BENCHMARK
Medical Group Inc.

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Functional Nutrition

1. GENERAL INFORMATION:

Date _____ First Name: _____ Middle Name: _____

Last Name: _____ Date of Birth: _____ Preferred Name: _____

Gender:
○ Male ○ Female

Genetic Background:
○ African ○ European ○ Native American ○ Mediterranean
○ Asian ○ Ashkenazi ○ Middle Eastern

Highest Education Level:
○ High School ○ Under-Graduate ○ Post-Graduate

Job Title: _____

Nature of Business: _____

2. Primary Address: City State Zipcode

_____ Apt./Unit #: _____

3. Primary Address:

_____

4. Home Phone 1: _____ Work Phone: _____ Cell Phone: _____

Fax: _____ E-mail: _____

5. Emergency Contact:

Name: _____ Phone: _____

Address: _____ Apt./Unit #: _____

6. If you do not have a primary care physician

Physician's Name: _____ Phone: _____ Fax: _____

7. Referred by:

☐ Google (which words): _____ ☐ Media: _____ ☐ Family Member: _____

☐ Friend: _____ ☐ Other: _____

PHARMACY INFORMATION

8. Primary Pharmacy:

Name: Phone:

Email: Fax:

Address: Apt./Unit #:

* It is extremely important that you list the pharmacy's fax number.

9. ALLERGIES:

	Medication/ Supplement/Food:	Reaction
1		
2		
3		

COMPLAINTS/CONCERNS

10. What do you hope to achieve in your visit with us?

11. When was the last time you felt well?

Did something trigger your change in health?
○ Yes ○ No

What makes you feel worse?

What makes you feel better?

12. Please list current and ongoing problems in order of priority:

	Describe Problem	Mild, Moderate or Severe
1		
2		
3		

13.

	Prior Treatment/Approach	Excellent, Good or Fair
1		
2		
3		

MEDICAL HISTORY DISEASES/DIAGNOSIS/CONDITIONS

Check appropriate box and provide date of onset.

14. GASTROINTESTINAL:

	Yes	Date of Onset
Irritable Bowel Syndrome		
Inflammatory Bowel Disease		
Crohn's		
Ulcerative Colitis		
Gastritis or Peptic Ulcer Disease		
GERD (reflux)		
Celiac Disease		
Other		

If other, please specify:

_____

15. CARDIOVASCULAR:

	Yes	Date of Onset
Heart Attack		
Other Heart Disease		
Stroke		
Elevated Cholesterol		
Arrythmia (irregular heart rate)		
Hypertension (high blood pressure)		
Rheumatic Fever		
Mitral Valve Prolapse		
Other		

If other, please specify:

_____

16. METABOLIC/ENDOCRINE:

	Yes	Date of Onset
Type 1 Diabetes		
Type 2 Diabetes		
Hypoglycemia		
Metabolic Syndrome		
Insulin Resistance or Pre-Diabetes		
Hypothyroidism (low thyroid)		
Hyperthyroidism (overactive thyroid)		
Endocrine Problems		
Polycystic Ovarian Syndrome (PCOS)		
Infertility		
Weight Gain		
Weight Loss		
Frequent Weight Fluctuations		
Bulimia		
Anorexia		
Binge Eating Disorder		
Night Eating Syndrome		
Eating Disorder (non-specific)		
Other		

If other, please specify:

17. CANCER:

	Yes	Date of Onset
Lung Cancer		
Breast Cancer		
Colon Cancer		
Ovarian Cancer		
Prostate Cancer		
Skin Cancer		

18. GENITAL AND URINARY SYSTEMS:

	Yes	Date of Onset
Kidney Stones		
Gout		
Interstitial Cystitis		
Frequent Urinary Tract Infections		
Frequent Yeast Infections		
Erectile Dysfunction or Sexual Dysfunction		
Other		

If other, please specify:

_____

19. MUSCULOSKELETAL/PAIN:

	Yes	Date of Onset
Osteoarthritis		
Fibromyalgia		
Chronic Pain		
Other		

If other, please specify:

_____

20. INFLAMMATORY/AUTOIMMUNE:

	Yes	Date of Onset
Chronic Fatigue Syndrome		
Autoimmune Disease		
Rheumatoid Arthritis		
Lupus SLE		
Immune Deficiency Disease		
Herpes-Genital		
Severe Infectious Disease		
Poor Immune Function		
Frequent Infections		
Food Allergies		
Environmental Allergies		
Multiple Chemical Sensitivities		
Latex Allergy		
Other		

If other, please specify:

_____

21. RESPIRATORY DISEASES:

	Yes	Date of Onset
Asthma		
Chronic Sinusitis		
Bronchitis		
Emphysema		
Pneumonia		
Tuberculosis		
Sleep Apnea		
Other		

If other, please specify:

22. SKIN DISEASES:

	Yes	Date of Onset
Eczema		
Psoriasis		
Acne		
Melanoma		
Skin Cancer		
Other		

If other, please specify:

23. NEUROLOGIC/MOOD:

	Yes	Date of Onset
Depression		
Anxiety		
Bipolar Disorder		
Schizophrenia		
Headaches		
Migraines		
ADD/ADHD		
Autism		
Mild Cognitive Impairment		
Memory Problems		
Parkinson's Disease		
Multiple Sclerosis		
ALS		
Seizures		
Other Neurological Problems		

If other, please specify:

_____

24. PREVENTIVE TESTS AND DATE OF LAST TEST: Check box if yes and provide date.

	Yes	Date of Last Test
Full Physical Exam		
Bone Density		
Colonoscopy		
Cardiac Stress Test		
EBT Heart Scan		
EKG		
Hemoccult Test-stool test for blood		
MRI		
CT Scan		
Upper Endoscopy		
Upper GI Series		
Ultrasound		

25. INJURIES:

☐ Back Injury ☐ Head Injury ☐ Neck Injury
☐ Broken Bones

26. SURGERIES: Check box if yes and provide date of surgery.

	Yes	Date of Surgery
Appendectomy		
Hysterectomy +/- Ovaries		
Gall Bladder		
Hernia		
Tonsillectomy		
Dental Surgery		
Joint Replacement –Knee/Hip		
Heart Surgery–Bypass Valve		
Angioplasty or Stent		
Pacemaker		
None		
Other		

If other, please specify:

_____

27. HOSPITALIZATIONS:

☐ None

28.

	Date	Reason
1		
2		
3		

GYNECOLOGIC HISTORY (FOR WOMEN ONLY)

29. OBSTETRIC HISTORY (Check box if yes and provide number)

	YES	Number
Pregnancies		
Caesarean		
Vaginal deliveries		
Miscarriage		
Abortion		
Living Children		

30.

☐ Post PartumDepression ☐ Toxemia ☐ Gestational Diabetes Baby Over 8 Pounds

31. Breastfeeding?

○ Yes
○ No

If yes, for how long?

_____

32. MENSTRUAL HISTORY:

Age at First Period: _____

Menses Frequency: _____

Length: _____

Pain?
○ Yes ○ No

Clotting?
○ Yes ○ No

33. Has your period ever skipped?

○ Yes
○ No

If yes, for how long?

