

Wellness 4 Life by Dr Pinkston

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INTEGRATIVE MEDICAL HISTORY QUESTIONAIRE

PART I:	PATIENT DE	MOGRAPHICS
Referred by:	Zip:	Cell phone: Home phone: Work phone: Birthplace: Age: Phone: Relationship:
Accompanied to office by:		Relationship:
Primary Language		
#1 #2 #3 #4 #5		
		URRENT MEDICAL CARE
If you are now being treated by another physician write the name of the physician, health practitioner	or physical or mei r or medical facility	ntal health practitioner, please describe each problem and treating you.
Name of Primary Care Physician		
Office contact information		
Other physicians involved in your care		

PART 2: TIMELINE OF MEDICAL ILLNESS(ES)

names, diagnoses, procedures, and results, and whether they were effective or ineffective. (1) PROBLEM/DIAGNOSIS (specify): When did the problem begin? What symptoms were present the symptoms were					
Was there pain? []Yes []No How much pain? (on scale Where? 1 2 3 4 5 Describe the course or progression of this problem.	of 1 to 1				
Was there pain? []Yes []No How much pain? (on scale Where? 1 2 3 4 5 Describe the course or progression of this problem.	of 1 to 1				
Where? 1 2 3 4 5 Describe the course or progression of this problem.					
Describe the course or progression of this problem.	6	7	rcle p	lease)
		7	8	9	10
Did anything make problem better? Did anything make it worse					
	?				
What tests/procedures were done?					
When were they done? Where were they done?					
Were you hospitalized for this condition? []Yes []No If yes, when were you hospitalized?	oitalized,	and f	or ho	w long	j?
What has happened to the problem since treatment until today?					
What medications or supplements are you taking for this condition?					
(2) PROBLEM/DIAGNOSIS (specify):					
When did the problem begin? What symptoms were pres	ent?				
	-541-4	10 -			,
Was there pain? []Yes []No How much pain? (on scale					
Where? 1 2 3 4 5	6	7	8	9	10
Describe the course or progression of this problem.					
Did anything make problem better? Did anything make it worse	?				
What tests/procedures were done?					
When were they done? Where were they done?					
Were you hospitalized for this condition? []Yes []No If yes, when were you hosp Where?	oitalized,	, and f	for ho	w lon	g?
What has happened to the problem since treatment until today?					
What medications or supplements are you taking for this condition?					

(3) PROBLEM/DIAGNOSIS (specify):

When did the problem begin?	What symptoms were present?
Was there pain? []Yes []No	How much pain? (on scale of 1 to 10 – circle please)
Where?	1 2 3 4 5 6 7 8 9 10
Describe the course or progression of this problem.	
Did anything make problem better?	Did anything make it worse?
What tests/procedures were done?	
When were they done?	Where were they done?
Were you hospitalized for this condition? []Yes []No Where?	If yes, when were you hospitalized, and for how long?
What has happened to the problem since treatment until today	1?
(4) PROBLEM/DIAGNOSIS (specify):	
When did the problem begin?	What symptoms were present?
Was there pain? []Yes []No	How much pain? (on scale of 1 to 10 – circle please)
Where?	1 2 3 4 5 6 7 8 9 10
Describe the course or progression of this problem.	
Did anything make problem better?	Did anything make it worse?
What tests/procedures were done?	
	Where were they done?
What tests/procedures were done? When were they done? Were you hospitalized for this condition? []Yes []No Where?	Where were they done? If yes, when were you hospitalized, and for how long?
When were they done? Were you hospitalized for this condition? []Yes []No	If yes, when were you hospitalized, and for how long?

PAST MEDICAL HISTORY

	YEAR		ILLNESS	YEAF	₹	ILLNESS	YEAR
Measles		Diabete	ae		ніу	AIDS	
/lumps		Heart o		-		l allergies	
Diptheria		Heart a		-		ey disease	
Pertussus		Stroke	illack			der infections	
Polio			d disease	-	Diau Arthi		
/leningitis			dder disease			pain	-
nfluenza			natory bowel disease			laches	-
Chicken Pox		Hemor		-	Anei		
Chlamydia			ce/liver disease	-	Seiz		
Sonorrhea		Depres			Epile		-
lepatitis			/panic attacks			ting/dizziness	-
uberculosis			nia/sleep disorder			disease	
sthma			g/edema		OTH		-
Allergies			s/joint pain		0111	,	-
Eczema			disease				
lives			(which type?)	-			-
leart conditio	n		FAMILY HEALT Relationship	TH HISTOR	Y	Re	elationship
	n				Y	Re	elationship
leart conditio leart attack ligh blood pre	7,000			Cancer Epilepsy		Re	elationship
leart attack ligh blood pre	7,000			Cancer Epilepsy Seizure disor	rder	Re	elationship
leart attack	essure			Cancer Epilepsy	rder akdown	Re	lationship
leart attack ligh blood pre stroke leeding disor	essure			Cancer Epilepsy Seizure disor Nervous brea	rder akdown der		elationship
eart attack igh blood pro troke leeding dison uberculosis	essure			Cancer Epilepsy Seizure disor Nervous brea Mental disord Alcoholism/D	rder akdown der drug Addiction		elationship
leart attack ligh blood pro troke leeding disor uberculosis	essure	Age		Cancer Epilepsy Seizure disor Nervous brea Mental disor Alcoholism/D Suicide/Atter Deceased	rder akdown der rug Addictior npted Suicide Age at	Year of	elationship Cause of deat
leart attack ligh blood pre troke leeding disor uberculosis liabetes Immediate	essure	Age	Relationship	Cancer Epilepsy Seizure disor Nervous brea Mental disor Alcoholism/D Suicide/Atter	rder akdown der drug Addictior npted Suicide		
leart attack ligh blood pre stroke bleeding disor uberculosis biabetes Immediate	essure	Age	Relationship	Cancer Epilepsy Seizure disor Nervous brea Mental disor Alcoholism/D Suicide/Atter Deceased	rder akdown der rug Addictior npted Suicide Age at	Year of	
leart attack ligh blood pre stroke leeding disor uberculosis biabetes Immediate ather	essure rder Family	Age	Relationship	Cancer Epilepsy Seizure disor Nervous brea Mental disor Alcoholism/D Suicide/Atter Deceased	rder akdown der rug Addictior npted Suicide Age at	Year of	
leart attack ligh blood prestroke leeding disor uberculosis biabetes Immediate ather lother rother[] S	essure rder Family Sister[]	Age	Relationship	Cancer Epilepsy Seizure disor Nervous brea Mental disor Alcoholism/D Suicide/Atter Deceased	rder akdown der rug Addictior npted Suicide Age at	Year of	
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leart attack ligh blood pre troke leeding disor uberculosis liabetes Immediate ather lother rother[] S rother[] S	essure rder Family Sister[]	Age	Relationship	Cancer Epilepsy Seizure disor Nervous brea Mental disor Alcoholism/D Suicide/Atter Deceased	rder akdown der rug Addictior npted Suicide Age at	Year of	

PART 4: PRESENT AND PAST SYMPTOMS

CURRENT SYMPTOMS

Please mark with an (X) any illnesses or medical problems you have, or have had, within the past year.

SYMPTOMS	(X)	DATE STARTED	SYMPTOMS	(X)	DATE STARTED
Frequent or severe headaches			Spots before eyes		
Fainting spells			Frequent eye infections		
Dizziness on change of position			Eye pain		
Unconscious spells			Change in vision		
Blurred vision			Eyeglasses needed		
Earaches			Recurrent head colds		
Discharge from ears			Sinus trouble	T	
Ringing in ears		Water Brown Co.	Hay fever/allergies		
Decrease in hearing			Persistent body odor		
Recurrent nose bleeds			Recurrent sore throats		
Strange taste or loss in taste			Recurrent mouth sores		
Persistent hoarseness			Soreness/bleeding gums		
Difficulty swallowing			Dentures?	T	
Swollen lymph nodes			Pain in arms or legs		-
Chest pain		74	Restless legs		
Chest pain			Palpitations/fluttering of heart		
Coughing up blood			High blood pressure	1 1	
Frequent cough			Swelling of hands, feet or ankles		***************************************
Frequent sinus infections			Leg cramps while walking or reclining?		
Wake up nights, short of breath			At what time of day?	1	
How many bed pillows at night?			Varicose veins	+	
Shortness of breath when:			Nausea or vomiting	+	
- Walking several blocks			Vomiting blood	 	
- Ascending flight of stairs			Avoiding any foods? (list)	 	
- Lying down or reclining			What kinds?		
Cold or discolored lips/fingers			Avoiding spices? (list)	+	
Recurrent stomach pain			Rectal pain with bowel movement	+-+	
Belching or hearburn			Blood in bowel movement	+	
Appetite: Good, Fair, or Poor			Full bladder feeling but little urination	+	
Abdominal cramping/pain			Urinate less than usual	\vdash	
Change in bowel movement?			Lose urine on coughing, sneezing or	-	
change in bower movement:			laughing		
Color of bowel movement (describe)			Discharge from penis/vagina		
Blood in stool?			Blood in urine?	-	
Pain on urinating			Tingling or weakness of hands or feet	-	
Getting up at night to urinate			Redness or heat in joints	-	
How many times?			Muscle spasms	-	
Urinating frequently					
Difficulty starting urination			Dry skin Easy bruising	\vdash	-
Recurrent backaches or pain					
Joint pain			Inability to tolerate heat		
			Inability to tolerate cold		
Swelling of any joints			Change in hair texture/hair loss		
Loss or change in sensation of hands or feet			Change in skin texture		
Tremor/shaking of extremities			Skin rashes		
Swollen neck or throat			Difficulty concentrating		
Hot flashes/night sweats			Poor memory		
Fatigue without obvious reason			Depressed mood	 	
Brittleness of nails			Anxiety		

LIST ALL CURRENT MEDICATIONS AND SUPPLEMENTS

List all medications, vitamins, or supplements you are now taking, including those you buy with/without a doctor's prescription.

