



Lifestyle Assessment Long Form

GETTING STARTED

Very poor health

Excellent health

- a. Please circle your current overall **LEVEL OF HEALTH**. 0 1 2 3 4 5 6 7 8 9 10
- b. Please rank the top **3 areas** you would like to improve with 1 being the most important and 3 the least important.
- Sleep _____ Weight Management _____ Nutrition _____
- Exercise _____ Purpose & Connection _____ Mental Health _____
- Substance Use _____

Not important at all

Very important

- c. How **IMPORTANT** is it for you to make the change you ranked as the **#1** most motivated topic area to address? 0 1 2 3 4 5 6 7 8 9 10
- d. How **CONFIDENT** are you regarding your ability to make the change you ranked as the **#1** most motivated topic area to address? 0 1 2 3 4 5 6 7 8 9 10
- e. How **IMPORTANT** is it for you to make the change you ranked as the **#2** most motivated topic area to address? 0 1 2 3 4 5 6 7 8 9 10
- f. How **CONFIDENT** are you regarding your ability to make the change you ranked as the **#2** most motivated topic area to address? 0 1 2 3 4 5 6 7 8 9 10
- g. How **IMPORTANT** is it for you to make the change you ranked as the **#3** most motivated topic area to address? 0 1 2 3 4 5 6 7 8 9 10
- h. How **CONFIDENT** are you regarding your ability to make the change you ranked as the **#3** most motivated topic area to address? 0 1 2 3 4 5 6 7 8 9 10

i. **What would you like to gain from this lifestyle visit?** *Check all that apply*

- More medical/scientific knowledge Practical health tips Other: _____
- Accountability Personalized plan

Patient Name: _____ DOB: _____

SLEEP

Please answer based on your sleeping patterns OVER the LAST TWO WEEKS

	Never	Seldom	Sometimes	Often	Always
a. How often have you had difficulty staying awake during routine tasks?	1	2	3	4	5
b. How often have you had difficulty staying awake while driving?	1	2	3	4	5
c. How often have you felt fatigued or needed to nap during the day?	1	2	3	4	5
d. How often has it taken you more than 30 minutes to fall asleep at night?	1	2	3	4	5
e. How often have you woken up at night?	1	2	3	4	5
f. How often have you unintentionally woken up early in the morning?	1	2	3	4	5
g. How often do you look at a screen within 2 hours of sleeping (i.e. TV, computer, iPad, or Phone)?	1	2	3	4	5
h. How often have your legs or arms jerked during sleep?	1	2	3	4	5
i. How often have you experienced "creeping" or "crawling" feelings in your legs?	1	2	3	4	5
j. How often have you snored loudly, gasped, choked, or stopped breathing during sleep?	1	2	3	4	5
k. How often have you used sleeping aids (i.e. tobacco, alcohol, over-the-counter medications, or prescription medications) to help you fall asleep?	1	2	3	4	5
l. Do you have a job that requires night shifts?	1	2	3	4	5
m. Do you have a medical condition or chronic pain that interferes with your sleep?	1	2	3	4	5
n. On an average weekday do you get at least 7-8 hours of sleep in a 24-hour period?	1	2	3	4	5
o. On an average weekend do you get at least 7-8 hours of sleep in a 24-hour period?	1	2	3	4	5

Patient Name: _____ DOB: _____



The 4Leaf Survey

For estimating the percent of your calories from whole plants

As you know, 4Leaf for Life was designed to help people everywhere leverage the simple, yet powerful, concept of maximizing the percentage of their calories from whole, plant-based foods — still in nature’s package. This survey identifies your current 4Leaf “level” of eating. Note that even the 1-Leaf level is in the top 10% — when it comes to healthy eating. These 12 questions will give you a pretty good idea of how you can improve your score.

The 4Leaf Survey

Take 2 minutes, be honest, circle your answers and tally your score. (A serving = about 1/4 of a plate)

1	FRESH FRUIT. On average, how many daily servings of whole fresh fruit do you eat? (Fruit juice doesn’t count; not a whole plant)	0	1-2	3-5	6+
2	WHOLE VEGETABLES. On average, how many daily servings of whole vegetables do you eat?	0	1-2	3-5	6+
3	WHOLE GRAINS, LEGUMES, POTATOES or other starches. On average, how many daily servings of these foods do you eat?	0	1-2	3-5	6+
4	OMEGA-3s. Are you getting all you need from whole, plant-based sources like flaxseeds, walnuts, hemp & chia seeds?	No	Maybe	Not Sure	Yes
5	DAIRY FOODS. How many days per week do you eat dairy foods like cheese, yogurt and ice cream? (Soy does not count)	0	1-2	3-5	6-7
6	EGGS. How many days per week do you either eat eggs or add them as an ingredient when cooking?	0	1-2	3-5	6-7
7	COW’S MILK OR CREAM. How many days per week do you drink them or add to your food, like cereal, coffee, etc.?	0	1-2	3-5	6-7
8	ADDED SUGAR. Are you really serious about eliminating added sugar at home and in food products that you buy?	You bet	Fairly	Not Very	No
9	WHITE FLOUR. Bread, pasta, cakes, cookies, etc. How would you describe your consumption level of these foods.	Zero	Light	Medium	Heavy
10	SWEETS & SALTY SNACKS. How would you best describe your consumption level of these unhealthy foods.	Minimal	Light	Medium	Heavy
11	MEAT, POULTRY AND FISH. How many of your meals per week include any animal flesh? (beef, pork, lamb, chicken, turkey or fish)	0-1	2-5	6-11	12+
12	VEGETABLE OIL. How many of your meals per week include vegetable oil, like olive or canola? (All oil is 100% fat, not whole plant)	0-1	2-5	6-11	12+

Patient Name: _____ DOB: _____

NUTRITION

EATING PATTERNS

Please answer based on your typical eating habits

- | | | | | | |
|---|---|---|---|----|-----|
| a. On average, how many cups (8 oz.) of caffeinated beverages do you drink per day (tea, soda, coffee, or energy drinks)? | 0 | 1 | 2 | 3 | 4+ |
| b. On average, how many servings of alcohol do you drink per day ? | 0 | 1 | 2 | 3 | 4+ |
| c. On average, how many cups (8 oz.) of sugary drinks (soda, sports drinks, juice) do you drink per day ? | 0 | 1 | 2 | 3 | 4+ |
| d. On average, how often do you snack on convenience or “junk” food per day ? (i.e. chips, candy, granola bars, crackers, cookies, etc.) | 0 | 1 | 2 | 3 | 4+ |
| e. On average, how many meals do you buy from a restaurant or fast food per week ? | 0 | 1 | 2 | 3 | 4+ |
| f. On average, do you drink at least 8 glasses of water per day ? | | | | No | Yes |
| g. On average, do you eat at least 5 handfuls of nuts per week ? | | | | No | Yes |
| h. Do you use natural or artificial sweeteners? (i.e. Equal, Stevia, Splenda, Sweet & Low, honey, agave, etc.) | | | | No | Yes |
| i. Do you add salt to most of your meals? | | | | No | Yes |
| j. Do you eat processed meats (i.e. sausage, hot dogs, salami, bacon)? | | | | No | Yes |
| k. Do you have any bad reactions (sensitivities or allergies) to food? If yes, please list here: _____ | | | | | |
| l. Do you avoid any particular foods? If yes, please list here: _____ | | | | | |
| m. Do you have foods that you crave? If yes, please list here: _____ | | | | | |
| n. Are you currently following a particular diet or nutrition plan? If yes, please list here: _____ | | | | | |
| o. During the last 3 months, did you have any episodes of excessive overeating? If yes please explain here: _____ | | | | | |
| p. Are you concerned about making the wrong food choices? If yes, please explain here: _____ | | | | | |
| q. Have you ever had an eating disorder? If yes, please list here: _____ | | | | | |

Do you use any of the following VITAMINS or SUPPLEMENTS? Check all that apply

- | | | |
|-------------------------------------|----------------------------------|---------------------------------------|
| <input type="checkbox"/> Vitamin D | <input type="checkbox"/> Calcium | <input type="checkbox"/> Vitamin B12 |
| <input type="checkbox"/> Probiotics | <input type="checkbox"/> Omega 3 | <input type="checkbox"/> Multivitamin |
| Other: _____ | | |

Do you use any of the following OILS with your meals or cooking? Check all that apply

- | | | |
|--------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Olive Oil | <input type="checkbox"/> Canola Oil | <input type="checkbox"/> Vegetable Oil |
| <input type="checkbox"/> Coconut Oil | <input type="checkbox"/> Butter | <input type="checkbox"/> Lard |
| Other: _____ | | |

FOOD RECALL: Please record below what AND how much you ate and drank yesterday (or the last typical day)

Breakfast: _____ Time: _____

Lunch: _____ Time: _____

Dinner: _____ Time: _____

Snacks: _____ Time: _____

Drinks/Beverages: _____ Time: _____

Patient Name: _____ DOB: _____

WEIGHT MANAGEMENT

BEHAVIOR PATTERNS

	Never	Seldom	Sometimes	Often	Always
a. How often do you skip meals?	1	2	3	4	5
b. How often do you snack in between meals?	1	2	3	4	5
c. How often do you eat while watching TV?	1	2	3	4	5
d. How often do you eat while in bed?	1	2	3	4	5
e. How often do you have difficulty sleeping?	1	2	3	4	5
f. How often do you lack physical activity or exercise?	1	2	3	4	5
g. How often do you feel a lack of purpose or meaning in your life?	1	2	3	4	5

Which of the following factors apply to your eating habits and current lifestyle? *Check all that apply*

- | | | |
|--|--|---|
| <input type="checkbox"/> Like healthy food | <input type="checkbox"/> Don't like healthy food | <input type="checkbox"/> Know how to cook healthy foods |
| <input type="checkbox"/> Fast eater | <input type="checkbox"/> Eat slowly | <input type="checkbox"/> Read nutrition labels |
| <input type="checkbox"/> Rely on packaged or fast foods | <input type="checkbox"/> Dislike cooking | <input type="checkbox"/> Prepare meals at home |
| <input type="checkbox"/> Do not plan meals | <input type="checkbox"/> Eat a variety of foods | <input type="checkbox"/> Always hungry |
| <input type="checkbox"/> Late night eater | <input type="checkbox"/> Negative relationship to food | <input type="checkbox"/> Erratic eater |
| <input type="checkbox"/> No time to prepare healthy food choices | <input type="checkbox"/> Don't know how to cook | <input type="checkbox"/> Live alone or eat alone often |

Do any of the following situations or emotions cause you to eat? *Check all that apply*

- | | | | |
|----------------------------------|--|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Sadness | <input type="checkbox"/> Pain | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Social or Family Situations | <input type="checkbox"/> Boredom | <input type="checkbox"/> Stress |

Patient Name: _____ DOB: _____

WEIGHT MANAGEMENT (continued)

WEIGHT HISTORY

- a. Have you ever been overweight or obese? If yes, answer below: No Yes
Were you overweight as a child? No Yes
Were you overweight as a teenager? No Yes
Were you overweight between the ages of 20-29? No Yes
Were you overweight between the ages of 30-39? No Yes
Were you overweight above the age of 40? No Yes
- b. Are you currently trying to lose or gain weight? No Yes
If yes, please circle your goal: Lose weight Gain weight
- c. Have you ever intentionally lost or reduced your weight by more than 5 lbs.? No Yes
If yes, did you regain weight within 1 year? No Yes
- d. Have you had weight loss surgery? No Yes
If yes, please list the type of surgery you had: _____

Have you ever used weight loss medications? If yes, circle which ones you have used? If other, please list.

- | | | | | | | |
|--------------------------------------|-----------------------------------|--|---------------------------------------|----------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Acutrim | <input type="checkbox"/> Alli | <input type="checkbox"/> Amphetamines | <input type="checkbox"/> Anorex | <input type="checkbox"/> Belviq | <input type="checkbox"/> Byetta | <input type="checkbox"/> Contrave |
| <input type="checkbox"/> Dexatrim | <input type="checkbox"/> Didrex | <input type="checkbox"/> Fastin | <input type="checkbox"/> Fenfluramine | <input type="checkbox"/> Mazanor | <input type="checkbox"/> Meridia | <input type="checkbox"/> Obalan |
| <input type="checkbox"/> Phendiet | <input type="checkbox"/> Fen-Phen | <input type="checkbox"/> Phentermine | <input type="checkbox"/> Plegine | <input type="checkbox"/> Plegine | <input type="checkbox"/> Prozac | <input type="checkbox"/> Pondimin |
| <input type="checkbox"/> Qsymia | <input type="checkbox"/> Redux | <input type="checkbox"/> Sanorex | <input type="checkbox"/> Tenuate | <input type="checkbox"/> Tepanol | <input type="checkbox"/> Vyvanse | <input type="checkbox"/> Wechless |
| <input type="checkbox"/> Wellbutrin | <input type="checkbox"/> Xenical | <input type="checkbox"/> I don't remember the name of the medication | | | | |
| <input type="checkbox"/> Other _____ | | | | | | |

WEIGHT LOSS STRATEGIES

Have you tried any of the following alternative therapies or programs? Check all that apply. If other, please list.

- | | | |
|---|--------------------------------------|--|
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Acupressure | <input type="checkbox"/> Nutritionist/Registered Dietitian |
| <input type="checkbox"/> Residential Programs | <input type="checkbox"/> Hypnosis | <input type="checkbox"/> Physical Activity/Exercises |
| <input type="checkbox"/> Other _____ | | |

Which commercial or fad diets have you tried in the past? Check all that apply. If other, please list.

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Atkins Diet | <input type="checkbox"/> Low Fat | <input type="checkbox"/> Calorie Counting | <input type="checkbox"/> Paleo |
| <input type="checkbox"/> CHIP | <input type="checkbox"/> South Beach | <input type="checkbox"/> DASH | <input type="checkbox"/> Vegan |
| <input type="checkbox"/> Mediterranean Diet | <input type="checkbox"/> Elimination Diet (Allergy) | <input type="checkbox"/> Gluten Free | <input type="checkbox"/> Vegetarian |
| <input type="checkbox"/> Jenny Craig | <input type="checkbox"/> Weight Watchers | <input type="checkbox"/> Low Carb | <input type="checkbox"/> Slim Fast/Meal Replacement |
| <input type="checkbox"/> Other _____ | | | |

Patient Name: _____ DOB: _____

EXERCISE

EXERCISE HABITS: AEROBIC/CARDIO TRAINING

- a. During the average week, how many **days** do you exercise at a moderate to strenuous intensity (i.e. brisk walking or enough to break a light sweat)? _____ days
- b. During an average session, how many **minutes** do you exercise at a moderate to strenuous intensity (i.e. brisk walking or enough movement to break a light sweat)? _____ min
_____ total min/week (days x min)
- c. List types of aerobic activities you do (i.e. walking, jogging, swimming, bicycling, dancing, etc.): _____

EXERCISE HABITS: STRENGTH/RESISTANCE TRAINING

- a. During the average week, how many **days** do you do strength/resistance training? _____ days
- b. How many **minutes** do you exercise with strength/resistance training? _____ min
_____ total min/week (days x min)
- c. List types of activities you do (i.e. weightlifting, Pilates, kettle ball, resistance machines, exercise bands, etc.): _____

What **MOTIVATES** you *or would motivate you to exercise?* Check top three

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Nothing would motivate me | <input type="checkbox"/> Family or partner | <input type="checkbox"/> Improve mood | <input type="checkbox"/> Weight reduction |
| <input type="checkbox"/> Control Blood glucose | <input type="checkbox"/> Body Image | <input type="checkbox"/> Increase Energy | <input type="checkbox"/> Reduce blood pressure |
| <input type="checkbox"/> Decrease stress | <input type="checkbox"/> Prevent heart disease | <input type="checkbox"/> Prevent Bone loss | <input type="checkbox"/> Improve sleep |
| <input type="checkbox"/> Increase self-esteem | <input type="checkbox"/> Other: _____ | | |

Are there any **BARRIERS** or **PROBLEMS** that limit exercise? Check all that apply

- | | | | |
|---|-------------------------------------|--|--------------------------------|
| <input type="checkbox"/> No barriers | <input type="checkbox"/> Depression | <input type="checkbox"/> Work Responsibility | <input type="checkbox"/> Cost |
| <input type="checkbox"/> Life Transition Period | <input type="checkbox"/> Time | <input type="checkbox"/> Fear | <input type="checkbox"/> Other |
| <input type="checkbox"/> Family Responsibility | <input type="checkbox"/> Apparel | <input type="checkbox"/> Energy | |

EXERCISE SAFETY

- | | | |
|--|----|-----|
| a. Do you have any injuries that would make it difficult to exercise?
If yes, please explain: _____ | No | Yes |
| b. Do you have any joint, muscle, or bone problems that might get worse with exercise?
If yes, please explain: _____ | No | Yes |
| c. Do you have any breathing problems while exercising?
If yes, please explain: _____ | No | Yes |
| d. Do you have any balance problems or have had a fall in the last 6 months?
If yes, please explain: _____ | No | Yes |
| e. Do you have any difficulty completing your activities of daily living (i.e. showering, dressing, toileting)?
If yes, please explain: _____ | No | Yes |

Do you have any of the following health problems? Check all that apply

- | | | |
|--|---|---|
| <input type="checkbox"/> Arrhythmia or irregular heartbeat | <input type="checkbox"/> Uncontrolled diabetes | <input type="checkbox"/> Recent heart attack |
| <input type="checkbox"/> Arthritis or significant joint pain | <input type="checkbox"/> Severe or uncontrolled heart failure | <input type="checkbox"/> Chronic or unusual fatigue/tiredness |
| <input type="checkbox"/> Chest pain/angina | <input type="checkbox"/> Uncontrolled asthma | <input type="checkbox"/> Difficulty breathing with activity |
| | | <input type="checkbox"/> Other |

Patient Name: _____ DOB: _____

MENTAL HEALTH

PERCEIVED STRESS

	Never	Seldom	Sometimes	Often	Always
a. How often have you felt that you were unable to control the important things in your life?	1	2	3	4	5
b. How often have you felt lack of confidence about your ability to handle your personal problems?	1	2	3	4	5
c. How often have you felt that things were not going your way?	1	2	3	4	5
d. Have often have you found it hard to let go of things that upset you?	1	2	3	4	5

How do you COPE with stress? *Check all that apply*

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Meditation | <input type="checkbox"/> Food (too much, too little) | <input type="checkbox"/> Gambling | <input type="checkbox"/> Distraction |
| <input type="checkbox"/> Exercise/Physical Activity | <input type="checkbox"/> Spirituality/Faith | <input type="checkbox"/> Journaling | <input type="checkbox"/> Hurting yourself (i.e. cutting, etc.) |
| <input type="checkbox"/> Counseling/Psychotherapy | <input type="checkbox"/> Sex | <input type="checkbox"/> Massage/Body work | <input type="checkbox"/> Pet therapy |
| <input type="checkbox"/> Socializing with friends or family | <input type="checkbox"/> Recreational drugs (i.e. marijuana, cocaine, etc.) | <input type="checkbox"/> Prayer | <input type="checkbox"/> Other |
| <input type="checkbox"/> Art | <input type="checkbox"/> Television and/or video games | <input type="checkbox"/> Substance (tobacco, alcohol) | |

RESILIENCE

	Never	Seldom	Sometimes	Often	Always
When I am under extreme stress					
a. I find a way to learn from my experience.	1	2	3	4	5
b. I find a way to take action.	1	2	3	4	5
c. I find it easy to prioritize what is important in my life.	1	2	3	4	5
d. I look at a stressful situation as an opportunity to grow.	1	2	3	4	5
e. I meet the goals I set for myself.	1	2	3	4	5
f. I believe that there are a lot of ways around a problem.	1	2	3	4	5
g. I feel motivated to pursue my goals.	1	2	3	4	5
h. I know I can get through it.	1	2	3	4	5

Patient Name: _____ DOB: _____

MENTAL HEALTH (continued)

MIND-BODY CONNECTION

	Never	Seldom	Sometimes	Often	Always
a. I meet the goals I set for myself.	1	2	3	4	5
b. Do thoughts or feelings affect your physical health?	1	2	3	4	5
c. Could you be experiencing some emotion and not be aware of it?	1	2	3	4	5
d. Are you aware of tension in your body?	1	2	3	4	5
e. Do you notice how your body changes when angry?	1	2	3	4	5
f. Do you notice stress in your body?	1	2	3	4	5
g. Do you notice how your body reacts to emotions?	1	2	3	4	5

DEPRESSION

	Not at all	Several days	Most days	Daily
Over the last 2 weeks, how often have you been bothered by the following?				
a. Little interest or pleasure in doing things.	0	1	2	3
b. Feeling down, depressed or hopeless.	0	1	2	3
c. Trouble falling asleep, staying asleep, or sleeping too much.	0	1	2	3
d. Feeling tired or having little energy.	0	1	2	3
e. Poor appetite or overeating.	0	1	2	3
f. Feeling bad about yourself or that you're a failure or have let yourself or your family down.	0	1	2	3
g. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
h. Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
i. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3

ANXIETY

	Not at all	Several days	Most days	Daily
Over the last 2 weeks, how often have you been bothered by the following?				
a. Feeling nervous, anxious, or on edge.	0	1	2	3
b. Not being able to stop or control worrying.	0	1	2	3
c. Worrying too much about different things.	0	1	2	3
d. Trouble relaxing.	0	1	2	3
e. Being so restless that it's hard to sit still.	0	1	2	3
f. Becoming easily annoyed or irritable.	0	1	2	3

Patient Name: _____ DOB: _____

PURPOSE AND CONNECTION

How often do you agree with the following:

	Never	Seldom	Sometimes	Often	Always
a. I live a purposeful and meaningful life	1	2	3	4	5
b. I have a spiritual community that I can turn to in times of need	1	2	3	4	5
c. I have a source of inner strength and meaning	1	2	3	4	5
d. I am satisfied with my current belief system	1	2	3	4	5
e. I have people who care about what happens to me	1	2	3	4	5
f. I have people who accept me at my worst and best	1	2	3	4	5
g. I have people I trust at home or work who I can talk to about my problems	1	2	3	4	5
h. I get help when I'm sick	1	2	3	4	5

SMOKING AND SUBSTANCE HISTORY

NICOTINE/TOBACCO (i.e. cigarettes, e-cigarettes, e-cigarettes/vaping, cigars, chew, snuff)

- a. Do you use any of the nicotine products listed above? No Yes
 If yes, do you want to quit using the nicotine/tobacco products? No Yes
 If yes, answer the questions below:
- b. How soon after you wake up do you use nicotine/tobacco?
 After 60 minutes 31-60 minutes 6-30 minutes Within 5 minutes
- c. How many cigarettes do you smoke per day?
 10 or less 11-20 21-30 31+
- | | |
|---|---|
| <p>d. What age did you start smoking? _____</p> <p>e. What is the longest time period you have stayed quit?
 _____</p> <p>f. What made you start smoking again? _____</p> <p>g. Which of the following people smoke around you?
 <i>Check all that apply</i>
 <input type="checkbox"/> Friends <input type="checkbox"/> Family <input type="checkbox"/> Partner
 <input type="checkbox"/> Co-Workers <input type="checkbox"/> Other: _____</p> | <p>h. How many times have you seriously tried to quit? ____</p> <p>i. For your most recent quit attempt, how long did it last?
 _____</p> <p>j. Who is supporting you to quit smoking? _____</p> <p>k. What is your most important reason to quit smoking?

 _____</p> |
|---|---|
- l. Are you currently using or have used any medications to help you quit smoking? No Yes
 If yes, check with of the following medications you have used:
 Nicotine Patch Nicotine Gum Nicotine Lozenge
 Wellbutrin/Bupropion Pill Chantix/ Varenicline Pill Other: _____
- m. If you used any of the medication listed above, did they help? No Yes
 If yes, list which ones helped: _____

Patient Name: _____ DOB: _____

SMOKING AND SUBSTANCE (continued)

- n. Have you used any methods in the past other than medications to try to quit? No Yes
- If yes, check which of the following methods you have used:
- | | | | |
|--------------------------------------|--|--|---------------------------------------|
| <input type="checkbox"/> Self-help | <input type="checkbox"/> Gradual reduction | <input type="checkbox"/> Cold turkey | <input type="checkbox"/> Hypnosis |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Special filters | <input type="checkbox"/> Vaping/e-cigarettes | <input type="checkbox"/> Other: _____ |

ALCOHOL

- a. Do you drink alcohol? No Yes
- If yes, please answer the questions below:
- b. What type of alcohol do you prefer? _____
- c. On average, how many servings do you drink per day/week/month/year on average? _____
- If yes, please answer the questions below:
- d. Have you ever felt you should “**Cut** down” on your drinking? No Yes
- e. Have people **Annoyed** you by criticizing your drinking? No Yes
- f. Have you ever felt **Guilty** about your drinking? No Yes
- g. Have you ever had a drink in the morning to steady your nerves or to get rid of a handover (eye opener)? No Yes
- h. Do you binge drink (more than 5 drinks for men or 4 drinks for women within 2 hours)? No Yes

Have you used any of the following substances in the past year?

Recreational drugs (cocaine, heroin, meth, etc.)

No Yes

If yes, what level of concern do you have regarding use of the substances

No Concern						High Concern
0	1	2	3	4	5	

If yes, how much substance do you usually use? _____

Marijuana

No Yes

If yes, what level of concern do you have regarding use of the substances

No Concern						High Concern
0	1	2	3	4	5	

If yes, how much substance do you usually use? _____

TREATMENT HISTORY

- Have you ever received treatment for a mental health problem? No Yes
- Have you ever received treatment for drug or alcohol use? No Yes

Patient Name: _____ DOB: _____

MEDICAL SYMPTOM QUESTIONNAIRE (MSQ)

This questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the **PAST 30 DAYS**. If you are taking after the first time, record your symptoms for the **LAST 48 HOURS ONLY**.

Point Scale

0 = Never or almost never have the symptom
 1 = Occasionally have it, effect is not severe
 2 = Occasionally have, effect is severe

3 = Frequently have it, effect is not severe
 4 = Frequently have it, effect is severe

DIGESTIVE Diarrhea 0 1 2 3 4 Constipation 0 1 2 3 4 Bloating feeling 0 1 2 3 4 Belching, passing gas 0 1 2 3 4 Heartburn 0 1 2 3 4 Intestinal/stomach pain 0 1 2 3 4 Nausea or vomiting 0 1 2 3 4 Total points _____	EMOTIONS Mood swings 0 1 2 3 4 Anxiety, fear, nervousness 0 1 2 3 4 Anger, irritability, aggressiveness 0 1 2 3 4 Depression 0 1 2 3 4 Total points _____
EARS Itchy ears 0 0 1 2 3 Earaches, ear infections 0 1 2 3 4 Drainage from ear 0 1 2 3 4 Ringing in ears, hearing loss 0 1 2 3 4 Total points _____	ENERGY/ACTIVITY Fatigue, sluggishness 0 1 2 3 4 Apathy, lethargy 0 1 2 3 4 Hyperactivity 0 1 2 3 4 Restlessness 0 1 2 3 4 Total points _____
HEAD Headaches 0 1 2 3 4 Faintness or lightheadedness 0 1 2 3 4 Dizziness 0 1 2 3 4 Insomnia 0 1 2 3 4 Total points _____	EYES Watery or itchy eyes 0 1 2 3 4 Swollen, reddened or sticky eyelids 0 1 2 3 4 Bags or dark circles under eyes 0 1 2 3 4 Blurred or tunnel vision (<i>does not include near or far sightedness</i>) 0 1 2 3 4 Total points _____
HEART Irregular or skipped heartbeat 0 1 2 3 4 Chest pain 0 1 2 3 4 Rapid or pounding heartbeat 0 1 2 3 4 Total points _____	NOSE Stuffy nose 0 1 2 3 4 Sinus problems 0 1 2 3 4 Sneezing attacks 0 1 2 3 4 Excessive mucous formation 0 1 2 3 4 Hay fever 0 1 2 3 4 Total points _____
JOINTS/MUSCLES Pains or aches in joints 0 1 2 3 4 Arthritis 0 1 2 3 4 Stiffness or limitations of movement 0 1 2 3 4 Pain or aches in muscles 0 1 2 3 4 Feeling of weakness or tiredness 0 1 2 3 4 Total points _____	SKIN Acne 0 1 2 3 4 Hives, rashes, dry skin 0 1 2 3 4 Hair loss 0 1 2 3 4 Flushing or hot flushes 0 1 2 3 4 Excessive sweating 0 1 2 3 4 Total points _____
LUNGS Chest congestion 0 1 2 3 4 Asthma, bronchitis 0 1 2 3 4 Shortness of breath 0 1 2 3 4 Difficulty breathing 0 1 2 3 4 Total points _____	WEIGHT Binge eating/drinking 0 1 2 3 4 Craving certain foods 0 1 2 3 4 Excessive weight 0 1 2 3 4 Water retention 0 1 2 3 4 Underweight 0 1 2 3 4 Compulsive eating 0 1 2 3 4 Total points _____
MIND Poor memory 0 1 2 3 4 Confusion, poor comprehension 0 1 2 3 4 Poor concentration 0 1 2 3 4 Poor physical coordination 0 1 2 3 4 Difficulty making decisions 0 1 2 3 4 Stuttering or stammering 0 1 2 3 4 Learning disabilities 0 1 2 3 4 Slurred speech 0 1 2 3 4 Total points _____	OTHER Frequent illness 0 1 2 3 4 Frequent or urgent urination 0 1 2 3 4 Genital itch or discharge 0 1 2 3 4 Total points _____
Total points _____	GRAND TOTAL _____

