

Health History Questionnaire

Please fill out this confidential questionnaire packet to the best you can so that I may know how to best treat you. Thank you.

—Dr. Amy Burkhart

Name (First, Middle, Last)

Address

City

State

Zip

Home Phone

Work Phone

Email Address

Cell Phone

Occupation

Birthdate

Age

Height

Weight

Sex

Primary Care Physician Name / Address / Phone

Referred By

Today's Date

Problem List

What is the primary reason for your visit today? Have you sought treatment for this before? What happened?

Beside the above health concern, list current ongoing problems in order of importance to you.
(#1 = most important)

Problem	Date of Onset	Treatment	Outcome
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

Do you have any disabilities? Yes No If yes, please describe:

Past Medical History

Problem	Currently?	Past?	Notes
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Back Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bronchitis/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Celiac Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Fatigue Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crohns or Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Food Allergies/Intolerances	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gallstones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gluten Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Attack/Angina	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Problems (Other)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Cholesterol or Triglycerides	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neck Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Diagnostic Studies

Type	Date	Reason
Appendectomy	_____	_____
Barium Enema	_____	_____
Barium Swallow	_____	_____
Chest X-ray	_____	_____
Colonoscopy	_____	_____
CT scan of Abdomen	_____	_____
CT scan of Brain	_____	_____
CT scan of Spine	_____	_____
EKG	_____	_____
Gall Bladder	_____	_____
Hernia	_____	_____
Hysterectomy	_____	_____
Upper Endoscopy	_____	_____
Lower GI	_____	_____
MRI Head	_____	_____
MRI other	_____	_____
Surgery	_____	_____
Tonsillectomy	_____	_____

Hospitalizations

Where	When	Why
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medication History

Name	Reason	Dose	Date Started
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Antibiotic History

How often have you taken antibiotics?

- Infancy/Childhood:** Never Rarely Often Very Often
- Teen:** Never Rarely Often Very Often
- Adulthood:** Never Rarely Often Very Often

Supplement History

Name and Brand	Reason	Dose	Date Started
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medication or Supplement Allergies

Allergen/Trigger

Reaction

Other Allergies—Food, Environmental, etc.

Allergen/Trigger

Reaction

Social

With whom do you live? Please include ages.

Do you have any regular hobbies? How often and with whom do you do them?

Have you lived or traveled outside of the USA? If so, when and where?

Do you have any pets or farm animals? If yes, what are they and where do they live (indoors, outdoors, both)?

Have you or your family recently had any life changes/stressors? If yes, please describe.

Have you experienced any major losses in life? If yes, please describe.

Do you belong to a group or community? If yes, please describe.

Do you have enough money to meet your needs? Yes No

Emotional/Spiritual

What are the major stressors in your life?

On a scale of 1-10, how would you rate your stress in the past month? Please circle a number.

(Relaxed) 1 2 3 4 5 6 7 8 9 10 (Completely Stressed)

Do you consider yourself a spiritual person? Why?

Do you practice an organized religion? If yes, which one?

Do you attend spiritual/religious services or gatherings? If yes, how often?

How important is spirituality/religion to you and your family?

Not important Somewhat important Very important

Mood

Have you ever had treatment for or been told you have emotional issues? (i.e. depression, anxiety, anger, panic attacks, phobias) If yes, please explain.

Are there any significant traumas (emotional or physical) that have affected you? If yes, please explain.

Over the past month, how often have you . . .

	None or little of the time	Some of the time	Most of the time	All of the time
1. been feeling low in energy or slowed down?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. been blaming yourself for things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. had poor appetite?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. had difficulty falling asleep or staying asleep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. been feeling hopeless about the future?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. been feeling blue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. been feeling no interest in things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. had feelings of worthlessness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. thought about or wanted to commit suicide?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. had difficulty concentrating or making decisions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Physical Activity

How often do you exercise? How many minutes each time?

What type of exercise/physical activity do you do?

How important is exercise to you?

Not important Somewhat important Very important

Environmental

Are you exposed to smoke at home? Yes No

Are you exposed to smoke at work? Yes No

Do you live near agricultural land or chemical plants? Yes No

Do you have any other significant environmental exposures? Yes No If yes, please explain.

Work History

What is your current occupation? How long have you had this occupation?

Please list your previous jobs:

How much time have you lost from school or work in the past year?

0-6 days 1-2 weeks More than 2 weeks

If you have lost more than 2 weeks from school or work in the past year, please explain.

Relaxation

What do you do to relax?

Please mark the boxes below where appropriate.

Relaxation Technique	Never tried	Use currently	Used in past	Not for me	Interested in
Biofeedback	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breathing exercises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Massage/body work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meditation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Progressive muscle relaxation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tai Chi/Qi Gong	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visualization/guided imagery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yoga	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Energy

On a scale of 1-10, how would you rate your overall energy? Please circle a number.

(Low Energy) 1 2 3 4 5 6 7 8 9 10 (High Energy)

Sleep

How many hours do you sleep each night? _____

Do you wake up rested? Yes No

Do you wake up during the night? Yes No

Do you have difficulty falling asleep? Yes No

Do you snore? Yes No

Habits

Do you smoke? How much? For how many years?

Would you like to quit? Yes No

Do you drink alcohol (i.e. beer, wine, liquor)? Yes No

How often do you drink alcohol?