Name	Dosage	Times per Day	Reason
			*
1			
ne lestrogens i	progesterone dhea tes	stosterone, growth hormone, steroi	ids)

Check [X] any you received	х	When?	Boosters	X	When?	Describe any adverse reaction
Smallpox			Within past 7 year	ars?		
DPT						
Diphtheria Check [X]						
any you received	x	When?	Boosters	X	When?	Describe any adverse reaction
Pertussis						
Tetanus			Tetanus booster	?		
Measles						
Mumps						
Rubella						
Polio			Within past 2 yea	ars?		
Hepatitis						
Influenza (flu)			Your last Flu sho	ot?		
Pneumovax						
Other (specify)						
11		£ 46 1	or in the last 2 year	0 5 10 5 107	When:	Where:
Have you been	out c	i the counti	y III tile last 2 year	rs?[]No[]Yes	vviicii.	William .
Tuberculin (TB) skin	ALL that you a	When: ERGIES, SEN	NSITIVITIES &	Positive[] R INTOLEF ds, medication	Negative[]
Tuberculin (TB	skin othing	ALL that you a w each affe	When: ERGIES, SEN are allergic to succepts you (e.g., cor	NSITIVITIES &	Positive[] R INTOLEF ds, medication	Negative[] RANCES ns, dust, chemicals, etc., and
Tuberculin (TB List any indica	skin othing	ALL that you a w each affe	When: ERGIES, SEN are allergic to succepts you (e.g., cor	NSITIVITIES &	Positive[] R INTOLEF ds, medication	Negative[] RANCES ns, dust, chemicals, etc., and
Tuberculin (TB	skin othing	ALL that you a w each affe	When: ERGIES, SEN are allergic to succepts you (e.g., cor	NSITIVITIES &	Positive[] R INTOLEF ds, medication	Negative[] RANCES ns, dust, chemicals, etc., and
Tuberculin (TB	skin othing	ALL that you a w each affe	When: ERGIES, SEN are allergic to succepts you (e.g., cor	NSITIVITIES &	Positive[] R INTOLEF ds, medication	Negative[] RANCES ns, dust, chemicals, etc., and
Tuberculin (TB	skin othing	ALL that you a w each affe	When: ERGIES, SEN are allergic to succepts you (e.g., cor	NSITIVITIES &	Positive[] R INTOLEF ds, medication	Negative[] RANCES ns, dust, chemicals, etc., and
List any indica Allergic, Sensit) skin rthing te ho	ALL I that you a w each affe	When: ERGIES, SEN are allergic to succepts you (e.g., cor	NSITIVITIES &	Positive[]	Negative[] RANCES ns, dust, chemicals, etc., and iculty breathing, dizzy, etc.)
List any indica Allergic, Sensit	thing te ho	ALL I that you a w each affe	When: ERGIES, SEN are allergic to succepts you (e.g., cor	h as specific foongestion, headac	Positive[] & INTOLEF ds, medication he, hives, diff	Negative[] RANCES ns, dust, chemicals, etc., and iculty breathing, dizzy, etc.) Yes[]
List any indica Allergic, Sensit Do you live with What kind of pe	thing te horive, Ir	ALL I that you a w each affect Intolerant to:	When: ERGIES, SEN are allergic to succepts you (e.g., cor	h as specific foongestion, headac	Positive[] & INTOLEF ds, medication he, hives, diff	Negative[] RANCES ns, dust, chemicals, etc., and iculty breathing, dizzy, etc.)
List any indica Allergic, Sensit Do you live with What kind of pe	thing te horive, Ir	ALL I that you a w each affect Intolerant to:	When: ERGIES, SEN are allergic to succepts you (e.g., cor	h as specific foongestion, headac	Positive[] & INTOLEF ds, medication he, hives, diff	Negative[] RANCES ns, dust, chemicals, etc., and iculty breathing, dizzy, etc.) Yes[]
List any indica Allergic, Sensit Do you live with What kind of pe	thing te horive, Ir	ALL I that you a w each affect Intolerant to:	When: ERGIES, SEN are allergic to succepts you (e.g., cor Effect: No[] Yes mical exposures, lis	h as specific foongestion, headac	Positive[] & INTOLEF ds, medication he, hives, diff ns? No[] hu have held.	Negative[] RANCES ns, dust, chemicals, etc., and iculty breathing, dizzy, etc.) Yes[]
List any indica Allergic, Sensit Do you live with What kind of pe	rthing te hor ive, Ir	ALL I that you a w each affect Intolerant to:	When: ERGIES, SEN The allergic to succepts you (e.g., considered) Effect: No[] Yes mical exposures, list	h as specific foorngestion, headac	Positive[] & INTOLER ds, medication he, hives, diff ns? No[] hu have held.	Negative[] RANCES ns, dust, chemicals, etc., and iculty breathing, dizzy, etc.) Yes[]
List any indica Allergic, Sensit Do you live with What kind of period to consider en	rthing te hor ive, Ir	ALL I that you a w each affe Intolerant to:	When: ERGIES, SEN The allergic to succepts you (e.g., considered) Effect: No[] Yes mical exposures, list	h as specific foongestion, headaces in the specific foongestion, headaces in the specific foongestion, headaces in the specific foongest relevant jobs your stretched in the specific footgas in the s	Positive[] & INTOLEF ds, medication he, hives, diff ns? No[] hu have held. ORY	Negative[] RANCES Ins., dust, chemicals, etc., and iculty breathing, dizzy, etc.) Yes[] How long?
List any indica Allergic, Sensit Do you live with What kind of period to consider en	rthing te hor ive, Ir h a peet(s)? vironr	ALL I that you a w each affect Intolerant to: et? mental/cheri	When: ERGIES, SEN The allergic to succepts you (e.g., corects you (e.g., corects) No[] Yes Mical exposures, list Will Your weig	h as specific foongestion, headaces in the specific foongestion, headaces in the specific foongestion, headaces in the specific foongest relevant jobs your stretched in the specific footgas in the s	Positive[] & INTOLEF ds, medication he, hives, diff ns? No[] hu have held. ORY	Negative[] RANCES Ins., dust, chemicals, etc., and iculty breathing, dizzy, etc.) Yes[] How long?

