

Name of Doctors, Chiropractors, or Health Practitioners:

Name: _____ Name: _____

Telephone: _____ Telephone: _____

Emergency Contact: _____ Telephone: _____

Circle the number that best describes you (one number per choice).

- State of well-being:
0. Not well at all
 1. Poorly most of the time
 2. Have good days, bad days
 3. Mostly well
 4. Always or almost always well

- Energy Level:
0. No energy ever
 1. Rarely have energy
 2. Sometimes have energy
 3. Usually are energetic
 4. Always full of energy – rarely, if ever, lack energy.

- Tobacco:
0. Do not now & never have used tobacco
 1. Smoke (circle one) ½ 1 2 3 4 or more packs per day
 2. Snuff or chewing tobacco (circle one) ½ 1 2 3 4 or more cans per day
 3. Stopped using tobacco (circle one) ½ 1 2 3 4 5 6 7 8 9 10 or more years ago

How many hours of sleep do you usually get per night? _____

What time do you usually go to bed? _____ AM / PM

What time do you usually get up? _____ AM / PM

Is your sleep restful and refreshing? Yes No

If not, is your sleep disturbed by difficulty getting to sleep? Yes No

Is your sleep disturbed by periods of wakefulness during the night? Yes No

How much water do you drink each day? _____ cups or glasses

- Exercise:
0. Don't exercise
 1. Exercise (½ hour) 1-2 days per week
 2. Exercise (½ hour) 3-5 days per week
 3. Exercise 1 hour 3-5 days per week
 4. Exercise more than 1 hour 5 days per week

How many minutes per week (average) do you do Resistance Exercise? (Exercise with weights or other form of resistance) _____

How many miles per day do you walk? _____

Other than minor complaints, have you had significant or recurrent problems with the following during the past year? (Circle the number that applies for each listing according to the following scale.) 0 = No complaint; 1 = Very minor complaint; 2 = Recurrent or moderate complaint two to three days per week; 3 = Moderate complaint seven days per week; 4 = Severe, continuous complaint

General:		Nose:	
Tire easily, weakness	0 1 2 3 4	Loss of Smell	0 1 2 3 4
Marked weight change	0 1 2 3 4	Frequent Colds	0 1 2 3 4
Night sweats	0 1 2 3 4	Obstruction	0 1 2 3 4
Persistent fever	0 1 2 3 4	Excess discharge	0 1 2 3 4
Sensitivity to cold	0 1 2 3 4	Nosebleeds	0 1 2 3 4
Sensitivity to heat	0 1 2 3 4		
Skin:		Mouth:	
Eruptions (rash)	0 1 2 3 4	Sore gums	0 1 2 3 4
Change in color	0 1 2 3 4	Soreness of tongue	0 1 2 3 4
Change in hair	0 1 2 3 4	Dental problems	0 1 2 3 4
Change in brown mole	0 1 2 3 4		
Eyes:		Throat:	
Trouble seeing	0 1 2 3 4	Post-nasal drip	0 1 2 3 4
Eye pain	0 1 2 3 4	Soreness	0 1 2 3 4
Inflamed eyes	0 1 2 3 4	Hoarseness	0 1 2 3 4
Double vision	0 1 2 3 4		
Wear glasses	Yes ___ No ___	Locomotor:	
Ears:		Muscle cramps	0 1 2 3 4
Loss of hearing	0 1 2 3 4	Muscle weakness	0 1 2 3 4
Ringing in ears	0 1 2 3 4	Pain in joints	0 1 2 3 4
Discharge	0 1 2 3 4	Swollen joints	0 1 2 3 4
		Stiffness	0 1 2 3 4
Cardio-Respiratory		Deformity of joints	0 1 2 3 4
Cough, persisting	0 1 2 3 4		
Sputum (phlegm)	0 1 2 3 4	Nervous System:	
Bloody sputum	0 1 2 3 4	Headaches	0 1 2 3 4
Wheezing	0 1 2 3 4	Dizziness	0 1 2 3 4
Chest pain or discomfort	0 1 2 3 4	Fainting	0 1 2 3 4
Pain on breathing	0 1 2 3 4	Convulsions or fits	0 1 2 3 4
Shortness of breath	0 1 2 3 4	Nervousness	0 1 2 3 4
Difficulty breathing	0 1 2 3 4	Sleeplessness	0 1 2 3 4
(while lying down)		Weakness or paralysis	0 1 2 3 4
Bluish fingers or lip	0 1 2 3 4	of muscles	
High blood pressure	0 1 2 3 4	Poor coordination	0 1 2 3 4
Palpitations	0 1 2 3 4	Memory loss	0 1 2 3 4
Vein trouble	0 1 2 3 4	Numbness	0 1 2 3 4
		Depression	0 1 2 3 4

