Whole Health Concord, LLC

Adult 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 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 ☐ Referral from friend/family member
☐ Social media ☐ Other _____

Current Health Concerns

Please rank current 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.									

Allergies

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

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: _____

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
☐ 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

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

Stress Level (circle one): (Low) 1 2 3 4 5 6 7 8 9 10 (High)

How well do you manage stress (circle one): (Easy) 1 2 3 4 5 6 7 8 9 10 (Hard)

How much stress do each of the following cause on a daily basis: *(Circle what stresses you)*
Work Family Social Finances Health Other

What techniques do you use to manage stress?

_____

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

Sexuality: ☐ Hetero ☐ LGBTQ Number of previous sexual partners: _____

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

_____

Current occupation: _____

Do you enjoy work? ☐ Yes ☐ No Number of hours worked/week:_____

Which resources do you have for emotional support? *(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									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 partner	☐	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

History

Patient's Birth/Childhood History:

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

Did you experience any chronic conditions in childhood and/or teen years?

☐ Colic ☐ Skin Concerns ☐ Mood Concern ☐ Weight ☐ Digestive Concerns ☐ Unknown

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

How frequently do you see a dentist? _____

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: _____

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: _____

How many pads/tampons do you go through on heaviest days? _____

Contraception: ☐ Birth control pills ☐ Patch ☐ Nuva ring ☐ IUD ☐ Condoms

☐ Other _____ How Long _____

Any problems with hormonal birth control? ☐ Yes ☐ No

If yes, explain _____

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) _____

Men's History *(Check box if applicable)*

☐ Testicular Mass ☐ Testicular Pain ☐ Prostate Enlargement ☐ Prostate Infection ☐ Change in sex drive

☐ Impotence ☐ Premature Ejaculation ☐ Difficulty obtaining an erection ☐ Difficulty maintaining an erection

☐ Loss of control of urine ☐ Urinary urgency/hesitancy/change in stream ☐ Vasectomy

☐ Nocturia (urination at night) # of times per night _____

☐ Sexually transmitted diseases (describe) _____

Screening/Procedures: *(If applicable, provide date)* Last PSA test: _____ PSA Level:_____

Other tests/procedures (list type and date)

_____

Family History:

Check family members that have/had any of the following

	Mother	Father	Brother (s)	Sister (s)	Parents
Age (if still alive)					
Age at death (if deceased)					
Cancer	☐	☐	☐	☐	☐
Heart disease / Stroke	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐
Obesity / Diabetes	☐	☐	☐	☐	☐
Autoimmune disease	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Thyroid problems	☐	☐	☐	☐	☐
Seizures/epilepsy	☐	☐	☐	☐	☐
Anxiety / Depression	☐	☐	☐	☐	☐
Asthma / Allergies	☐	☐	☐	☐	☐
ADHD	☐	☐	☐	☐	☐
Autism	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐
Substance abuse	☐	☐	☐	☐	☐
Genetic disorders	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐

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	☐	☐
Anxiety	☐	☐
Autism	☐	☐
Multiple sclerosis	☐	☐
Parkinson's disease	☐	☐
Dementia	☐	☐
Other:	☐	☐
Cancer		
Lung	☐	☐
Breast	☐	☐
Colon	☐	☐
Ovarian	☐	☐
Skin	☐	☐
Other:	☐	☐

Medical History *(cont.)*

Diagnostic Studies	Date	Comments
CT scan		
Colonoscopy		
Cardiac stress test		
EKG		
MRI		
Endoscopy		
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	☐	☐	☐
Fatigue	☐	☐	☐
Fever	☐	☐	☐
Flushing	☐	☐	☐
Heat intolerance	☐	☐	☐
Head, Eyes, and Ears			
Distorted sense of smell	☐	☐	☐
Distorted taste	☐	☐	☐
Ear ringing/buzzing	☐	☐	☐
Eye pain	☐	☐	☐
Headache	☐	☐	☐
Hearing problems	☐	☐	☐
Migraine	☐	☐	☐
Vision problems	☐	☐	☐
Musculoskeletal			
Calf cramps	☐	☐	☐
Chest tightness	☐	☐	☐
Foot cramps	☐	☐	☐
Joint deformity	☐	☐	☐
Joint pain	☐	☐	☐
Joint stiffness	☐	☐	☐
Muscle pain	☐	☐	☐
Muscle spasms	☐	☐	☐
Muscle stiffness	☐	☐	☐
Muscle twitches	☐	☐	☐
Muscle weakness	☐	☐	☐