PART 5: FOR WOMEN ONLY

Menstrual History Age and year periods began (onset of menarche) Date of LMP (last menstrual period) How many days from start of one period to start of next? How many days does your period last? Is your cycle regular?]yes []no Do you pass any clots? Is the flow heavy , medium or light tampons used on heavy days? How many pads Do you have cramps BEFORE period? []yes]no **DURING** period? []no []yes Any change in breast size? []yes []no Do you examine your breasts? []yes []no Do you experience tender breasts? []yes []no If so, when? Nipple discharge? If so, what color? []yes []no Date of last mammogram and findings Age and year of menopause Do you have hot flashes? []yes []no Ever taken estrogen or hormone replacements (HRT)? []yes []no Age and year at time of estrogen/HRT Date of last pelvic/gynecological exam and result of exam Date of last pap test and result of test Do you experience itching or burning of vaginal area? []yes []no Do you experience discharge from vagina? []yes []no If so, Amount: Color: When began? **Birth Control Methods** Have you used Pills? []yes []no Have you used an IUD? []yes []no If so, what type? Describe any problems with pills or IUD **Pregnancies** Have you ever been pregnant? []yes []no How old were you during pregnancies? Describe any complications with pregnancies/deliveries: Did you breastfeed? []yes []no If so, how long? Number of miscarriages Any medical complications? Number of stillbirths Reason give Number of premature births Reason given: Number of Cesarean sections Reason given: Number of abortions? Reason:

PART 6: PERSONAL HYGIENE & LIFE STYLE

How often do you brush your teeth?			Do you use enemas?	[]yes []no
How many minutes each time?			What kind and for what purpose?		
Do you use fluoridated toothpaste?	[]yes	[]no	Do you use vaginal douches?	[]yes []nc
What type of dental floss do you use? waxed[] unwaxed[] none[]			What kind and for what purpose?		
How often do you use dental floss?			Do you take saunas or steam baths?	[]yes []no
Do you use antiseptic mouthwash?	[]yes	[]no	Are you right-handed?	[]yes []no
Do you use deodorants?	[]yes	[]no	Left-handed?	[]yes []no
Do you use antiperspirant	[]yes	[]no	Ambidextrous?	[]yes [Ino

SMOKING / ALCOHOL / DRUG HISTORY

SMOK	ING		ALC	OHOL		
Do you smoke?	[]yes	[]no	How many drinks do you normally	have?		
How many years?			Beer	per c	lay / week / i	month
Have you ever smoked?	[]yes	[]no	Wine	per o	lay / week / ı	month
How many years?			Hard liquor	per o	lay / week / ı	month
Stopped when?			Have you ever had a problem with	alcohol?	[]yes	[]no
Cigarettes, packs/day			Where were you treated?		[]yes	[]no
How many Cigars/ day?						
How many Pipes/day?			DRU	G USE		
Co-workers smoke?	[]yes	[]no	Have you ever used drugs?		[]ves	[]no
How many years?			Have you ever smoked marijuana?	?	[]yes	[]no
How many hours/day?			Have you ever used "hard" drugs?	?	[]yes	[]no
Anyone smoke at home?	[]yes	[]no	Which drugs?			
How many hours/day?			How many years?			
Do you drink alcohol?	[]yes	[]no	Were you ever treated for drug use	e?	[]yes	[]no
How many years?			Where were you treated?			

		E HISTORY	
Do you ha	ow more or less capable physically than you were a ave time for exercise? []No []Yes		[]More []Same []Less you make time for exercise? []No []Yes
	eck mark alongside activities in which you do or		yearmane unio foi exercise. []No []Tes
Activity		Activity	
Jog	[]Now []Past []Weekly []Monthly	Isometrics	[]Now []Past
Run	[]Now []Past []Weekly []Monthly	Bicycling	[]Now []Past []Daily []Weekly []Monthly
Swim	[]Now []Past []Weekly []Monthly	Garden	[]Now []Past []Daily []Weekly []Monthly
Lift Weights	[]Now []Past []Weekly []Monthly	Breath Exercises	[]Now []Past []Daily []Weekly []Monthly
Walk	[]Now []Past []Weekly []Monthly	Martial Arts	[]Now []Past
Dance	[]Now []Past []Daily []Weekly []Monthly	OTHER (specify)	