_____

34. Last Menstrual Period:

_____

35. Use of hormonal contraception such as:
☐ Birth Control Pills ☐ Patch ☐ Nuva Ring

How long? _____

36. Do you use contraception?

○ Yes
○ No

37. If yes, which ones:

○ Condom
○ IUD
○ Diaphragm
○ Partner Vasectomy

38. WOMEN'S DISORDERS/HORMONAL IMBALANCES:

☐ Fibrocystic Breasts ☐ Endometriosis ☐ Fibroids ☐ Infertility ☐ Painful Periods ☐ Heavy periods ☐ PMS

Last Mammogram: _____

Breast Biopsy/Date: _____

Last Bone Density: _____

Results:
○ High ○ Low ○ Within Normal Range

39. Are you in menopause?

○ Yes
○ No

If yes, age at menopause:

_____

40. ☐ Hot Flashes ☐ Mood Swings ☐ Concentration/Memory Problems
☐ Vaginal Dryness ☐ Decreased Libido

41. ☐ Heavy Bleeding ☐ Joint Pains ☐ Headaches
☐ Weight Gain ☐ Loss of Control of Urine ☐ Palpitations

42. Use of hormone replacement therapy?

○ Yes
○ No

If yes, how long?

_____

MEN'S HISTORY (FOR MEN ONLY)

43. Have you had a PSA done?

- ○ Yes
- ○ No

44. If yes, PSA Level:

- ○ 0-2
- ○ 2-4
- ○ 4-10
- ○ >10

45.
- ☐ Prostate Enlargement
- ☐ Prostate infection
- ☐ Change in Libido
- ☐ Impotence
- ☐ Difficulty Obtaining an Erection
- ☐ ifficulty Maintaining an Erection
- ☐ Urgency/Hesitancy/Change in Urinary Stream
- ☐ Loss of Control of Urine

46. Nocturia (urination at night)?

- ○ Yes
- ○ No

If yes, how many times at night?

_____

GI HISTORY

47. Foreign Travel?

- ○ Yes
- ○ No

If yes, where:

_____

48. Wilderness Camping?

- ○ Yes
- ○ No

If yes, where:

_____

49. Have you ever had severe:

- ☐ Gastroenteritis
- ☐ Diarrhea

50. Do you feel like you digest your food well?

- ○ Yes
- ○ No

51. Do you feel bloated after meals?

- ○ Yes
- ○ No

52. PATIENT BIRTH HISTORY:

○ Term ○ Premature

Pregnancy Complications:

Birth Complications:

53. Are you:

- ○ Breast fed
- ○ Bottle fed

If breastfed, how long?

54. Age at introduction of:

	Age
Solid Foods	
Dairy	
Wheat	

55. Did you eat a lot of candy or sugar as a child?

- ○ Yes
- ○ No

56. DENTAL HISTORY:

- ☐ Silver Mercury Fillings (How many?): _____
- ☐ Gold Fillings _____
- ☐ Root Canals (How many?): _____
- ☐ Implants _____
- ☐ Tooth Pain _____
- ☐ Bleeding Gums _____
- ☐ Gingivitis _____
- ☐ Problems with Chewing _____

57. Do you floss regularly?

- ○ Yes
- ○ No

MEDICATIONS

58. CURRENT MEDICATIONS:

	MEDICATION	DOSE	FREQUENCY	START DATE (MONTH/YEAR)	REASON FOR USE
1					
2					
3					

59. PREVIOUS MEDICATIONS: Last 10 years.

	MEDICATION	DOSE	FREQUENCY	START DATE (MONTH/YEAR)	REASON FOR USE
1					
2					
3					

60. NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY):

	SUPPLEMENT AND BRAND	DOSE	FREQUENCY	START DATE (MONTH/YEAR)	REASON FOR USE
1					
2					
3					

61. Have your medications or supplements ever caused you unusual side effects or problems?

- ○ Yes
- ○ No

62. If yes, please describe:

_____

63. Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin?

- ○ Yes
- ○ No

64. Have you had prolonged or regular use of Tylenol?

- ○ Yes
- ○ No

65. Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.)

- ○ Yes
- ○ No

66. Frequent antibiotics > 3 times/year?

- ○ Yes
- ○ No

67. Long term antibiotics?

- ○ Yes
- ○ No

68. Use of steroids (prednisone, nasal allergy inhalers) in the past?

- ○ Yes
- ○ No

69. Use of oral contraceptives?

- ○ Yes
- ○ No

70. FAMILY HISTORY:

	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age (if still alive)												
Age at death (if deceased)												

71. Check family members that apply:

	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Othe
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Sondylitis)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Thyroid Problems												
Lupus												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities or Intolerances												

Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												
Other												

If other, specify:

_____

SOCIAL HISTORY

72. NUTRITION HISTORY:

Have you ever had a nutrition consultation?

○ Yes ○ No

73. Have you made any changes in your eating habits because of your health?

○ Yes

○ No

74. If yes, please describe:

_____

_____

_____

_____

75. Do you currently follow a special diet or nutritional program?

○ Yes

○ No

76. Check all that apply:

- ☐ Low Fat
- ☐ Low Carbohydrate
- ☐ High Protein
- ☐ Low Sodium
- ☐ Diabetic
- ☐ No Dairy
- ☐ No Wheat
- ☐ Gluten Restricted
- ☐ Vegetarian
- ☐ Vegan
- ☐ Specific Program for Weight Loss/Maintenance Type:
- ☐ Other:

77. Height:

Current Weight:

Usual Weight Range +/- 5 lb:

Desired Weight Range +/- 5 lbs:

Highest adult weight:

Lowest adult weight

Weight Fluctuations (> 10 lbs.):
○ Yes ○ No

No Body Fat %:

78. How often do you weigh yourself?

- ○ Daily
- ○ Weekly
- ○ Monthly
- ○ Rarely
- ○ Never

79. Do you avoid any particular foods?

- ○ Yes
- ○ No

80. If yes, types and reason:

81. Do you grocery shop?

- ○ Yes
- ○ No

If no, who does the shopping?

82. Do you read food labels?

- ○ Yes
- ○ No

83. Do you cook?

- ○ Yes
- ○ No

If no, who does the cooking?

84. How many meals do you eat out per week?

- ○ 0-1
- ○ 1-3
- ○ 3-5
- ○ >5 meals per week

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

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

86. The most important thing I should change about my diet to improve my health is:

_____

_____

_____

_____

87. SMOKING:

Currently Smoking?

○ Yes ○ No

88. If currently smoking:

How many years? _____

Packs per day: _____

Attempts to quit: _____

89. Previous Smoking:

How many years? _____

Packs per day? _____

Second Hand Smoke Exposure?

○ Yes ○ No

90. ALCOHOL INTAKE:

How many drinks currently per week? 1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits

○ None ○ 1-3 ○ 4-6 ○ 7-10 ○ > 10

91. Previous alcohol intake?

○ Yes ○ No

If yes:

○ Mild ○ Moderate ○ High

92.

	Yes	No
Have you ever been told you should cut down your alcohol intake?		
Do you get annoyed when people ask you about your drinking?		
Do you ever feel guilty about your alcohol consumption?		
Do you ever take an eye-opener?		
Do you notice a tolerance to alcohol (can you “hold” more than others)?		
Have you ever been unable to remember what you did during a drinking episode?		
Do you get into arguments or physical fights when you have been drinking?		
Have you ever been arrested or hospitalized because of drinking?		
Have you ever thought about getting help to control or stop your drinking?		

93. OTHER SUBSTANCES:

Caffeine Intake:
○ Yes ○ No

Coffee cups/day:
○ 1 ○ 2-4 ○ > 4

Tea cups/day:
○ 1 ○ 2-4 ○ > 4

Caffeinated Sodas or Diet Sodas Intake:
○ Yes ○ No

12-ounce can/bottle:
○ 1 ○ 2-4 ○ > 4 per day

List favorite type (Ex. Diet Coke, Pepsi, etc.):

_____

94. Are you currently using any recreational drugs?

○ Yes
○ No

If yes, what type:

_____

95. 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			
Strength			
Other (yoga, pilates, gyrotonics, etc.)			
Sports or Leisure Activities (golf, tennis, rollerblading, etc.)			