Digestive System:		Genitourinary System:	
Change in appetite	0 1 2 3 4	Increase in frequency urinating (day)	0 1 2 3 4
Difficulty swallowing	0 1 2 3 4	Increase in frequency urinating (night)	0 1 2 3 4
Heartburn	0 1 2 3 4	Feel need to urinate without much urine	0 1 2 3 4
Abdominal distress	0 1 2 3 4	Unable to hold urine	0 1 2 3 4
Belching or excess gas	0 1 2 3 4	Pain or burning	0 1 2 3 4
Abdominal enlargement	0 1 2 3 4	Blood in urine	0 1 2 3 4
Nausea	0 1 2 3 4	Lack of sex drive	0 1 2 3 4
Vomiting	0 1 2 3 4		
Vomiting of blood	0 1 2 3 4	OB-GYN:	
Rectal bleeding	0 1 2 3 4	Any problems with monthly periods	0 1 2 3 4
Tarry stools	0 1 2 3 4	Discharge	0 1 2 3 4
Jaundice	0 1 2 3 4	Pain	0 1 2 3 4
Constipation	0 1 2 3 4	Abnormal bleeding	0 1 2 3 4
Diarrhea	0 1 2 3 4	Menopausal symptoms	0 1 2 3 4
Hemorrhoids	0 1 2 3 4	No. of pregnancies	0 1 2 3 4
Need for laxatives	0 1 2 3 4	Number of normal	0 1 2 3 4
		Number of abnormal	0 1 2 3 4
Endocrine:		Pain during intercourse	0 1 2 3 4
Thyroid trouble	0 1 2 3 4		
Adrenal trouble	0 1 2 3 4	Breasts (Female):	
Cortisone treatment	0 1 2 3 4	Lumps	0 1 2 3 4
Diabetes	0 1 2 3 4	Discharge	0 1 2 3 4

Height:

How tall are you? ____ feet ____ inches.

Weight:

What do you consider a good weight for yourself? _____ lbs.

How much do you weigh now? _____ What did you weigh 1 year ago? _____

Have you ever tried to lose weight? Yes No

Did you have good success, lose weight and keep it off? Yes No

Did you temporarily lose weight, but gain it back again? Yes No

Diet: _____ Choose from 0 – 4 the diet that best describes your usual eating habits.

0 = Vegan - no meat or meat products

1 = Lacto ovo vegetarian - milk & egg products

2 = Occasional meat - mainly vegetarian

3 = Fish and/or chicken regularly, but no red meat

4 = Full meat and potatoes

Circle the appropriate number: 0 = Do not use at all, up to 7 = use 7 days per week.