KEY: Add individual scores and total each group. Add each group score to give a grand total.

*Optimal is <10; Mild Symptoms: 10-50; Moderate Symptoms: 50-100; Severe Symptoms: over 100

Patient Name: _____ DOB: _____

PREVENTIVE SERVICES

- | | |
|--|----------------------------|
| <p>a. Have you had a physical exam and/or “Wellness” Visit in the past 12 months?
If yes, list date and outcome: _____</p> | <p>No Yes I don't know</p> |
| <p>b. Have you had a dental exam and teeth cleaning in the past 12 months?
If yes, list date and outcome: _____</p> | <p>No Yes I don't know</p> |
| <p>c. Have you been screened for diabetes with blood work?
If yes, list date and outcome: _____</p> | <p>No Yes I don't know</p> |
| <p>d. Have you had your cholesterol, lipids or triglycerides measured?
If yes, list date and outcome: _____</p> | <p>No Yes I don't know</p> |
| <p>e. Have you ever had a bone density test to check for osteoporosis?
If yes, list date and outcome: _____</p> | <p>No Yes I don't know</p> |
| <p>f. Do you have any balance problems or have had a fall in the last 6 months?
If yes, list date and outcome: _____</p> | <p>No Yes I don't know</p> |
| <p>g. Do you have any difficulty completing your activities of daily living (i.e. showering, dressing, toileting)?
If yes, list date and outcome: _____</p> | <p>No Yes I don't know</p> |
| <p>h. Do you have any concerns about your ability to drive safely or have you had any car accidents in the past 12 months?
If yes, list date and outcome: _____</p> | <p>No Yes I don't know</p> |
| <p>i. Do you have any concerns about your memory?
If yes, list date and outcome: _____</p> | <p>No Yes I don't know</p> |
| <p>j. Do you have any trouble with your hearing?
If yes, list date and outcome: _____</p> | <p>No Yes I don't know</p> |
| <p>k. Have you had your eyes checked for vision problems?
If yes, list date and outcome: _____</p> | <p>No Yes I don't know</p> |
| <p>l. Have you ever had your metabolism or thyroid checked?
If yes, list date and outcome: _____</p> | <p>No Yes I don't know</p> |
| <p>m. Have you ever been told that you have a sexually transmitted disease/infection?
If yes, list date and outcome: _____</p> | <p>No Yes I don't know</p> |
| <p>n. If you smoke, have you ever had an abdominal ultrasound to check for possible aneurysms?
If yes, list date and outcome: _____</p> | <p>No Yes I don't know</p> |
| <p>o. Have you ever received counseling behavioral therapy for any of the following problems?
 <input type="checkbox"/> Weight management or obesity <input type="checkbox"/> Nutrition <input type="checkbox"/> Smoking or use of other nicotine products <input type="checkbox"/> Alcohol use</p> | |
| <p>p. Which of the following screenings have you completed
 <input type="checkbox"/> Colon cancer screen (stool test or colonoscopy) <input type="checkbox"/> Breast cancer screen (mammogram) <input type="checkbox"/> Cervical cancer screen (PAP smear)
 <input type="checkbox"/> HIV/AIDS blood work screen <input type="checkbox"/> Hepatitis C blood work screen <input type="checkbox"/> Depression or sadness screen</p> | |
| <p>q. Have you had the following vaccines?
 <input type="checkbox"/> Flu <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Pneumococcal or Pneumonia</p> | |

Patient Name: _____ DOB: _____