The Mind-Body Clinic

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OFFICE POLICIES

Insurance

Due to unsustainably low rates paid by insurance companies, I am no longer on any panels. I will, however, provide patients who have PPO plans insurance-suitable invoices so that reimbursement for office visit fees can be facilitated.

In many cases lab work will be paid for even when the fees for office visits are not reimbursed. Some of the laboratories we utilize will bill insurance and wait for payment. Others, who have "pay-assured" programs may require a guaranteed minimum be paid at the time of sample submission, and pursue the insurer for the remainder. A few others are preferred providers, and will not charge covered patients. Most labs, however, will do courtesy billing to aid you in obtaining reimbursement but will require up-front payment.

Fees

Consultations

Psychotherapy is a treatment that requires continuity and some degree of frequency – at least once a week for the duration of care – to be optimally effective. To make this affordable, patients who are receiving naturopathic medical care and who are in psychotherapy with Dr. Clifford or me will pay a fee of $210.00 per session for all visits. The same fee will be charged to those patients who are receiving only psychotherapy.

Patients receiving only naturopathic medical care are charged at a rate of $300.00 per 50-minute session.

Occasionally, double appointments are indicated.

There is no charge for brief telephone consultations of 5 minutes or less.

Patients have the options of paying at the time of each consultation appointment, or at the beginning of the month for all scheduled appointments.

Under circumstances of significant financial hardship, a lower fee may be negotiated.

Laboratory Diagnostic Services

The cost for diagnostic tests vary depending on the fee schedule of the specific laboratories utilized and the tests ordered. Patients will be informed of these costs before any tests are ordered. We make no profit or commission from these tests. In most cases, payment to these labs must be made at the time samples are submitted.

Supplements, Medical Foods, and Medications

The cost for these items will vary according to the specific products and dosage recommended. For the convenience of patients, supplements may be ordered through our web site. While it may be possible to find the same or equivalent products from other sources, we utilize a distributor that handles only medical-grade products and who gives our patients a 10% discount off of the retail price. Twenty percent of that retail price is paid to us as a partial compensation for the time required to research and determine the most appropriate botanical medicines and nutritional supplement for each patient.

Most hormone prescriptions are sent to a pharmacy that specializes in compounding bio-identical hormones. For the convenience of patients, refills can ordered from them through our web site. We derive no commission from the prescriptions. All financial transactions regarding these prescriptions are handled by the pharmacy itself.

Cancellation Policy

Naturopathic Consultations

If appointments are cancelled with a minimum of 24 hours notice, there will be no charge, and every effort will be made to reschedule the appointment. If notice is not given, the patient will be charge based on the amount of time reserved for the appointment.

Psychotherapy Sessions

Given the schedule commitments necessary for long term in-depth weekly psychotherapy, missed hours cannot usually be filled by other patients. Therefore, once an hour is reserved for a patient, he or she will be expected to pay. However, if a minimum of 24 hours notice of an absence is given, the session can be rescheduled for a time later in the month. This rescheduling is not just fundamental to the financial viability of my practice but essential to the clinical integrity of the work itself. It facilitates the continuity that is so vital to the effectiveness of psychotherapy.

Vacations will be exempt from this policy, provided there is some advanced notice given. Those missed sessions will not have to be rescheduled or paid for. However, patients whose vacations are longer than two weeks may not be able to hold the hour reserved for them in the event that there is a demand for that hour.

Confidentiality in Psychotherapy

All information discussed within the patient-therapist relationship, including records, is confidential and will not be revealed to anyone without your written permission. There are several important situations when I am legally and ethically **required** to go outside the context of the therapeutic relationship. These are:

a.) If you communicate to me a serious threat of violence toward someone, I must warn that person and the police.

b.) If I have reasonable suspicion that a child, a helpless adult, or an elder is being abused, I must report it to the appropriate agency.

c.) If during a legal proceeding a patient brings into evidence his or her own psychotherapy, the court will waive privilege in requesting therapy records, as well as the possible testimony from the therapist.

There are some instances in which I have the legal **option** of going outside the therapeutic relationship. These are:

a.) If I believe a patient is a danger to himself or herself or others, or is gravely disabled, I must do whatever I can within the limits of the law to ensure that that person is not injured, does not injure others, and receives proper medical care. Under these circumstances I may communicate with the persons you list on this form as emergency contacts, and/or I may arrange for the patient to be transported to the hospital.

b.) If a patient refuses to pay his or her balance, the necessary information can be given to a collection agency or to a small claims court.

While all the above limits to confidentiality apply in the case of couples therapy, each member of a couple must keep in mind the following additional considerations: When one partner communicates with me individually (without the presence of the other), whether by phone, letter, or in person, confidentiality will not apply between members of the couple. I will use my clinical judgment when deciding to reveal such information.

Disclosure of confidential information may be required by your health insurance carrier in order to process the claims. Only the minimum necessary information will be communicated to the carrier. I have no control over, or knowledge of what insurance companies do with the information, or who has access to it.

Arbitration

Attached is an arbitration agreement, which I respectfully urge you to sign. We will thereby agree that any disputes arising out of the services you receive from this office will be resolved through binding arbitration rather than in a court of law.

Binding arbitration has benefits for both doctors and patients. Jurists, such as former United States Supreme Court Chief Justice Warren Burger and California Supreme Court Chief Justice Malcolm Lucas, favor arbitration as an alternative method of dispute resolution. The California Supreme Court has noted that arbitration is speedier and less costly than are jury trials for resolving disputes between doctors and patients. Both parties are spared some of the rigors of trial, and the publicity that may accompany judicial proceedings. In addition, because virtually no appeals of an arbitrated award are allowed, the prevailing party can expect either prompt payment or prompt dismissal of the case without facing the lengthy appeals process.

Please sign the agreement after reading it carefully and asking any questions you may have.

I/we have read, understand, and accept the above statements and policies.

Print Name	Signature	Date

Print Name	Signature	Date

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Consent to Release Information

I/we (print names)_____give my/our permission to Dr. Stephen J. Ducat and the following people to speak with one another, and/or to exchange pertinent medical or psychological information and documents whenever necessary for the coordination of my treatment:

Name: Address: Phone:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Signed: Date:

_____
_____

GENERAL INFORMATION

Name

_____

Preferred Name_____Date _____

Address_____City_____State_____Zip Code _____

Home Phone_____Work Phone _____

Cell Phone _____ Email _____

Age_____Date of birth_____Place of birth_____Gender: female___ male___

Occupation_____Hours per week _____ Retired _____

Nature of business_____

Insurance carrier (indicate if PPO or HMO)_____

The problem(s) you would like help with_____

How did you hear about this practice? Book_____Website_____Media_____Friend/ family member_____

Other/referred by _____

Next of kin or other to reach in an emergency _____

Relationship_____Phone _____

Address _____

Genetic background: Please check appropriate box(es):

❑ African American ❑ Hispanic ❑ Mediterranean ❑ Asian

❑ Native American ❑ Caucasian ❑ Northern European ❑ Other

Who is your primary medical physician?_____His or her address & phone#_____

PERSONAL DESCRIPTIVE INFORMATION

Marital/domestic partner status:

❑ Single ❑ Married ❑ Divorced

❑ Widow ❑ Long Term Partnership

List Children:

Child's Name	Age	Gender

With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)
Example: Wendy, age 7, sister

_____

_____

Do you have any pets or animals? Yes_____ No____

If yes, where do they live? Indoors_____Outdoors_____Both indoors and outdoors _____

Have you ever lived or travelled outside the United States? Yes_____No _____

If so, when and where? _____

_____

Have you or your family recently experienced any major life changes? Yes____ No____

If yes, please comment:

_____

_____

Have you experienced any major losses in life? Yes_____ No____

If so, please comment:

_____

_____

How much time have you lost from work or school due to illness or other difficulties in the past year?

a._____0-2 days b._____3 –14 days c._____> 15 days

Jobs held prior to current occupation:

_____

_____

Please list your highest level of education:

- ❑ High School
- ❑ College _____ Major: _____ Year: _____
- ❑ Graduate School _____ Field: _____ Year: _____
- ❑ Professional School _____ Field: _____ Year: _____
- ❑ Did you have learning problems?_____Explain _____

Health Questionnaire

Please complete the following health questionnaire to the best of your ability. You may need family members to help supply information. You will notice that this is a longer set of questionnaires than you typically fill out at the doctor's office. The breadth and depth of this history form are essential to identifying the multiple and interacting factors that have contributed to your physical and/or psychological symptoms. Your answers will be crucial guides to which laboratory tests are the most appropriate.

Your thoroughness in answering all these questions will not only help me evaluate the root cause of your health concerns and determine an effective treatment program. It will also enable us to make the most economical use of our consultation time; you won't be paying me to ask these questions and write down your answers.

I am interested in so-called minor complaints, as well as major problems. Some patients are reluctant to mention very many symptoms for fear that they will be viewed as hypochondriacal. The perspective in this practice is different. I try to listen to all the messages your body communicates, no matter how seemingly irrelevant, odd, idiosyncratic, or inexplicable. Such symptoms can often be useful clues in the kind of medical detective work we will do together. So, do include as much information as you can on this form.

Please print or write legibly.

COMPLAINTS/CONCERNS

Please list your chief symptoms in order of decreasing severity, starting with the worst one. Please note how long each symptoms has been present.

Problem	Onset	Frequency	Severity
e.g. Headaches	June 2007	4 times per week	Mild / moderate / severe
1.			
2.			
3.			
4.			
5.			
6.			

What diagnosis or explanations have been given to you?

_____

_____

_____

_____

When was the last time you felt really well for more than a few days at a time?

_____

_____

What are your thoughts about what might have triggered your change in health?

What makes you feel **worse**?

What makes you feel **better**?

Please list all physicians or other health care providers you have seen for the above health conditions:

1. 4.
2. 5.
3. 6.

To what extent have prior treatments been helpful?

PAST MEDICAL & SURGICAL HISTORY

ILLNESSES	Date	Date	Date	Comments
Chicken pox		X	X	
German measles		X	X	
Measles		X	X	
Mononucleosis		X	X	
Mumps		X	X	
Whooping cough		X	X	
Tonsillitis				
Anemia				
Arthritis				
Asthma				
Bronchitis				
Cancer				
Chronic fatigue syndrome				
Chronic constipation				
Crohn's disease or Ulcerative colitis				
Diabetes				

Emphysema				
Epilepsy, convulsions				
Gallstones				
Gout				
Heart attack/Angina				
Heart failure				
Hepatitis				
High blood pressure				
Irritable bowel				
Kidney stones				
Pneumonia				
Rheumatic fever				
Sinusitis				
Sleep apnea				
Stroke				
Thyroid disease				
Other (describe)				
INJURIES	**Date**	**Date**	**Date**	**Comments**
Head injury				
Neck injury				
Back injury				
Fracture				
Other (describe)				
DIAGNOSTIC STUDIES	**Date**	**Date**	**Date**	**Comments**
Chest X-ray				
Mammogram				
EKG				
Sigmoidoscopy				
Colonoscopy				
Upper GI series				
Barium enema				
CAT scan of abdomen				
CAT scan of brain				
CAT scan of spine				
Liver scan				
Bone scan				
Neck X-rays				
Back X-rays				
MRI				
Bone density test				
Carotid artery ultrasound				
Blood tests				
Other (describe)				

OPERATIONS	Date	Date	Date	Comments
Tonsillectomy		X	X	
Tubes in ears				
Appendectomy		X	X	
Gall bladder		X	X	
Hernia				
Hysterectomy		X	X	
Dental surgery				
Other (describe)				
Other (describe)				

HOSPITALIZATIONS

Where Hospitalized	When	For What Reason

PATIENT BIRTH HISTORY

Question	Yes	No	Don't Know	Comment
Were you a full term baby?				
A preemie?				
Forceps delivery?				
Cesarean section?				
Epidural used?				
Breast fed?				
Bottle fed?				
When your mother was pregnant with you, did she:				
Smoke tobacco?				
Drink alcohol?				
Take estrogen?				

CHILDHOOD ILLNESSES AND CONDITIONS

Please indicate which, if any, of the following problems/conditions developed when you were a child (ages birth to age12) by indicating the approximate age of onset.