ENVIRONMENT Check any of the following that create stress for you at work or home []Chemicals []Summer []Spring []Pollution []Fall []Exhaust []Winter []Poor Air Ventilation []Cold []Lighting []Heat []Lack of Sunshine []Noise []Lunar Cycles []Deadlines []High Humidity []Pressure to perform []Dampness []Relationship with Co-workers []Relationship with household members []Season Change Do you adapt well to change? []yes []no []Other (specify): SLEEP PATTERN How many sleep hours do you need? Describe how you fall asleep: Do you have trouble falling asleep? []yes []no If you awaken during the night, how often? When you awaken at night, do you have trouble falling back to sleep? []yes []no Are your sleep habits routine? []yes []no Do you have trouble waking up in the morning? []yes []no What time of day are you most awake and alert? From To **DAILY ACTIVITIES** Describe how your "typical" day usually unfolds from morning to night with approximate times. (A.M.) Morning: (P.M.) Afternoon: Evening (5:00 - 7:00): (P.M.) Night: Weekend: FOR MEN AND WOMEN - SEXUAL PATTERNS -What is your attitude towards sex? Do you have any questions or concerns about sex? Is your present sex life satisfactory? []Yes []No Do you have any pain or discomfort with sexual intercourse? []Yes []No If yes, please explain: How many partners have you had in the past ten years? What is the frequency of your present sexual activity? Do you practice birth control? []Yes []No If yes, please describe what type: Do you have any questions about birth control? If you have used any form of birth control, please indicate how long. Diaphragm: Foam: Condoms: Pill: Other: Do you find your present method satisfactory for your experience of sex? []Yes []No Do you find your present method satisfactory for your health? []Yes []No Do you have any problems with or questions about venereal disease? []Yes []No Have you ever had a sexually transmitted disease? []Yes []No If yes, please explain:

PART 7: STRESS & SATISFACTION

		STRESS RA	ATING SC	ALE	
Check (X) stres	ses you have or have had. If experienced	within the la	st 3 y	ears, add a check mark (√).
SCORE	X√	LIFE EVENT / SITUATION	SCORE	Χv	LIFE EVENT / SITUATION
100		Death of spouse	29		Trouble with in-laws
75		Divorce	28		Outstanding personal achievement
65		Separation from spouse or relationship	26		Began new work or stopped working
65		Incarceration	26		Began or ended school
65		Death of close family member	25		Change in living conditions
55		Personal injury or illness	24		Revision of personal habits
50		Marriage	23		Trouble with boss
47		Fired from job	20		Change in work hours or conditions
45		Marital or similar reconciliation	20		Change in residence
44		Retirement	20		Change in schools
44		Change in health of family member	19		Change in recreation
40		Pregnancy	19		Change in religious activities
39		Sex difficulties	18		Change in social activities
39		Addition to family	17		Mortgage/loan less than \$10,000
39		Business readjustment	16		Change in sleeping habits
38		Change in financial state	15		Change in eating habits

15

13

Change in family get-togethers

Stressful experience of holidays

Other, specify (assign your own number)

Abortion (Yourself, if female) (Your spouse or girlfriend, if male)

37

36

35

31

30

29

29

Death of close friend

Mortgage over \$10,000

Change to different line of work

Foreclosure of mortgage or loan

Son or daughter leaving home

Change in responsibilities at work

Change in argument style with spouse

Other, specify (assign your own number)

	PERSONAL STRESS CONCERNS
Is there an	thing about your present behavior that you would like to change? If so, what?
Are there s	ituations in your life currently causing problems, or ones you would like to change?
Do you use	stress reduction techniques [] YES [] NO If so, describe:
What do yo	u do for enjoyment or relaxation?
	STRESS RESPONSE
How are yo	STRESS RESPONSE u handling your feelings about illness and treatment?
	u handling your feelings about illness and treatment?
	rom 1 (your most probable response) to 6 (your least probable response).
	rom 1 (your most probable response) to 6 (your least probable response). Keep your feelings to yourself.
	rom 1 (your most probable response) to 6 (your least probable response). Keep your feelings to yourself. Maintain a calm appearance to those around you.
	rom 1 (your most probable response) to 6 (your least probable response). Keep your feelings to yourself. Maintain a calm appearance to those around you. You would discuss your feelings openly and constructively.

		EMPLOYME	NT & E	DUCATION
Do you enjoy	vour work	and daily activities?	[]Yes	[]No
		responsibility for your work?	[]Yes	[]No
		k, fulfilled by your place in life?	[]Yes	[]No
		you with the necessities of life?	[]Yes	[]No
		tion out of your work?	[]Yes	[]No
If no, what me			[]Yes	[]No
	de signific	ant occupational changes in the la	st 10 year	rs? []Yes []No
Please indica	te the high	est level of education completed:		
		PR	IORITII	ES
		ith 1 as the most important to you, ese aspects of your life. Scale from		ith 8 as the least important. Then indicate how satisfied dissatisfied to (3) very satisfied.
Importance	1-3			
Importance	+ : -	Vitality and performance		
		Associations / relationships (fami	lv. friends	3)
		Appearance	ij, monac	1
		Longevity		
		Libido (sexual drive)		
		Solace (freedom from pain)		
		Security / Safety (physical and er	notional)	
		Recognition / Acknowledgment for		ork
	P/	ART 8: LIFE PATTERN of Section I: Life Ex		
FAMILY LIFE	=-	Section 1. Life L	reints c	Life Context
I CHIVILLI LIFE	ression o	f the atmosphere of the home i between parents, between par		you grew up. I children, attitudes toward education, type of
Give an imp Include: con discipline, e	tc.:			
Give an imp Include: con discipline, e	tc.:	najor life events or crises during	:	