None Twice a week 3-5 times a week Daily

Does anyone in your family have a problem with drugs or alcohol? Yes No

When you drink, you typically have:

1 drink 2 drinks 3 drinks More than 3 drinks

Do you drink caffeine daily (i.e. cola, coffee, tea)? Yes No How many per day? _____

Do you currently use drugs (i.e. pot, cocaine, crack, heroin, speed) Yes No

If yes, please describe the type of drugs and how often you use them.

History with Alternative or Complementary Therapies

Method	Never tried	Use currently	Used in Past	Not for me	Interested in
Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Energy Medicine (i.e. Reiki, healing touch, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Herbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homeopathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Massage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mind body (i.e. hypnotherapy, meditation, biofeedback)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NAET	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteopathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Childhood History

Birth History:

Full term Premature How many weeks premature? _____

Bottle fed Breast fed Breast fed for how long? _____

How would you rate your health as a child? Good Fair Poor

List any serious childhood illnesses:

Women's Health History

Last Menstrual Period: _____

Are your cycles regular? Yes No Duration? _____

Any difficulty with your periods? Yes No

Any recent changes in your cycle? Yes No

Any history of reproductive problems? Yes No

Number of pregnancies: _____

Number of live births: _____

Have you ever had a bone density study? Yes No If yes, write date of study: _____

Date of last mammogram: _____

Family History

Family history of cancer? Yes No If yes, which type? _____

Family history of autoimmune disease? Yes No If yes, which type? _____

Family history of celiac disease? Yes No If yes, who? _____

Family history of gluten intolerance? Yes No If yes, who? _____

Are there any other medical conditions that run in your family? Yes No

Problem	Family Member	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Nutrition and Digestive History

Your current weight: _____ height: _____

How much did you weigh 5 years ago? _____ lbs.

How much did you weigh when you were 21? _____ lbs.

In the last year, have you experienced significant weight loss or gain? Yes No

If yes, please describe: _____

List all the foods you have eaten in the last 24 hours, including snacks and beverages:

Breakfast	Foods/Beverage:	Amount:	How prepared?	Where eaten?	At what time?
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

Lunch	Foods/Beverage:	Amount:	How prepared?	Where eaten?	At what time?
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

Dinner	Foods/Beverage:	Amount:	How prepared?	Where eaten?	At what time?
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

Snacks	Foods/Beverage:	Amount:	How prepared?	Where eaten?	At what time?
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

Nutrition and Digestive History (continued)

Is the chart on the previous page represent a typical day for you? Yes No If not, how is it different?

Who usually prepares your meals? _____

Do you usually eat alone or with someone? _____

What percentage of meat, eggs, poultry, fruits and vegetables you eat are organic? _____ %

Do you have any symptoms immediately after eating such as bloating, hives, belching? Yes No

Do those symptoms occur with a particular food? Yes No

If so, what food or type of food is it (i.e. fat, carbohydrate, protein)? _____

Do you have delayed symptoms with certain foods (i.e. several hours to 24 hours later) such as fatigue, muscle aches, sinus congestion? Yes No

What happens when you skip a meal? _____

Do you crave particular foods? Yes No

Do you have an aversion to particular foods? Yes No

Do you salt your food? Yes No

Are you on a special diet? Yes No If yes, why? _____

If yes, please mark the special diet you are on:

Gluten Free

Blood Type Diet

Elimination Diet

Dairy Free

FODMAPS Diet

Candida Diet

Diabetic

Specific Carbohydrate Diet

Body Ecology Diet

Vegetarian

Anti-Inflammatory Diet

Paleo Diet

Vegan

GAPS Diet

Other: _____

Is there any other thing about your diet I should know? If yes, please describe.

Nutrition and Digestive History (continued)

Please circle how often the following symptoms occur.

Symptom	Never	Sometimes	Often	Frequently/Always
Burping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Iron Deficiency Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food Allergies/Sensitivities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fullness after meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea after supplements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach upsets easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sour Taste in Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nighttime Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nighttime sweating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty swallowing liquids or solids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal cramping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion 1-3 hours after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive gas/flatulence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alternating constipation/diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fiber causes constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous in stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poorly formed stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shiny stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
More than 3 bowel movement per day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brittle Hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain in left side under rib cage or chronic stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty gaining weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Nutrition and Digestive History (continued)

Please circle how often the following symptoms occur.

Symptom	Never	Sometimes	Often	Frequently/Always
Foul smelling stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder problems or history of gallbladder problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Undigested food in stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reflux/Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive bloating with sugar, fiber or carbohydrate intake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritable bowel syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless Leg Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intolerance to probiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are taking antacids or proton pump inhibitors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain, swelling or arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic tiredness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus or nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic or frequent inflammation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema, skin rashes, hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma, hayfever, airborne allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Confusion poor memory or mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of NSAIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol consumption makes you feel sick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcerative Colitis, Crohn's or Celiac disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache or migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Nasal Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression/Anxiety or Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infertility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis or Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brain Fog	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get infections easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Conclusion

What statement most accurately describes your approach to your health?

Is there anything else you would like to tell me about your health or any other concerns you may have?

Please reiterate your goals for this visit:
