NEO Institute of Functional Medicine
...Your Center for Hope & Healing

8398 Kinsman Road
Novelty, Ohio 44072
Phone: 440-338-6344
Fax: 440-338-6355

"Functional Medicine is a patient centered, science based, health care that identifies and addresses underlying biochemical, physiological, environmental, and psychological factors to reverse disease progression and enhance vitality." Jeffrey Bland, Ph,D.

What is unique about medical care at the Center for Hope and Healing?

Your initial consultation will include a comprehensive review of current medical concerns, within the context of your personal and family history. Current medications are reviewed, and potential laboratory assessments are discussed.

Our medical professionals view you as being genetically unique, and are always mindful of the connection between your physical and emotional well-being. We focus on the underlying causes of your medical issues, with less emphasis on diagnosis codes that automatically lead to prescription drug therapy. Your treatment plan is customized to reflect your unique physical characteristics and potential for disease.

Self-awareness and self-empowerment are encouraged at every step in your journey. The treatment plan will be the result of a real collaboration between you and our medical staff.

What Can I Expect?

You should allow approximately 2 to 2 ½ hours for your initial consultation. At the conclusion of your medical evaluation, you will receive specific recommendations for therapy. These recommendations often include diet and lifestyle changes, and possible referral to other professionals who embrace the Functional Medicine approach to long-term health. Follow up visits are scheduled to review laboratory test results, current symptoms, and appropriate adjustments to your treatment plan.

What about Insurance?

Because of the unique nature of the practice, The Center for Hope and Healing is not a participating provider in any current health insurance plans. Health Insurance claim forms are provided to each patient with commercial insurance for submission to their insurance carrier. Office appointments are treated by most insurance carriers as visits to an out-of-network physician, and benefits are generally paid directly to the patient by the insurance company.

The Medical Staff

Dorothy S. Sprecher, M D. is a Board-Certified Family Practice Physician and Board-Certified Functional Medicine Practitioner. Her specialty is Functional Medicine.

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PERSONAL INFORMATION

Name **BIRTH DATE**

ADDRESS **CITY** **STATE** **ZIP**

HOME PHONE **WORK PHONE** **CELL PHONE** **E-MAIL**

☐ MALE ☐ FEMALE ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

EMPLOYER OCCUPATION

SOCIAL SECURITY REFERRED BY

PHARMACY PHONE NUMBER (RX) EMERGENCY CONTACT

MEDICAL INFORMATION

CHIEF COMPLAINT / REASON FOR VISIT

LIST ANY ALLERGIES YOU HAVE (DRUG, FOOD, HAY FEVER, OTHER)

LIST ANY MEDICATIONS YOU ARE TAKING

DESCRIBE ANY MEDICAL CONDITIONS WE SHOULD KNOW ABOUT

☐ DO YOU HAVE HIGH BLOOD PRESSURE? ☐ DIABETES?

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY INSURANCE ADDRESS POLICY NUMBER GROUP NUMBER

POLICYHOLDERS' NAME RELATIONSHIP TO POLICYHOLDER

POLICYHOLDERS' BIRTH DATE INSURED SOCIAL SECURITY NUMBER

POLICY HOLDERS EMPLOYER INSURED ADDRESS IF DIFFERENT

FINANCIAL INFORMATION

CREDIT CARD ON FILE

CREDIT CARD NUMBER EXPIRATION DATE NAME ON CARD

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES PROVIDED TO ME, INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF POSSIBLE INSURANCE BENEFITS.

PLEASE SIGN / DATE

RELEASE OF INFORMATION

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION, NECESSARY TO PROCESS FUTURE CLAIMS.

PLEASE SIGN / DATE

The Center for Hope and Healing
Dorothy S. Sprecher, M.D.

PATIENT NAME:_____

Patient Consent Form

New federal requirements regarding the privacy of information for health care patients went into effect in April of 2003. H.I.P.P.A. (Health Insurance Portability and Protection Act) requires that all medical providers, insurance companies, and others put in place controls to ensure that your personal medical information remains confidential. We are requesting that you sign this form to allow us to share protected health information with other physician's offices, your hospital and insurance company. By signing this form, you consent to our use and disclosure of protected health information about you, for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on you prior consent.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Signature of Patient or Representative:_____**Date**_____

Name of Patient or Representative:_____**Date of Birth**_____

Authorization to Release Information to Family Members

Many of our patients allow immediate family members, such as a spouse, parent, or others to call our office and request the results of tests, procedures, and medical information. Under the requirements of H.I.P.P.A., we are not allowed to give this information to anyone without your consent. If you wish to have your information released to family members, you must sign this form. Signing this form will give consent to release information to family members indicated below.

You have the right to revoke this consent, in writing, except where we already made disclosures in reliance on your prior consent.