Early childhood:

Recent years:

Who are the most in	mportant people in your life?	
	Name	Relationship
	RELATIONSH	IDS B
Dogoribo vour marrie	age(s) or long term relationships:	IF3-B
Describe your marria	age(s) or long term relationships.	
Describe your divorc	e(s) or separations:	
2 2 2 2 1 DO JOUR GIVOID	C(C) C. Copulations.	
Describe your prese	nt relationship:	
	RELATIONSH	IIPS – C
How many children a	are in the family in which you were raised?	
Where do you fit in the	he birth order? You were # child ou	t ofchildren
Mark the box next to	the words that describe your childhood (and	add others that might apply)
Mark the box next to	the words that describe your childhood (and	
Mark the box next to	the words that describe your childhood (and	add others that might apply)
Mark the box next to	the words that describe your childhood (and]fair []unhappy []terribly depressing []ve	add others that might apply) rbally abusive []physically abusive []other
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Mark the box next to []happy []good [] Describe the quality	the words that describe your childhood (and]fair []unhappy []terribly depressing []ve RELATIONSH of your relationships with people in general (i	add others that might apply) rbally abusive []physically abusive []other IIPS – D nclude co-workers):
Mark the box next to happy []good []	the words that describe your childhood (and]fair []unhappy []terribly depressing []ve RELATIONSH of your relationships with people in general (i	add others that might apply) rbally abusive []physically abusive []other IIPS – D nclude co-workers):
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Mark the box next to happy []good []Describe the quality Describe the quality ndicate by number	the words that describe your childhood (and]fair []unhappy []terribly depressing []ve RELATIONSH of your relationships with people in general (i of your relationships with your family and in-lateral formula in the second secon	add others that might apply) rbally abusive []physically abusive []other IPS – D nclude co-workers): aws: IPS – E s best describe these people: 7 - Fearful and anxious, distrustful
Mark the box next to happy []good []Describe the quality Describe the quality ndicate by number ather	the words that describe your childhood (and]fair []unhappy []terribly depressing []ve RELATIONSH of your relationships with people in general (i of your relationships with your family and in-lateral formula in the second secon	add others that might apply) rbally abusive []physically abusive []other IIPS – D Include co-workers): IIPS – E IIPS –
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		ı	EATING	HABITS - Sect	tion 1					
Where were you born?	Country			State/Province		City				
What was the general	geographic clim	ate?								
	1	NO	YES		NO	YES			NO	YE
Infant/ Childhood Diet	Breast fed			American			Vegetaria	ın		
	Bottle fed			Macrobiotic			Other (ex	plain):		
Explain, if you indicate	ed Other:				•			. ,		
					NO	YES			NO	YES
Adult Diet			American			Vegetaria	ın			
				Macrobiotic			Other (ex			
Explain, if you indicate	ed Other:				-		1 - 1.1.5. (0).	p.u,.		1
					NO	YES			NO	YE
Present Diet				American			Vegetaria	ın	1	
				Macrobiotic			Other (ex	1		
Explain, if you indicate							1 0 (0).	pidirij.		
Was your childhood d	iet similar to your	presen	t one?						NO	YE
How many meals do y	ou now eat per o	day?								•
Describe your dining a	atmosphere:									
What % of your meals		ne?		What % are	eaten o	ut?		***************************************	T	
What % of the food yo				What % is co	oked?					
What energy source d		oking?	Gas	[] Electric[]	Micr	owave[
Describe your present										
What foods or mixture	s do you avoid a			oid them?						
What are your favorite		et[] 5	Salty[]	Sour[] Bitter[] P	ungent[] Spicy[]			
When you have inter	ise food craving	s, whic	h foods	or types of food	ds) do	you usu	ally crave?			
Most intense craving										
Sometimes crave										
Least intense								-		
What did you eat and	drink vesterda	v?								
Breakfast	Lunch		1	Dinner Snac			cks R		verage	
									- c. age	•