Milks:		Beverages:	
Whole	0 1 2 3 4 5 6 7	Fruit juice	0 1 2 3 4 5 6 7
Low-fat	0 1 2 3 4 5 6 7	Kool-aide, punch, etc.	0 1 2 3 4 5 6 7
Non-fat buttermilk	0 1 2 3 4 5 6 7	Cola drinks	0 1 2 3 4 5 6 7
Cream or half/half	0 1 2 3 4 5 6 7	Soft drinks (diet)	0 1 2 3 4 5 6 7
Other: yogurt, etc.	0 1 2 3 4 5 6 7	Coffee	0 1 2 3 4 5 6 7
		Decaf coffee	0 1 2 3 4 5 6 7
Breads:	0 1 2 3 4 5 6 7	Tea	0 1 2 3 4 5 6 7
Whole grain	0 1 2 3 4 5 6 7	Cocoa	0 1 2 3 4 5 6 7
White	0 1 2 3 4 5 6 7	Beer	0 1 2 3 4 5 6 7
Dinner roll	0 1 2 3 4 5 6 7	Wine	0 1 2 3 4 5 6 7
Tortillas	0 1 2 3 4 5 6 7	Other alcohol	0 1 2 3 4 5 6 7
Other _____		Other _____	0 1 2 3 4 5 6 7
Fruits:	0 1 2 3 4 5 6 7	Desserts:	
Citrus	0 1 2 3 4 5 6 7	Cake	0 1 2 3 4 5 6 7
Strawberries	0 1 2 3 4 5 6 7	Pie	0 1 2 3 4 5 6 7
Other fresh fruit	0 1 2 3 4 5 6 7	Pudding	0 1 2 3 4 5 6 7
Canned fruit	0 1 2 3 4 5 6 7	Ice cream	0 1 2 3 4 5 6 7
Frozen fruit		Candy	0 1 2 3 4 5 6 7
		Milk shakes, malt	0 1 2 3 4 5 6 7
Vegetables:	0 1 2 3 4 5 6 7	Cookies	0 1 2 3 4 5 6 7
Raw salads	0 1 2 3 4 5 6 7	Chocolate	0 1 2 3 4 5 6 7
Cooked green leafy	0 1 2 3 4 5 6 7		
Other cooked		Misc:	
vegetables	0 1 2 3 4 5 6 7	Jam, jelly, syrup	0 1 2 3 4 5 6 7
Potatoes	0 1 2 3 4 5 6 7	Sugar, honey	0 1 2 3 4 5 6 7
		Protein supplements	0 1 2 3 4 5 6 7
Protein:	0 1 2 3 4 5 6 7	Vitamins & minerals	0 1 2 3 4 5 6 7
Beef	0 1 2 3 4 5 6 7	Chips	0 1 2 3 4 5 6 7
Other red meat	0 1 2 3 4 5 6 7		
Chicken or turkey	0 1 2 3 4 5 6 7	Seasonings:	
Other fowl	0 1 2 3 4 5 6 7	Black pepper	0 1 2 3 4 5 6 7
Bacon, ham, or pork	0 1 2 3 4 5 6 7	Mustard	0 1 2 3 4 5 6 7
Organ meats (liver,		Horseradish	0 1 2 3 4 5 6 7
heart)	0 1 2 3 4 5 6 7	Chili	0 1 2 3 4 5 6 7
Beans, peas, lentils	0 1 2 3 4 5 6 7	Pickles	0 1 2 3 4 5 6 7
Shellfish	0 1 2 3 4 5 6 7	Vinegar	0 1 2 3 4 5 6 7
Other fish	0 1 2 3 4 5 6 7		
Meat analogs	0 1 2 3 4 5 6 7	Fats:	
Cheese	0 1 2 3 4 5 6 7	Butter	0 1 2 3 4 5 6 7
Cottage cheese	0 1 2 3 4 5 6 7	Margarine	0 1 2 3 4 5 6 7
Eggs	0 1 2 3 4 5 6 7	Mayonnaise	0 1 2 3 4 5 6 7
		Salad dressing	0 1 2 3 4 5 6 7