_____Frequent colds or flu
_____Bronchitis
_____Measles
_____Chicken pox
_____Strep infections
_____Significant dental work
_____ADD
_____Difficulty learning:
_____High # of absences from school
_____Jaundice
_____Ear infections
_____Premature at birth
_____Fever blisters
_____Abusive or alcoholic parent (s)
_____Bed wetting
_____Major illness(s) that required hospitalization.
_____Tonsillitis
_____Chronic constipation
_____Mumps
_____Whooping cough
_____Seasonal allergies
_____Behavior problems
_____Hyperactivity
_____Frequent headaches
_____Upset stomach, indigestion
_____Colic
_____Congenital abnormalities
_____Pneumonia
_____Parent(s) smoked
_____Skin disorders (eczema)
_____Encopresis (fecal incontinence)

If yes, please explain your illness:

_____
_____
_____
_____
_____
_____
_____

IMMUNIZATION HISTORY

Please indicate if you have been vaccinated against any of the following diseases:

- ❑ Smallpox
- ❑ Tetanus
- ❑ Diphtheria
- ❑ Pertussis
- ❑ Polio (oral)
- ❑ Polio (Injection)
- ❑ Mumps
- ❑ Measles
- ❑ Rubella (German measles)
- ❑ Typhoid
- ❑ Cholera

Other_____

FEMALE MEDICAL HISTORY

OBSTETRICS HISTORY *Check box if yes and provide number*

❑ Pregnancies _____
❑ Caesarean _____
❑ Vaginal deliveries _____
❑ Miscarriage _____
❑ Abortion _____
❑ Living Children

❑ Post partum depression ❑ Toxemia ❑ Gestational diabetes

❑ Baby over 8 pounds ❑ Breast feeding For how long?_____

GYNECOLOGICAL HISTORY

Age at 1st period:_____ Menses Frequency: _____ Length: _____ Pain: Yes____No _____

Clotting: Yes _____ No _____ Has your period skipped?_____For how long? _____

Last Menstrual Period: _____

Do you currently use contraception? Yes_____No_____If yes, what type do you use?

❑ Condom ❑ Diaphragm ❑ IUD ❑ Partner vasectomy

Have you ever used hormonal contraception? Yes_____No If yes, when _____

_____

❑ Birth control pills -- How long? _____ ❑ Patch -- How long? _____ ❑ Nuva ring – How long? _____

Are you using the pill now? Yes _____ No _____ Does/did taking the pill produce side effects? Yes _____ No_____What were they? _____

In the 2nd half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)? ❑ Yes ❑ No

Last mammogram _____ Breast biopsy/date _____

Last PAP Test: _____ Normal _____ Abnormal _____

Date of last bone density: _____ Results: ❑ High ❑ Low ❑ Within normal range

Are you in menopause? Yes_____No _____ Age at menopause _____

Do you take: ❑ Estrogen ❑ Ogen ❑ Estrace ❑ Premarin Other _____

❑ Progesterone ❑ Provera Other _____

How long have you been on hormone replacement? _____

FAMILY HISTORY

(Please mark any health problem(s) your family has suffered with, either now or in the past)

Check Family Members that Apply	Father	Mother	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)												
Heart attack												
Stroke												
Uterine cancer												
Colon cancer												
Breast cancer												
Ovarian cancer												
Prostate cancer												

Skin cancer												
ADD/ADHD												
ALS or other motor neuron diseases												
Alzheimer's												
Anemia												
Anxiety												
Arthritis												
Asthma												
Autism												
Autoimmune diseases (such as Lupus)												
Bipolar disorder												
Bladder disease												
Blood clotting problems												
Celiac disease												
Dementia												
Depression												
Diabetes												
Eczema												
Emphysema												
Environmental sensitivities												
Epilepsy												
Flu												
Food Allergies, Sensitivities, Intolerances												
Genetic disorders												
Glaucoma												
Headache												
Heart disease												
High blood pressure												
High cholesterol												
Check Family Members that Apply	**Father**	**Mother**	**Brother(s)**	**Sister(s)**	**Children**	**Maternal Grandmother**	**Maternal Grandfather**	**Paternal Grandmother**	**Paternal Grandfather**	**Aunts**	**Uncles**	**Other**
Inflammatory arthritis (rheumatoid, psoriatic, ankylosing spondylitis)												
Inflammatory bowel disease												
Insomnia												
Irritable bowel syndrome												
Kidney disease												
Multiple sclerosis												
"Nervous breakdown"												
Obesity												
Osteoporosis												
Other												
Parkinson's												
Pneumonia/bronchitis												
Psoriasis												
Psychiatric disorders												

