes ❒ no
Is there a partner from a previous relationship who is making you feel unsafe now?..... ❒ yes ❒ no

Social Support:

Does someone you live with have serious health or emotional problems? ..... ❒ yes ❒ no
Do you frequently feel isolated or alone? ..... ❒ yes ❒ no
Do you feel people take advantage of you or try to control you?..... ❒ yes ❒ no
How do you deal with conflict in your family?_____

_____

Are you dissatisfied with the way your family communicates or expresses affection?..... ❒ yes ❒ no
Who provides you with emotional support(family, close friend, religious advisor, other)? _____

_____

Pets: Do you have any pets or companion animals?..... ❒ yes ❒ no

Name	Species	Name	Species
_____	_____	_____	_____
_____	_____	_____	_____

Spiritual Life/Meditation/Relaxation:

Do you practice meditation or relaxation techniques? ❒ no ❒ yes. How often?_____
Check all that apply ❒ Yoga ❒ Mindfulness ❒ Imagery ❒ Breathing ❒ Tai chi ❒ Prayer ❒ Other:_____
Is there a particular spiritual practice or belief system that is meaningful to you? ..... ❒ yes ❒ no
Name or Description (optional): _____
Do you practice this singly and/or with a group?..... ❒ alone ❒ yes, with a group
Would you be willing to have us contact your spiritual advisor and/or other support people in the event you became very ill? ..... ❒ yes ❒ no
Contact person: _____ Phone: (_____) _____ - _____
Did you/your family follow a particular spiritual practice when you were a child?..... ❒ yes ❒ no
If so, name or description: _____

Sleep/Rest:
Average number of hours you sleep per night: ❒ <6 ❒ 6-8 ❒ 8-10 ❒ >10
Do you have trouble falling asleep? ..... ❒ yes ❒ no
Do you have trouble staying asleep? ..... ❒ yes ❒ no
Do you feel rested upon awakening? ..... ❒ yes ❒ no
Do you snore? ..... ❒ yes ❒ no
Hobbies, other activities (church groups, sports, musical instruments, etc.): _____

_____

Assistive Devices:
Do you use: ❒ glasses or contact lens ❒dentures, crowns, or bridges ❒any assistive devices (walker, cane, grasper, etc.)
Current symptoms: please mark any symptoms you have been noticing, and write details next to it or below.

Constitutional: ❒ fatigue ❒ fever ❒ chills ❒ weight loss or weight gain ❒ _____

Mouth: ❒ Tooth pain ❒ Bleeding Gums ❒ Gingivitis ❒ bad breath ❒ Problems with Chewing ❒ Canker sores ❒ Dry mouth

Do you floss regularly? ❒ yes ❒ no Do you have a dentist? ❒ yes ❒ no

Head, neck: ❒ double vision ❒ blurred vision ❒ dry eyes ❒ eye pain ❒ ear discharge ❒ ear pain ❒ ringing in the ears

❒ nasal/sinus congestion ❒ nosebleeds ❒ postnasal drip ❒ sore throat ❒ hoarseness ❒ abnormal smell/taste ❒ _____

Breathing: ❒ shortness of breath ❒ cough ❒ wheezing ❒ _____

Heart/Circulation: ❒ chest pain ❒ palpitations(racing or irregular heartbeat) ❒ swelling in ankles ❒ leg pain with walking

❒ dizziness/lightheadedness ❒ fainting ❒ _____

Breast: ❒ breast tenderness ❒ discharge from nipple ❒ breast mass ❒skin changes on the breast ❒ _____

Eating: ❒ Binge eating ❒ Bulimia ❒ Can't gain weight ❒ Can't lose weight ❒ Poor appetite

❒ Cravings (for ❒ salt ❒ carbohydrates ❒ sweets ❒ chocolate ❒ other_____- including clay, dirt, and other strange things)