Nuts & Seeds:		In Cooking, baking or frying:	
All types	0 1 2 3 4 5 6 7	Butter, lard, meat drippings	0 1 2 3 4 5 6 7
Nutbutters (peanut, almond, cashew)	0 1 2 3 4 5 6 7	Solid vegetable shortening	0 1 2 3 4 5 6 7
Grains:	0 1 2 3 4 5 6 7	Margarine	0 1 2 3 4 5 6 7
Whole grain cereal	0 1 2 3 4 5 6 7	Vegetable oil	0 1 2 3 4 5 6 7
Wheat bran or germ	0 1 2 3 4 5 6 7	What did we miss?	
Dry or boxed cereal	0 1 2 3 4 5 6 7	_____	0 1 2 3 4 5 6 7
Brown rice	0 1 2 3 4 5 6 7	_____	0 1 2 3 4 5 6 7
White rice	0 1 2 3 4 5 6 7	_____	0 1 2 3 4 5 6 7
Pasta	0 1 2 3 4 5 6 7		
Pancakes/waffles	0 1 2 3 4 5 6 7		
Crackers	0 1 2 3 4 5 6 7		
Popcorn	0 1 2 3 4 5 6 7		

Are you on a special diet? Yes No What kind? _____
 Number of meals you eat daily: _____ Do you eat breakfast? Yes No
 How many times per week do you eat out? _____ Do you eat before going to bed? Yes No

Foods not Eaten:

Dislike _____ Religious reasons _____
 Allergy _____ Other _____

24 Hour Food Intake Record - Please record typical food intake.

BREAKFAST	TIME
SNACK	TIME
LUNCH	TIME
SNACK	TIME
SUPPER	TIME
SNACK	TIME

For Married Persons:

Are you happily married? Yes No Maybe

Do you have a problem in your marriage related to :

Finance	Yes	No	Showing or receiving enough affection	Yes	No
Religion	Yes	No	Trusting your spouse	Yes	No
Sex	Yes	No	Understanding each other	Yes	No
Children	Yes	No	Spending time together	Yes	No
Business	Yes	No	Relatives living with you	Yes	No
Drinking	Yes	No	Communication	Yes	No
Social life	Yes	No	Other	Yes	No

Belief:

Please circle the appropriate religious preference:

Catholic Protestant Jewish Other No Preference SDA

Circle the number that best describes your experience in the following:

- 0 I am an atheist, I do not believe in God.
- 1 I believe in a higher power, not necessarily a personal God.
- 2 I believe in a personal God, but do not worship regularly with any fellowship of believers.
- 3 I believe in a personal God, enjoy regular fellowship with like believers, but am not satisfied with my religious experience.
- 4 I believe in a personal God, worship regularly with a fellowship of like believers and feel that I am growing in my Christian experience.

Emotional Health:

The mind is the capital of the being. According to the Academy of Psychosomatic Medicine, 92% of patients who currently see their doctor have symptoms that have their origin in the mind. To determine the state of health of the mind is the purpose of these questions.

Circle the number which best applies to you.

- 0 I am so bitter about certain parts of my life that I have trouble functioning; it is all that I can think about.
 - 1 I often feel bitterness and resentment in my life.
 - 2 I sometimes feel bitter at first, but I am usually able to get over it quickly.
 - 3 I never feel bitter when I feel that I am wronged
-
- 0 I have nothing for which to be grateful.
 - 1 I know that I should be grateful, but it is not easy.
 - 2 I sometimes feel gratitude, but not very often.
 - 3 I am filled with gratitude for all that God and others have done for me.

- 0 I have no purpose in life.
 - 1 I may have some purpose in life but I am not aware of it.
 - 2 I know that I have some purpose but I often lose sight of it.
 - 3 I know that I have a purpose in life and I am actively pursuing it.
-
- 0 I have no hope.
 - 1 I have some hope that there may be something better for me.
 - 2 I have hope some days and not other days.
 - 3 I have the assurance that there is a better life for me both now and forever.

The BDI questionnaire that comes with our mailed packet is specifically designed for those who have been clinically diagnosed as depressed or feel that they may be depressed. However, **everyone** is encouraged to fill out the questionnaire as it gives an important measure of your tendency to be depressed. Also, many of us do not realize that we may have even a mild mood disturbance that could be the source of some of our medical problems or, that may improve with improved physical health.