Schizophrenia												
Sleep apnea												
Smoking addiction												
Stroke												
Substance abuse (such as alcoholism)												
Ulcers												

Any other family history we should know about? Yes _____ No _____

If yes, please comment:

_____

_____

What is the attitude of those close to you about your illness? ❑ Supportive ❑ Non-supportive

MEDICATIONS & SUPPLEMENTS

ANTIBIOTIC USE

Antibiotics: How often have you taken antibiotics?

	< 5 times	**> 5 times**
Infancy/Childhood		
Teen		
Adulthood		

STEROID USE

Oral Steroids: How often have you taken oral steroids (e.g. Prednisone, Cortisone, etc.)?

	< 5 times	**> 5 times**
Infancy/Childhood		
Teen		
Adulthood		

Indicate any medications you're currently taking or have taken in the last month:

- ❑ Acid blocking drugs
- ❑ Anti-anxiety medications
- ❑ Antibiotics
- ❑ Anticonvulsants
- ❑ Antidepressants
- ❑ Antifungals
- ❑ Aspirin/Ibuprofen
- ❑ Asthma inhalers
- ❑ Beta blockers
- ❑ Birth control pills/implant contraceptives
- ❑ Chemotherapy
- ❑ Cholesterol lowering medications
- ❑ Diuretics
- ❑ Estrogen or progesterone (pharmaceutical or prescription)
- ❑ Estrogen or progesterone (natural)
- ❑ Heart medications
- ❑ High blood pressure medications
- ❑ Laxatives
- ❑ Relaxants/sleeping pills
- ❑ Testosterone (natural or prescription)
- ❑ Thyroid medication
- ❑ Acetaminophen (Tylenol)
- ❑ Ulcer medications

- ❑ Cortisone/steroids
- ❑ Diabetic medications/insulin
- ❑ Sildenafil citrate (Viagra or similar)

MEDICATION LOG

Please indicate the specific medications you are taking now. Please include non-prescription drugs.

Medication Name	Date Started	Dated Stopped	Dosage	# per day

SUPPLEMENT LOG

Supplements: List all vitamins, minerals and other nutritional supplements

Supplement Name/Brand	Dose	Frequency	Dated Started	Reason for Use

Have your medications or supplements ever caused you unusual side effects or problems?
Yes_____No_____If yes, please describe_____

_____

ALLERGIES

Medication/Supplement/Food	Reaction

NUTRITION & LIFESTYLE HISTORY

Have you made any changes in your eating habits because of your health? Yes_____ No_____

Do you currently follow a special diet or nutritional program? Yes_____ No_____

Check all that apply:

- ❑ Low fat
- ❑ Mixed food diet (animal and vegetable sources)
- ❑ High protein
- ❑ Vegetarian
- ❑ Vegan
- ❑ Gluten restricted
- ❑ Low sodium
- ❑ Fat restriction
- ❑ Low starch/carbohydrate
- ❑ The Blood type diet
- ❑ Metabolic Typing diet
- ❑ The Zone diet
- ❑ Total calorie restriction
- ❑ Ovo-lacto diet
- ❑ Diabetic
- ❑ No dairy
- ❑ No wheat
- ❑ Specific program for weight loss/maintenance Type:_____

Please check any specific food restrictions you have:

- ❑ Dairy
- ❑ Soy
- ❑ Other_____
- ❑ Wheat
- ❑ Corn
- ❑ Eggs
- ❑ All gluten

Is there anything special about your diet that we should know?