96. Rate your level of motivation for including exercise in your life?

○ Low
○ Medium
○ High

97. List problems that limit activity:

_____
_____
_____
_____

98. Do you feel unusually fatigued after exercise?

- ○ Yes
- ○ No

99. If yes, please describe:

_____

100Do you usually sweat when exercising?

- ○ Yes
- ○ No

101PSYCHOSOCIAL:

	Yes	No
Do you feel significantly less vital than you did a year ago?		
Are you happy?		
Do you feel your life has meaning and purpose?		
Do you believe stress is presently reducing the quality of your life?		
Do you like the work you do?		
Have you ever experienced major losses in your life?		
Do you spend the majority of your time and money to fulfill responsibilities and obligations?		
Would you describe your experience as a child in your family as happy and secure?		

102STRESS/COPING:

Have you ever sought counseling?

○ Yes ○ No

103Are you currently in therapy?

- ○ Yes
- ○ No

104If yes, describe:

_____

_____

_____

_____

105Do you feel you have an excessive amount of stress in your life?

- ○ Yes
- ○ No

106Do you feel you can easily handle the stress in your life?

- ○ Yes
- ○ No

107. Daily Stressors: Rate on scale of 1-10.

	Rate
Work	
Family	
Social	
Finances	
Health	
Other	

108. Do you practice meditation or relaxation techniques?

- ○ Yes
- ○ No

If yes, how often:

_____

109. Check all that apply:

- ☐ Yoga
- ☐ Meditation
- ☐ Imagery
- ☐ Breathing
- ☐ Tai Chi
- ☐ Prayer
- ☐ Other

If other, specify:

_____

110. Have you ever been abused, a victim of a crime, or experienced a significant trauma?

- ○ Yes
- ○ No

111. SLEEP/REST:

Average number of hours you sleep per night:
○ >10 ○ 8-10 ○ 6-8 ○ < 6

112.

	Yes	No
Do you have trouble falling asleep?		
Do you feel rested upon awakening?		
Do you have problems with insomnia?		
Do you snore?		

113. Do you use sleeping aids?

- ○ Yes
- ○ No

114. If using sleeping aids, please explain:

_____

_____

_____

_____

ROLES/RELATIONSHIP

115. Marital status:

○ Single ○ Married ○ Divorced ○ Gay/Lesbian ○ Long Term Partnership ○ Widow

116. List Children:

	Child's Name	Age	Gender
1			
2			
3			

117. Who is Living in Household? Number:

_____

118.

	Name/s	Their employment/Occupations
1		
2		
3		

119. Resources for emotional support? Check all that apply:

☐ Spouse ☐ Family ☐ Friends

☐ Religious/Spiritual ☐ Pets ☐ Other

If other, specify:

_____

120. Are you satisfied with your sex life?

○ Yes

○ No

121. How well have things been going for you?

	Very Well	Fine	Poorly	Does Not Apply
Overall				
At School				
In your job				
In your social life				
With your friends				
With sex				
With your attitude				
With your boyfriend/girlfriend				
With your children				
With your parents				
With your spouse				

ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

122. Do you have known adverse food reactions or sensitivities?

○ Yes

○ No

123. If yes, describe symptoms:

_____

_____

_____

_____

124. Do you have any food allergies or sensitivities?

- ○ Yes
- ○ No

125. If yes, list all:

	Allergy / Sensitivity	Reaction
1		
2		
3		

126. Do you have an adverse reaction to caffeine?

- ○ Yes
- ○ No

127. When you drink caffeine do you feel:

- ☐ Irritable or wired
- ☐ Aches & Pains

128. Do you adversely react to (Check all that apply):

- ☐ Monosodium glutamate (MSG)
- ☐ Aspartame (Nutrasweet)
- ☐ Caffeine
- ☐ Bananas
- ☐ Garlic
- ☐ Onion
- ☐ Cheese
- ☐ Cheese
- ☐ Chocolate
- ☐ Alcohol
- ☐ Red Wine
- ☐ Sulfite Containing Foods (wine, dried fruit, salad bars)
- ☐ Preservatives (ex. sodium benzoate)
- ☐ Other