Musculoskeletal *(cont.)*	Mild	Moderate	Severe
Tendonitis	☐	☐	☐
Headache	☐	☐	☐
TMJ problems	☐	☐	☐
Mood/Nerves			
Anxiety / Panic Attacks	☐	☐	☐
Blackouts	☐	☐	☐
Depression	☐	☐	☐
Difficulty:	☐	☐	☐
With balance	☐	☐	☐
With memory	☐	☐	☐
Dizziness / Light-headedness	☐	☐	☐
Fainting	☐	☐	☐
Irritability	☐	☐	☐
Numbness / Tingling	☐	☐	☐
Other phobias	☐	☐	☐
Paranoia	☐	☐	☐
Seizures	☐	☐	☐
Suicidal thoughts	☐	☐	☐
Tremor	☐	☐	☐
Cardiovascular			
Chest pain	☐	☐	☐
Breathlessness	☐	☐	☐
Heart murmur	☐	☐	☐
High blood pressure	☐	☐	☐
Palpitations	☐	☐	☐
Swollen ankles/feet	☐	☐	☐
Varicose veins	☐	☐	☐

Symptom Review

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

Urinary	Mild	M
Bed wetting	☐	
Infection	☐	
Kidney disease	☐	
Kidney stone	☐	
Leaking/incontinence	☐	
Pain/burning	☐	
Urgency	☐	
Digestion		
Abdominal bloating	☐	
Blood in stools	☐	
Canker sores	☐	
Constipation	☐	
Diarrhea	☐	
Difficulty swallowing	☐	
Dry mouth	☐	
Flatulence (gas burping)	☐	
Fissures	☐	
Heartburn / Reflux	☐	
Hemorrhoids	☐	
Abdominal pain	☐	
Mucus in stools	☐	

Digestion *(cont.)*	Mild	Moderate	Severe
Nausea	☐	☐	☐
Sore tongue	☐	☐	☐
Strong stool odor	☐	☐	☐
Undigested food in stools	☐	☐	☐
Vomiting	☐	☐	☐
Eating			
Binge eating	☐	☐	☐
Bulimia	☐	☐	☐
Carbohydrate craving	☐	☐	☐
Poor appetite	☐	☐	☐
Frequent dieting	☐	☐	☐
Respiratory			
Bad breath	☐	☐	☐
Cough	☐	☐	☐
Hayfever	☐	☐	☐
Hoarseness	☐	☐	☐
Nasal stuffiness	☐	☐	☐
Nose bleeds	☐	☐	☐
Post nasal drip	☐	☐	☐
Sinus infection	☐	☐	☐
Sore throat	☐	☐	☐
Wheezing	☐	☐	☐

Symptom Review

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

Skin, Dryness of	Mild	Moderate	Severe
Eyes	☐	☐	☐
Feet	☐	☐	☐
Any cracking?	☐	☐	☐
Any peeling?	☐	☐	☐
Hair	☐	☐	☐
And unmanageable?	☐	☐	☐
Hands	☐	☐	☐
Any cracking?	☐	☐	☐
Any peeling?	☐	☐	☐
Mouth/throat	☐	☐	☐
Scalp	☐	☐	☐
Any dandruff?	☐	☐	☐
Skin in general	☐	☐	☐
Skin Problems			
Athlete's foot	☐	☐	☐
Bumps on back of upper arms	☐	☐	☐
Cold sores	☐	☐	☐
Dark circles under eyes	☐	☐	☐

Skin Problems *(cont.)*	Mild	Moderate	Severe
Easy bruising	☐	☐	☐
Eczema	☐	☐	☐
Herpes – genital	☐	☐	☐
Hives	☐	☐	☐
Genital itching	☐	☐	☐
Psoriasis	☐	☐	☐
Rash	☐	☐	☐
Rosacea	☐	☐	☐
Vitiligo	☐	☐	☐
Itching			
Anus	☐	☐	☐

Medications/Supplements

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

Medication	Dosage

Nutritional supplements (vitamins/minerals/herbs etc.)

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

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: _____

Readiness Assessment and Health Goals

Readiness Assessment

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

In order to improve your heath, 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
Take 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 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

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? _____

_____

_____