Digestive: ❒ loss of appetite ❒ abdominal pain ❒ difficulty swallowing ❒ nausea ❒ vomiting ❒ constipation ❒ diarrhea ❒ heartburn

❒ blood in stools ❒ mucus in stools ❒ Excessive gas ❒ Recent changes in bowel habits ❒ _____

Do you feel like you digest your food well? . . . . ❒ yes ❒ no

Do you feel bloated after meals? . . . . . ❒ yes ❒ no

How often do you have a bowel movement: _____times per day ____days per week

Are your bowel movements: ❒ Hard ❒ Formed but soft ❒ Soft and unformed ❒ Liquid ❒ Varies

Kidney/Bladder: ❒ Increased frequency of urination ❒ burning or pain on urination ❒ loss of control of urine(accidents)

❒ incomplete emptying of bladder ❒ getting up more than twice a night to urinate ❒ kidney stone ❒ _____

Sexual problems: ❒ lack of interest in sex ❒ pain with sex ❒ loss of lubrication ❒ lack of climax

Female: ❒ vaginal discharge ❒ problem with periods: ❒ heavy periods ❒ irregular bleeding ❒ severe cramps ❒ PMS

❒ genital sores ❒ _____

Male: ❒ problems with erections ❒ discharge from penis ❒ lumps in testicles ❒ genital sores ❒ _____

Lymph/Blood: ❒ Swollen glands ❒ bruises easily ❒ _____

Muscle/Bones: ❒ neck pain ❒ joint pain ❒ back pain ❒ muscle pain ❒ leg cramps with exercise or at night ❒ muscle twitches

❒ Muscle spasm ❒ joint redness or swelling ❒ limits on range of motion ❒ _____

Skin/Hair/Nails: ❒ acne ❒ athlete's foot ❒ bumps on back of upper arm ❒ eczema ❒ itching ❒ changing moles or sores ❒ dry skin

❒ brittle nails ❒ ridges in nails ❒ hair loss ❒ change in pigment ❒ _____

Nerves: ❒ Headache ❒ dizziness ❒ weakness ❒ numbness or tingling ❒ tremor/shaking ❒ poor coordination ❒ seizure ❒ memory

problems ❒ speech problems ❒ _____

Psychiatric: ❒ difficulty sleeping ❒ mood swings ❒ feeling anxious ❒ feeling depressed ❒ Suicidal thoughts ❒ bad temper

❒ Hallucinations ❒ _____

Hormone: ❒ hungry all the time ❒ thirsty all the time ❒ feeling unusually cold or hot ❒ Menopause symptoms ❒ _____

Allergic, immunologic: ❒ hives ❒ allergies in nose or eyes ❒ _____

Are there other issues that you would like to discuss with your provider? Please describe: _____

_____

_____

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:

Keep a record of everything you eat each day:	❒ 5	❒ 4	❒ 3	❒ 2	❒ 1
Significantly modify your diet:	❒ 5	❒ 4	❒ 3	❒ 2	❒ 1
Take several supplements or medications daily:	❒ 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

Comments: _____

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

Comments: (If you are not willing or not confident, what are the barriers to fully engaging in these activities?)

_____

_____

At the present time, how supportive do you think the people in your household will be to your implementing the above changes?

❒ Very supportive ❒ Neutral ❒ Unsupportive

How much ongoing support and contact (e.g. telephone consults, e-mail correspondence) from our staff would be helpful to you as you implement your personal health program? ❒ Very frequent contact ❒ Occasional contact ❒ I'll work on it on my own

Comments:

_____

Coordination with other providers involved in your care:

Do you see other health care providers than your primary doctor here (such as a therapist, other physicians, chiropractors, accupuncturists, naturopaths, herbalists, etc.) on a regular basis? . . . . . ❒ yes ❒ no

Who do you see? Name	Profession
_____	_____
_____	_____
_____	_____
_____	_____

Would you like your provider at our clinic to consult with/coordinate your care with your other provider(s)? . . . . . ❒ yes ❒ no