If other, specify:

_____

129. Which of these significantly affect you? Check all that apply:

- ☐ Cigarette Smoke
- ☐ Perfumes/Colognes
- ☐ Auto Exhaust Fumes
- ☐ Other

If other, specify:

_____

130. In your work or home environment, are you exposed to:

- ☐ Chemicals
- ☐ Electromagnetic Radiation
- ☐ Mold

131. Have you ever turned yellow (jaundiced)?

- ○ Yes
- ○ No

132. Have you ever been told you have Gilbert's syndrome or a liver disorder?

- ○ Yes
- ○ No

133.If yes, please explain:

134.Do you have a known history of significant exposure to any harmful chemicals such as the following:

- ☐ Herbicides
- ☐ Insecticides (frequent visits of exterminator)
- ☐ Pesticides £Organic Solvents
- ☐ Heavy Metal
- ☐ Other

135.

	Chemical Name	Date	Length of Exposure
1			
2			
3			

136.Do you dry clean your clothes frequently?

- ○ Yes
- ○ No

137.Do you or have you lived or worked in a damp or moldy environment or had other mold exposures?

- ○ Yes
- ○ No

138.Do you have any pets or farm animals?

- ○ Yes
- ○ No

SYMPTOM REVIEW

Please check all current symptoms or those present in during the past the 6 months.

139. GENERAL:

- ☐ Cold Hands & Feet
- ☐ Cold Intolerance
- ☐ Low Body Temperature
- ☐ Low Blood Pressure
- ☐ Low Blood Pressure
- ☐ Difficulty Falling Asleep
- ☐ Early Waking
- ☐ Fatigue
- ☐ Fever
- ☐ Flushing
- ☐ Heat Intolerance
- ☐ Night Waking
- ☐ Nightmares
- ☐ No Dream Recall

140. HEAD, EYES & EARS:

- ☐ Conjunctivitis
- ☐ Distorted Sense of Smell
- ☐ Distorted Taste
- ☐ Ear Fullness
- ☐ Ear Pain
- ☐ Ear Ringing/Buzzing
- ☐ Lid Margin Redness
- ☐ Eye Crusting
- ☐ Eye Pain
- ☐ Hearing Loss
- ☐ Hearing Problems
- ☐ Headache
- ☐ Migraine
- ☐ Sensitivity to Loud Noises
- ☐ Vision problems (other than glasses)
- ☐ Macular Degeneration
- ☐ Vitreous Detachment
- ☐ Retinal Detachment

141. MUSCULOSKELETAL:

- ☐ Back Muscle Spasm
- ☐ Calf Cramps
- ☐ Chest Tightness
- ☐ Foot Cramps
- ☐ Joint Deformity
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Stiffness
- ☐ Muscle Pain
- ☐ Muscle Spasms
- ☐ Muscle Stiffness

142. Muscle Twitches:

- ☐ Around Eyes
- ☐ Arms or Legs
- ☐ Muscle Weakness
- ☐ Neck Muscle Spasm
- ☐ Tendonitis
- ☐ Tension Headache
- ☐ TMJ Problems

143. MOOD/NERVES:

- ☐ Agoraphobia
- ☐ Anxiety
- ☐ Auditory Hallucinations
- ☐ Black-out
- ☐ Depression
- ☐ Dizziness (Spinning)
- ☐ Fainting
- ☐ Fearfulness
- ☐ Irritability
- ☐ Light-headedness
- ☐ Numbness
- ☐ Other Phobias
- ☐ Panic Attacks
- ☐ Paranoia
- ☐ Seizures
- ☐ Suicidal Thoughts
- ☐ Tingling
- ☐ Tremor/Trembling
- ☐ Visual Hallucinations