Enter how much or how often you eat or drink seach item listed: per day (Dy), per week (Wk), or per month (Mt	Mo):			
Milk	k M			
Frozen	ES			
Valid				
Ice Cream Canned Spring Distilled				
Ice Milk				
Sodas (non-colas) Herbal Tea Decaf Coffee EGGS VEGETABLES CAFFEINATED BEVERAG Coffee (with caffeine) Raw, or Salad Fresh Colfee (with caffeine) Raw, or Salad Tea (regular) Frozen Cola, Diet Cola Decaf Coffee CAFFEINATED BEVERAG Coffee (with caffeine) Tea (regular) Tea (regular) Cola, Diet Cola Decaf Coffee Cola, Diet Cola Cola, Die				
Connections Content				
EGGS VEGETABLES CAFFEINATED BEVERAG Fresh Raw, or Salad Raw, or Salad Raw, or Salad Reef, Burgers Lamb Pork/Bacon/Ham Hot Dogs Cold Cuts Cold Cuts Tofu, Tempeh Beans, Peas Chicken Lentils, Others Turkey Nuts, Seeds Nut Butters Pasts Refined Grains: Ray Nole grains: Beer Beer Beer Beer Beer Beer Berad, Whole Grain Decaf Coffee Coffee (with caffeine) Coffee (with caffeine) Coffee (with caffeine) Cold, Diet Cola Cola, Diet Cola Chocolate Led Umes Cohocolate Led Umes Condount Confee (with Confee (with Confee (with Confee (with Caffeine) Chocolate Condount Cold, Diet Cola Confee (with Confee (with Caffeine) Condount Condount Condount Condount Condount Condount Condount Condount Condount Confee (with Condount C				
Beef Burgers Canned Ca				
Fresh				
Raw, or Salad Tea (regular)				
Raw, or Salad Tea (regular)	CAFFEINATED BEVERAGES			
MEAT				
Seed Surgers Sprouts Chocolate				
Seed Surgers Sprouts Chocolate				
Lamb Juices Canned Pork/Bacon/Ham Canned Canned Hot Dogs LEGUMES CONDIMENTS Cold Cuts Tofu, Tempeh Salt Veal Beans, Peas Salt Substitute Chicken Lentils, Others Salty Foods Turkey Nuts, Seeds Pickles, Olives Fish Nut Butters Pepper Shellfish Seed Butters Spices FATS GRAINS ALCOHOL Butter Whole Grains: Beer Margarine Brown Rice Wine Cream Pasta, whole gr Distilled Spirits Vegetable Oil Oatmeal Oatmeal Fried Foods Flour, Whole Wheat, Bulgur Bulgur Fat Substitute Flour, Whole Wheat Supper Other Bread, Whole Grains: Supplements Sugar White Rice Bran Sugar Substitute White Rice Bran Cereal Cereal Cereal Chocolate	1			
Dogs				
Cold Cuts Tofu, Tempeh Salt Veal Beans, Peas Salt Substitute Chicken Lentils, Others Salt Substitute Turkey Nuts, Seeds Pickles, Olives Fish Nut Butters Peppper Shellfish Seed Butters Spices Shellfish Seed Butters Spices FATS GRAINS ALCOHOL Butter Whole Grains: Beer Margarine Brown Rice Wine Cream Pasta, whole gr Distilled Spirits Vegetable Oil Oatmeal Whole Wheat, Bulgur Fat Substitute Flour, Whole Wheat, Bread, Whole Grain Sulpur Other Bread, Whole Grains: SUPPLEMENTS Sugar White Rice Bran Sugar Substitute White Flour Products Wheat Germ Honey Breakfast Cereal Yeast Chocolate Pasta Lecithin				
Cold Cuts Tofu, Tempeh Salt Veal Beans, Peas Salt Substitute Chicken Lentills, Others Salty Foods Turkey Nuts, Seeds Pickles, Olives Fish Nut Butters Peppper Shellfish Seed Butters Spices Shellfish Seed Butters Spices FATS GRAINS ALCOHOL Butter Whole Grains: Beer Margarine Brown Rice Wine Cream Pasta, whole gr Distilled Spirits Vegetable Oil Oatmeal Whole Wheat, Bulgur Fat Substitute Flour, Whole Wheat, Bulgur Bulgur Fat Substitute Fread, Whole Grains: SUPPLEMENTS Sweets Refined Grains: SUPPLEMENTS Sugar White Rice Bran White Flour Products Wheat Germ Honey Breakfast Cereal Yeast Chocolate Pasta Lecithin	CONDIMENTS			
Veal Beans, Peas Salt Substitute Chicken Lentils, Others Salty Foods Turkey Nuts, Seeds Pickles, Olives Fish Nut Butters Pepper Shellfish Seed Butters Spices Shellfish Seed Butters Spices Butter Whole Grains: Beer Margarine Brown Rice Wine Cream Pasta, whole gr Distilled Spirits Vegetable Oil Oatmeal Distilled Spirits Fried Foods Whole Wheat, Bulgur Distilled Spirits Fat Substitute Flour, Whole Wheat, Bulgur Sulgur Other Bread, Whole Grain Stread, Whole Grain Stread, Whole Grain Other Bread, Whole Grain Bread, Whole Grain Supplements Sugar White Rice Bran Sugar Substitute White Flour Products Wheat Germ Honey Breakfast Cereal Yeast Chocolate Pasta Lecithin				