_____

_____

Height (feet/inches)_____

Current weight_____

Usual weight range +/- 5 lbs_____

Desired weight range +/- 5 lbs_____

Highest adult weight _____

Lowest adult weight _____

Weight fluctuations (>10lbs) Yes_____ No _____

Body fat % _____

How often do you weigh yourself? Daily_____Weekly_____Monthly_____Rarely_____Never _____

Eating Patterns

Are there any foods that you avoid because they give you symptoms? Yes_____ No_____

If yes, please name the food and symptom e.g. wheat – gas and bloating

Food	Symptom	Other comments

If you could only eat a few foods a week, what would they be?

_____

_____

_____

Do you grocery shop? Yes_____No_____If no, who does the shopping? _____

When you shop do you purchase the following?

❑ Organic Foods ❑ Hormone free and antibiotic free meat

Do you read food labels? Yes_____No _____

Do you cook? Yes_____No_____If no, who does the cooking?

_____

How many meals do you eat out per week? 0-1_____ 1-3____ 3-5____ >5_____

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

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

Place a check mark next to the food/drink that applies to your current diet. **Usual Breakfast**	**Usual Lunch**	**Usual Dinner**
❑ None	❑ None	❑ None
❑ Bacon/sausage	❑ Butter	❑ Beans (legumes)
❑ Bagel	❑ Coffee	❑ Brown rice
❑ Butter	❑ Eat in a cafeteria	❑ Butter
❑ Cereal	❑ Eat in restaurant	❑ Carrots
❑ Coffee	❑ Fish sandwich	❑ Coffee
❑ Donut	❑ Fried foods	❑ Fish
❑ Eggs	❑ Hamburger	❑ Green vegetables
❑ Fruit	❑ Hot dogs	❑ Juice
❑ Juice	❑ Juice	❑ Margarine
❑ Margarine	❑ Leftovers	❑ Milk
❑ Milk	❑ Lettuce	❑ Pasta
❑ Oat bran	❑ Margarine	❑ Potato
❑ Sugar	❑ Mayo	❑ Poultry
❑ Sweet roll	❑ Meat sandwich	❑ Red meat
❑ Sweetener	❑ Milk	❑ Rice
❑ Tea	❑ Pizza	❑ Salad
❑ Toast	❑ Potato chips	❑ Salad dressing
❑ Water	❑ Salad	❑ Soda
❑ Wheat bran	❑ Salad dressing	❑ Sugar
❑ Yogurt	❑ Soda	❑ Sweetener
❑ Oat meal	❑ Soup	❑ Tea
❑ Milk protein shake	❑ Sugar	❑ Vinegar
❑ Slim fast	❑ Sweetener	❑ Water
❑ Carnation shake	❑ Tea	❑ White rice
❑ Soy protein	❑ Tomato	❑ Yellow vegetables
❑ Whey protein	❑ Vegetables	❑ Other: (List below)
❑ Rice protein	❑ Water	
❑ Other: (List below)	❑ Yogurt	
	❑ Slim Fast or Carnation shake	
	❑ Protein shake	
	❑ Other_____	

Check foods/drinks that you consume a minimum of 3 days or more each week.