I authorize The Center for Hope and Healing to release to the following individuals: (Please initial)

_____ All Medical Information (no Demographics)
_____ All Medical Information and Demographics
_____ Lab results
_____ Test results only

1.) _____ Relation to Patient:_____

2.) _____ Relation to Patient:_____

Patient Name:_____**Patient Signature:**_____**Date**_____

Authorization to Leave Messages with Household Members / Answering Machine

It is sometimes necessary for our staff to leave telephone messages for our patients. The purpose of these messages is to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss lab or procedure results, or to ask a patient to call The Center for Hope and Healing regarding an issue of concern. At no time will a representative of The Center of Hope and Healing discuss you medical circumstances or condition, without your consent. This authorization will permit us to leave messages with members of your household, in voice mail, or on your answering machine. You have the right to revoke this consent, in writing, except where we have already made disclosures, in reliance on you prior consent. Please check the appropriate locations for which we have your permission to leave messages.

_____ HOME _____ WORK _____ CELL _____ E-MAIL

Patient Name:_____**Patient Signature:**_____**Date**_____

ADULT MEDICAL QUESTIONNAIRE

Thank you for your interest in The Northeast Ohio Institute of Functional Medicine: Center for Hope and Healing. As a new patient, our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will also assist us to formulate a treatment plan. We appreciate your time and attention and look forward to helping you achieve a healthier you!

First Name: _____ Middle Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: (_____) _____-_____ Birth Date: ____/____/_____ Age: _____
(month /day / year)

Work Phone: (_____) _____-_____ SSN: _____

Height: ___' ____" Weight: _____ Sex: _____ Place of Birth: _____ ____
City or town & country (if not US)

Occupation: _____

Referred by: _____ Today's Date _____

1. Please check appropriate box(es):

☐ African American ☐ Hispanic ☐ Mediterranean ☐ Asian
☐ Native American ☐ Caucasian ☐ Northern European ☐ Other

2. Please list current and ongoing problems & provide other information as completely as possible:

	Describe Problem *Example: sinusitis*	**Mild/Moderate/Severe** *moderate*	**Treatment approach** *herbs/acupuncture*	**Outcome** *moderate*
A.				
B.				
C.				
D.				
E.				
F.				
G.				

3. Current Marital Status:

Single (never married) Married Widowed Divorced Separated Partnered

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

_____

_____

_____

5. Do you have any pets or farm animals? ____ Yes ____ No
If yes, where do they live? ____ Indoors ____ Outdoors ____ Both indoors and outdoors

6. Have you lived or traveled outside of the United States? ____ Yes ____ No
If so, when and where?

_____

_____

7. As you look back over your life - list any events, experiences, that have been of significance or caused major change in your life. (i.e. death of a close friend or relative or loss of a job)

_____

_____

_____

8. How important is religion (or spirituality) for you and your family's life?

Not at all important 0 1 2 3 4 5 6 7 8 9 10 Extremely important

9. How much time have you lost from work or school in the past year?
a. _____ 0-2 days
b. _____ 3 –14 days
c. _____ >15 days

10. Occupational history - include volunteer work:

_____

_____

_____

11. Past Medical and Surgical History:

Illnesses/Conditions	When	Comments/Treatment
A. Anemia		
B. Arthritis, stiff joints, fibromyalgia		
bursitis, tendonitis, gout, joint pain		
C. Asthma, wheezing, bronchitis,		
emphysema, short of breath,		
pneumonia, lung cancer		
D. Atrial Fibrillation, heart disease,		
MI, heart surgery, murmur,		
palpitations, MVP, chest pain,		
angina, rheumatic fever, heart		
failure, pacemaker		
E. High cholesterol, high blood		
pressure (hypertension), stroke		

F. Diabetes, hypoglycemia, metabolic syndrome_____ _____

G. HIV/AIDS _____ _____

H. Cancer, Leukemia, Hodgkin's, _____ _____

non-Hodgkin's Lymphoma _____ _____

I. Chronic fatigue syndrome, mono _____ _____

J. Crohn's disease, ulcerative colitis,_____ _____

Gallstone, gall bladder, hepatitis, _____ _____

IBS, kidneystone _____ _____

K. Epilepsy, convulsions, seizures, dementia_____ _____

L. Allergies, food, environment, drug_____ _____

seasonal, hay fever, sinus, post nasal drip_____ _____

M. Thyroid disease _____ _____

N. Adrenal disease, cushings, addisons_____ _____

O. Skin cancer, hives, acne, psoriasis, eczema_____ _____

P. Sleep apnea, insomnia _____ _____

Q. Breast cancer, fibrocystic breasts_____ _____

R. Prostate disease _____ _____

S. Other describe _____ _____

Injuries	**When**	**Comments**
T. Back injury	_____	_____
U. Broken bones–describe	_____	_____
V. Head injury	_____	_____
W. Neck injury	_____	_____
X. Other - describe	_____	_____

Diagnostic Studies	**When**	**Comments**
1. Barium enema	_____	_____
2. Bone scan	_____	_____
3. CT scan of abdomen	_____	_____
4. CT scan of brain	_____	_____
5. CT scan of spine	_____	_____
6. Chest x-ray	_____	_____
7. EKG	_____	_____
8. Stress test/Echocardiogram	_____	_____
9. Holter monitor	_____	_____
10. Heart catheterization	_____	_____
11. Liver scan	_____	_____
12. Neck x-ray	_____	_____
13. NMR/MRI	_____	_____
14. Colonoscopy	_____	_____