144. Difficulty:

- ☐ Concentrating
- ☐ With Balance
- ☐ With Thinking
- ☐ With Judgment
- ☐ With Speech
- ☐ With Memory

145. EATING:

- ☐ Binge Eating
- ☐ Bulimia
- ☐ Can't Gain Weight
- ☐ Can't Lose Weight
- ☐ Can't Maintain Healthy Weight
- ☐ Frequent Dieting
- ☐ Poor Appetite
- ☐ Salt Cravings
- ☐ Carbohydrate Craving (breads, pastas)
- ☐ Sweet Cravings (candy, cookies, cakes)
- ☐ Chocolate Cravings
- ☐ Caffeine Dependency

146DIGESTION:

- ☐ Anal Spasms
- ☐ Bad Teeth
- ☐ Bleeding Gums
- ☐ Blood in Stools
- ☐ Burping
- ☐ Canker Sores
- ☐ Cold Sores
- ☐ Constipation
- ☐ Cracking at Corner of Lips
- ☐ Cramps
- ☐ Dentures w/Poor Chewing
- ☐ Diarrhea
- ☐ Alternating Diarrhea and Constipation
- ☐ Difficulty Swallowing
- ☐ Dry Mouth
- ☐ Excess Flatulence/Gas
- ☐ Fissures
- ☐ Foods “Repeat” (Reflux)
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Upper Abdominal Pain
- ☐ Upper Abdominal Pain
- ☐ Liver Disease/Jaundice (Yellow Eyes or Skin)
- ☐ Abnormal Liver Function Tests
- ☐ Lower Abdominal Pain
- ☐ Mucus in Stools
- ☐ Periodontal Disease
- ☐ Sore Tongue
- ☐ Strong Stool Odor
- ☐ Undigested Food in Stomach

147Bloating of:

- ☐ Lower Abdomen
- ☐ Whole Abdomen
- ☐ Bloating After Meals

148SKIN PROBLEMS:

- ☐ Acne on Back
- ☐ Acne on Chest
- ☐ Acne on Face
- ☐ Acne on Shoulders
- ☐ Athlete’s Foot
- ☐ Bumps on Back of Upper Arms
- ☐ Cellulite
- ☐ Dark Circles Under Eyes
- ☐ Ears Get Red
- ☐ Easy Bruising
- ☐ Lack Of Sweating
- ☐ Eczema
- ☐ Hives
- ☐ Jock Itch
- ☐ Lackluster Skin
- ☐ Moles w/Color/Size Change
- ☐ Oily Skin
- ☐ Pale Skin
- ☐ Patchy Dullness
- ☐ Rash
- ☐ Red Face
- ☐ Sensitivity to Bites
- ☐ Sensitivity to Poison Ivy/Oak
- ☐ Shingles
- ☐ Skin Darkening
- ☐ Strong Body Odor
- ☐ Hair Loss
- ☐ Vitiligo

149ITCHING SKIN:

- ☐ Skin in General
- ☐ Anus
- ☐ Arms
- ☐ Ear Canals
- ☐ Eyes
- ☐ Feet
- ☐ Hands
- ☐ Legs
- ☐ Nipples
- ☐ Nose
- ☐ Penis
- ☐ Roof of Mouth
- ☐ Scalp
- ☐ Throat

150SKIN, DRYNESS OF:

- ☐ Eyes
- ☐ Feet
- ☐ Hair
- ☐ Hands
- ☐ Mouth/Throat
- ☐ Scalp
- ☐ Skin In General

151.Feet:

☐ Cracking? ☐ Peeling?

Hair:

☐ Unmanageable?

Hands:

☐ Cracking? ☐ Peeling?

Scalp:

☐ Dandruff?