- ❑ Almonds
- ❑ Almond Butter
- ❑ Alcohol
- ❑ Apples
- ❑ Avocado
- ❑ Asparagus
- ❑ Bagels
- ❑ Barley
- ❑ Banana
- ❑ Burger King
- ❑ Bacon
- ❑ Bean, lima
- ❑ Bread, white
- ❑ Bread, wheat
- ❑ Bread, rye
- ❑ Bagels
- ❑ Biscuits
- ❑ Bean, pinto
- ❑ Bean, string
- ❑ Broccoli
- ❑ Brazil nuts
- ❑ Brussels sprouts
- ❑ Blueberries
- ❑ Butter
- ❑ Cabbage
- ❑ Cereal, Special K
- ❑ Cereal, bran flakes
- ❑ Cereal, Cornflakes
- ❑ Cereal, _____
- ❑ Cereal, _____
- ❑ Celery
- ❑ Cantaloupe
- ❑ Candy
- ❑ Chinese food
- ❑ Cream Cheese
- ❑ Carrot
- ❑ Chicken
- ❑ Chili pepper
- ❑ Cinnamon
- ❑ Clam
- ❑ Cloves
- ❑ Cocoa-Chocolate
- ❑ Carnation drink
- ❑ Chewing gum, sweetened
- ❑ Chewing gum, sugar free
- ❑ Coconut
- ❑ Cod
- ❑ Coffee
- ❑ Corn
- ❑ Crab
- ❑ Cranberry
- ❑ Cashew
- ❑ Cheese
- ❑ Cucumber
- ❑ Deli meats
- ❑ Desserts
- ❑ Deli sandwich
- ❑ Eggplant
- ❑ Ensure
- ❑ Flounder
- ❑ Fried foods
- ❑ French fries
- ❑ French toast
- ❑ Garlic
- ❑ Ginger
- ❑ Grape
- ❑ Grits
- ❑ Greek food
- ❑ Grapefruit
- ❑ Grape Nuts
- ❑ Haddock
- ❑ Ham
- ❑ Halibut
- ❑ Herring
- ❑ Hot dogs, pork
- ❑ Hot dogs, beef,
- ❑ Hamburgers
- ❑ Hardies food
- ❑ Honey
- ❑ Italian food
- ❑ Ice cream
- ❑ Indian food
- ❑ Jack in the Box food
- ❑ Japanese food
- ❑ Jelly
- ❑ Ketchup
- ❑ Lamb
- ❑ Lemon
- ❑ Lentil
- ❑ Lettuce
- ❑ Lime
- ❑ Lobster
- ❑ Mackerel
- ❑ Margarine
- ❑ McDonalds food
- ❑ Millet
- ❑ Mung bean
- ❑ Mushroom
- ❑ Mustard
- ❑ Milk, cow
- ❑ Milk, goat
- ❑ Milk, rice
- ❑ Milk, almond
- ❑ Milk, soy
- ❑ Mexican food
- ❑ Malt
- ❑ Nutmeg
- ❑ NutriSweet
- ❑ Oatmeal, regular
- ❑ Oatmeal, instant
- ❑ Olive
- ❑ Onion
- ❑ Orange juice
- ❑ Oregano
- ❑ Oyster
- ❑ Orange
- ❑ Papaya
- ❑ Parsley
- ❑ PopTarts
- ❑ Peanuts
- ❑ Peanut butter
- ❑ Peas
- ❑ Peach
- ❑ Pecan
- ❑ Pepper
- ❑ Pepper, green
- ❑ Perch
- ❑ Pineapple
- ❑ Pancakes
- ❑ Protein shakes, soy
- ❑ Protein shakes, milk
- ❑ Protein shakes, whey
- ❑ Protein shakes, _____
- ❑ Protein shakes, _____
- ❑ Plum
- ❑ Pork
- ❑ Peanut
- ❑ Potato, sweet
- ❑ Potato, white
- ❑ Pumpkin
- ❑ Quinoa
- ❑ Radish
- ❑ Rye
- ❑ Safflower
- ❑ Sage
- ❑ Salt
- ❑ Salmon
- ❑ Scallops
- ❑ Sausage
- ❑ Slim Fast
- ❑ Sweet & Low
- ❑ Sesame
- ❑ Shrimp
- ❑ Snapper
- ❑ Soft drinks
- ❑ Sole
- ❑ Sour cream
- ❑ Soybean
- ❑ Spinach
- ❑ Strawberry
- ❑ Sucralose
- ❑ Sugar
- ❑ Sunflower
- ❑ Salad bar
- ❑ Sardines
- ❑ Squash
- ❑ Taco Bell food
- ❑ Tea, black
- ❑ Tea, decaffeinated
- ❑ Thai food
- ❑ Tomato
- ❑ Trout
- ❑ Tuna
- ❑ Turkey
- ❑ Tangerine
- ❑ Vinegar
- ❑ Walnut
- ❑ Waffles
- ❑ Whitefish
- ❑ Wheat
- ❑ Wendy's food
- ❑ Yeast, bakers
- ❑ Yeast, brewers
- ❑ Yogurt
- ❑ Yam
- ❑ Zucchini

What snacks do you eat or drink between:

Breakfast & Lunch:

_____

Lunch & Dinner:

_____

After Dinner:

_____

How much of the following do you consume each day/week?