Chicken Lentils, Others Salty Foods Turkey Nuts, Seeds Pickles, Olives Fish Nut Butters Pepper Shellfish Seed Butters Spices Shellfish Seed Butters Spices Botter Herbs Herbs FATS GRAINS ALCOHOL Butter Whole Grains: Beer Margarine Brown Rice Wine Cream Pasta, whole gr Distilled Spirits Vegetable Oil Oatmeal Distilled Spirits Fried Foods Whole Wheat, Bulgur Bulgur Fat Substitute Flour, Whole Wheat, Bread, Whole Grain Superson Other Bread, Whole Grain Supplements Sweets Refined Grains: Supplements Sugar White Rice Bran Sugar Substitute White Flour Products Wheat Germ Honey Breakfast Cereal Yeast Chocolate Pasta Lecithin				
Turkey Nuts, Seeds Pickles, Olives Fish Nut Butters Pepper Shellfish Seed Butters Spices Herbs Herbs FATS GRAINS ALCOHOL Butter Whole Grains: Beer Margarine Brown Rice Wine Cream Pasta, whole gr Distilled Spirits Vegetable Oil Oatmeal Fried Foods Whole Wheat, Bulgur Fat Substitute Flour, Whole Wheat Other Dy Wk Mo Dy Wk Mo Dy Wk SWEETS Refined Grains: SUPPLEMENTS Sugar White Rice Bran Sugar Substitute Wheat Whole Wheat White Flour Products Honey Breakfast Cereal Chocolate Pasta Lecithin				
Fish Shellfish Seed Butters Spices Herbs FATS GRAINS ALCOHOL Butter Whole Grains: Beer Wine Cream Pasta, whole gr Distilled Spirits Vegetable Oil Oatmeal Silled Spirits Fat Substitute Flour, Whole Wheat Bread, Whole Grains: SUPPLEMENTS Sweets Refined Grains: SUPPLEMENTS Sugar Substitute White Rice Silled Spirits Wheat Grain White Rice Silled Grain Wheat Grain Silled Spirits Supplements Sugar Substitute Products Silled Spirits Silled Spirit				
Shellfish Seed Butters Spices Herbs FATS GRAINS ALCOHOL Butter Whole Grains: Beer Margarine Brown Rice Wine Cream Vegetable Oil Pasta, whole gr Vegetable Oil Oatmeal Fried Foods Bulgur Fat Substitute Flour, Whole Wheat, Bulgur Other Bread, Whole Grains: SUPPLEMENTS Sugar Substitute White Flour Products Whole Wheat Products Whole Wheat Products Whole Wheat Products White Flour Products Breakfast Cereal Chocolate				
FATS Butter Margarine Cream Vegetable Oil Fat Substitute Other Dy Wk Mo SWEETS Sugar Substitute Chocolate Brown Rice Whole Grains: Beer Wine Distilled Spirits Distilled Spirits				
Butter				
Margarine Brown Rice Wine Wine Distilled Spirits Vegetable Oil Oatmeal Distilled Spirits Fried Foods Whole Wheat, Bulgur Flour, Whole Wheat Germ Dy Wk Mo Dy Wk Mo Droducts Sugar Substitute White Rice Bran Wheat Germ Dy White Flour Products Honey Breakfast Cereal Chocolate Brown Rice Wine Wine Wine Distilled Spirits Fat Substitute Whole Grain Show Mo Dy Wk Mo Dy Wk Whole Wheat Bread, Whole Grain Show Mo Dy Wk White Flour Products Bran Show Wheat Germ Show Mo Dy Wheat Germ Show Meat Sh				
Cream Pasta, whole gr Distilled Spirits Vegetable Oil Oatmeal Image: Common of the comm	T			
Vegetable Oil Fried Foods Fat Substitute Other Dy Wk Mo Dy Wk Mo Refined Grains: Sugar Sugar Sugar Substitute White Rice White Flour Products Whole Wheat Bread, Whole Grain White Rice White Flour Products Honey Breakfast Cereal Chocolate Pasta Dy Statiled Spints Distilled Spints Distilled Spints Distilled Spints Brian Sugar Bran Wheat Germ Yeast Cereal Chocolate Day Wk Mo Dy Wk Mo Dy Wk Mo Dy Wk Mo Dy Wk Lecithin				
Vegetable Oil Oatmeal				
Bulgur Fat Substitute Other Dy Wk Mo Dy Wk Mo Dy Wk Mo SWEETS Refined Grains: Sugar Sugar Sugar Substitute White Rice White Flour Products Honey Breakfast Cereal Chocolate Bulgur Flour, Whole Wheat Dy Wk Mo Dy Wk Mo Dy Wk Mo Dy Wk Mo Dy Wk Mo Dy Wk Mo Dy Wk Mo Dy Wk Mo Dy Wk Mo Dy Wk Mo Dy Wk Mo Dy Wk Mo Dy Wk Am Dy Wk Lecithin				
Fat Substitute Other Dy Wk Mo Dy Wk Mo SWEETS Refined Grains: Sugar Sugar Substitute White Flour Products Honey Breakfast Cereal Chocolate Flour, Whole Wheat Dy Wk Mo Dy Wk Mo SUPPLEMENTS SUPPLEMENTS SUPPLEMENTS SUPPLEMENTS SUPPLEMENTS Whole Flour Products				
Other Bread, Whole Grain Dy Wk Mo Dy Dy Wk </td <td></td>				
SWEETS Refined Grains: SUPPLEMENTS Sugar White Rice Bran Sugar Substitute White Flour Products Wheat Germ Honey Breakfast Cereal Yeast Chocolate Pasta Lecithin				
SWEETS Refined Grains: SUPPLEMENTS Sugar White Rice Bran White Flour Products Honey Breakfast Cereal Chocolate Pasta Lecithin	K Mo			
Sugar White Rice Bran Sugar Substitute White Flour Products Honey Breakfast Cereal Chocolate Pasta Lecithin				
Sugar Substitute White Flour Products Wheat Germ Honey Breakfast Yeast Cereal Lecithin	1			
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Chocolate Pasta Lecithin				
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Desserts Trotein Towder	_			