152. LYMPH NODES:

- ☐ Enlarged/neck
- ☐ Tender/neck
- ☐ Other Enlarged/Tender
- ☐ Lymph Nodes

153. NAILS:

- ☐ Bitten
- ☐ Brittle
- ☐ Curve Up
- ☐ Frayed
- ☐ Fungus-Fingers
- ☐ Fungus-Toes
- ☐ Pitting
- ☐ Ragged Cuticles
- ☐ Ridges
- ☐ Soft

154. Thickening of:

- ☐ Fingernails
- ☐ Toenails
- ☐ White Spots/Lines

155. RESPIRATORY:

- ☐ Bad Breath
- ☐ Bad Odor in Nose
- ☐ Cough-Dry
- ☐ Cough-Productive
- ☐ Hoarseness
- ☐ Sore Throat
- ☐ Nasal Stuffiness
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Fullness
- ☐ Sinus Infection
- ☐ Snoring
- ☐ Wheezing
- ☐ Winter Stuffiness

156. Hay Fever:

- ☐ Spring
- ☐ Summer
- ☐ Fall
- ☐ Change Of Season

157. CARDIOVASCULAR:

- ☐ Angina/chest pain
- ☐ Breathlessness
- ☐ Heart Murmur
- ☐ Irregular Pulse
- ☐ Palpitations
- ☐ Phlebitis
- ☐ Swollen Ankles/Feet
- ☐ Varicose Veins

158. URINARY:

- ☐ Bed Wetting
- ☐ Hesitancy (trouble getting started)
- ☐ Infection
- ☐ Kidney Disease
- ☐ Leaking/Incontinence
- ☐ Pain/Burning
- ☐ Prostate Infection
- ☐ Urgency

159. MALE REPRODUCTIVE:

- ☐ Discharge From Penis
- ☐ Ejaculation Problem
- ☐ Genital Pain
- ☐ Genital Pain
- ☐ Prostate or Urinary Infection
- ☐ Lumps In Testicles
- ☐ Poor Libido (Sex Drive)

160. FEMALE REPRODUCTIVE:

- ☐ Breast Cysts
- ☐ Breast Lumps
- ☐ Breast Tenderness
- ☐ Ovarian Cyst
- ☐ Poor Libido (Sex Drive)
- ☐ Vaginal Discharge
- ☐ Vaginal Odor
- ☐ Vaginal Itch
- ☐ Vaginal Pain with Sex

161. Premenstrual:

- ☐ Bloating Breast Tenderness
- ☐ Carbohydrate Cravings
- ☐ Chocolate Cravings
- ☐ Constipation
- ☐ Decreased Sleep
- ☐ Diarrhea
- ☐ Fatigue
- ☐ Increased Sleep
- ☐ Irritability

162Menstrual:

- ☐ Cramps
- ☐ Heavy Periods
- ☐ Irregular Periods
- ☐ No Periods
- ☐ Scanty Periods
- ☐ Spotting Between

READINESS ASSESSMENT

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

In order to improve your health, how willing are you to:	5 - Very willing	4	3	2	1 - Not willing
Significantly modify your diet					
Take several nutritional supplements each day.					
Keep a record of everything you eat each day					
Modify your lifestyle (e.g., work demands, sleep habits)					
Practice a relaxation technique					
Engage in regular exercise					
Have periodic lab tests to assess your progress					

164. Comments:

165. Rate on a scale of 5 (very confident) to 1 (not confident at all):

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

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities?

166. 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

Comments:

167. Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact):

How much on-going support and contact (e.g., telephone consults, e-mail correspondence) from our professional staff would be helpful to you as you implement your personal health program?
○ 5 ○ 4 ○ 3 ○ 2 ○ 1

Comments:

168. ADDITIONAL NOTES:

I hereby certify that the above statements are true and correct to the best of my knowledge. I understand that a false statement may lead to poor outcomes and slower progress with my program. It may also render incorrect protocols. I also certify that any additional information not listed in this form has been provided both verbally and in written communication to the medical providers at Benchmark Medical Group.

Signature

Date