ITEM	Daily	Weekly	Favorite Type
Candy			
Cheese			
Chocolate			
Cups of caffeine containing coffee			
Cups of decaffeinated coffee or tea			
Cups of hot chocolate			
Cups of caffeine containing tea			
Diet sodas (12-ounce can/bottle)			
Sodas with caffeine (12-ounce can/bottle)			
Sodas without caffeine (12-ounce can/bottle)			
Energy drinks (12-ounce can/bottle)			
Ice cream			
Salty foods			
Slices of white bread (rolls/bagels)			

❑ **Water:** Glasses/day___**Type**: Tap:_ Distilled:_ Spring:_ Well:_ Reverse Osmosis:_____

Do you have symptoms **immediately after** eating, such as belching, bloating, sneezing, hives, etc.?

Yes _____ No _____ If yes, please explain:_____

_____

If yes, are these symptoms associated with a particular food or supplement(s)? Yes _____ No _____

If yes, please name the food and symptom e.g. wheat – gas and bloating

Food	Symptom	Other comments

Do you feel you have **delayed** symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? Yes _____ No _____

Do you feel **worse** when you eat a lot of:

- ❑ High fat foods
- ❑ High protein foods
- ❑ High carbohydrate foods (breads, pasta, potatoes)
- ❑ Refined sugar (junk food)
- ❑ Fried foods
- ❑ 1 or 2 alcoholic drinks
- ❑ Other_____

Do you feel **better** when you eat a lot of:

- ❑ High fat foods
- ❑ High protein foods
- ❑ High carbohydrate foods (breads, pasta, potatoes)
- ❑ Refined sugar (junk food)
- ❑ Fried foods
- ❑ 1 or 2 alcoholic drinks
- ❑ Other_____

Does skipping meals greatly affect your symptoms? Yes _____ No _____

Has there ever been a food that you have craved or really "pigged out" on over a period of time?

Yes _____ No _____ If yes, what food(s) _____

_____

_____

_____

Do you have an aversion to certain foods? Yes _____ No _____

If yes, what food(s) _____

_____

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

_____

_____

_____

TOBACCO HISTORY

Currently using tobacco? Yes _____ No _____ How many years?_____Packs per day: _____

If yes, what type? Cigarette _____ Smokeless_____Cigar_____Pipe_____Patch/Gum _____

Attempts to quit: _____

Previous smoking: How many years?_____ Packs per day: _____

Are you exposed to 2nd hand smoke? Yes_____3rd hand smoke (smell or residue) Yes_____? If yes, please explain: _____

_____

ALCOHOL INTAKE

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

None_____1-3_____4-6_____7-10_____>10_____*If none skip to "Other Substances"*

Past alcohol intake? Yes_____(Mild_____Moderate_____High_____)

Have you ever been told to cut down your alcohol intake? Yes_____ No____

Do you get annoyed when people ask you about your drinking? Yes_____ No____

Do you ever feel guilty about your alcohol consumption? Yes_____ No____

Do you ever drink in the morning? Yes_____ No____

Do you notice a tolerance to alcohol (can you "hold" more than others?) 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____

Have you ever thought about getting help to control or stop your drinking? Yes_____ No____

Was your mother an alcoholic? _____ Father? _____ Other family member? _____

OTHER SUBSTANCES

Are you currently using recreational drugs? Yes_____ No____

If yes, what types? _____

Have you ever used IV or inhaled recreational drugs? Yes_____ No____

If yes, what types? _____

EXERCISE

Current Exercise program: *Activity (list type, number of sessions/week, and duration of activity)*	**Type**	**Frequency per week**	**Duration in minutes**
Activity			
Stretching			
Cardio/Aerobics			
Strength Training			
Other (Pilates, yoga, etc.)			
Sports or Leisure Activities (golf, tennis, rollerblading 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 after exercise? Yes _____ No _____

If yes, please describe:_____

_____

Do you usually sweat when exercising? Yes ____ No ___

Please include here any additional information about you or your health that you think would be important for me to know.