15. Sigmoidoscopy _____ _____
16. Upper GI series _____ _____
17. Pulmonary function study _____ _____
18. Other (describe) _____ _____

Operations/Surgeries	When	Comments
19. Appendectomy		
20. Dental surgery		
21. Removal of mercury, fillings		
22. Gall bladder (cholecystectomy)		
23. Colostomy		
24. Hernia		
25. Hysterectomy		
26. Tonsillectomy		
27. Cosmetic/plastic surgery		
28. Reconstructive surgery		
29. Breast implants		
30. Other prosthesis		

Hospitalizations-Where	When	For what reason

12. How often have you taken antibiotics? Infancy/childhood _____ Teen _____ Adulthood _____
13. How often have you taken oral steroids? ____ Never ____ Occasional ____ Chronic
14. List any prescription medications you are now taking:

	Medication Name	Date started	Dosage	Reason for Taking
1.				
2.				
3.				
4.				
5.				
6.				
7.				

15. Are you allergic to any medications? ____ Yes ____ No
If yes, please list:

_____

_____

16. List all vitamins, minerals, nutritional supplements or over-the-counter products that you are taking now.

	Vitamin/Mineral/Supp. Name	**Date started**	**Dosage**	**Reason for Taking**
A.				
B.				
C.				
D.				
E.				
F.				
G.				
H.				
I.				
J.				

Describe your childhood health

17. Frequent doctor visits ____ Yes ____ No

18. Sore throat, allergies, stomach aches ____ Yes ____ No

19. Missed a lot of school ____ Yes ____ No

20. Shy, withdrawn, isolated ____ Yes ____ No

21. Food reactions

Food (ex. Milk)	**Reaction** (gas & diarrhea)

22. Place a check mark next to the food/drink that applies to your current diet.

Breakfast		Lunch		Dinner	
none	____	none	____	none	____
bacon/sausage	____	salad hot/cold	____	beans (legumes)	____
bagel/toast	____	sandwich	____	meat	____
butter	____	leftovers	____	fish	____
cereal hot/cold	____	restaurant	____	poultry	____
coffee	____	meat	____	salad hot/cold	____
donut/pastry	____	chicken	____	veggies/hot	____
eggs	____	fish	____	veggies/cold	____
fruit	____	soup	____	potato	____
muffin	____	veggies hot/cold	____	rice	____
margarine	____	yogurt	____	pasta	____
milk	____	fruit	____	nuts	____
oat bran/meal	____	cottage cheese	____	seeds	____
sugar	____	eat in cafeteria	____	milk	____
juice	____	coffee	____	water	____
sweetener	____	soda/pop	____	coffee	____
tea	____	tea	____	tea	____
coffee	____	sugar	____	sweetener	____
water	____	sweetener	____	soda/pop	____
yogurt	____	milk	____	beer	____
other _____		water	____	wine	____
_____		wine/beer	____	mixed drink	____
_____		mixed drink	____	other _____	
_____		other _____		_____	
_____		_____		_____	
_____		_____		_____	

23. How many times a week do you skip meals? _____ If so, which meal(s) _____

24. Do you feel better if you do not eat? ____ Yes ____ No

25. Please fill in the chart below with information about your bowel movements:

a. Frequency

____ Multiple times in a day
____ Once daily
____ Every other day
____ Only a few times a week

b. Additional Support

____ I use fiber/laxative to help with bowel movements
____ I get colonics/ colon hydrotherapy
____ Other (i.e. Vitamin C, Magnesium, teas, etc.)

26. Do you drink alcohol? ____ Yes ____ No
    a. What type? ____ Beer ____ Wine ____ Mixed drinks
    b. How often? ____ Daily ____ Weekends ____ Infrequent ____ Rare
    c. Have you ever had a problem with alcohol? ____ Yes ____ No
       If yes, please indicate time period (month/year) _____

28. Have you ever used recreational drugs? ____ Yes ____ No

29. Have you ever used tobacco? ____ Yes ____ No
If yes, number of years as a nicotine user _____Amount per day _____Year quit

30. Do you have mercury amalgam (silver) fillings? ____ Yes ____ No

31. Do you have any artificial joints or implants? ____ Yes ____ No

Explain: _____
(i.e. hip replacement, breast implants, teeth)

32. Do you feel worse at certain times of the year? ____ Yes ____ No
If yes, when? ____Spring ____Summer ____Fall ____ Winter

33. Have you, to your knowledge, been exposed to toxic metals/chemicals in your job or at home?
____ Yes ____ No
If yes, which one(s)?
____ Lead ____ Cadmium ____ Arsenic ____ Mercury ____ Aluminum ____ Other

34. Do strong odors affect you (ex. spray perfume)? ____ Yes ____ No

If yes, how? _____
(i.e. nausea, headache, etc.)

35. Have you ever had psychotherapy or counseling? ____ Yes ____ No
Currently? _____ Previously? _____ Dates of Treatment, from _____ to _____.

What kind? _____

Comments: _____

36. Are you currently, or have you ever been, married? ____ Yes ____ No
If so, when were you married? _____ Spouse's occupation _____

When were you separated? _____ N/A _____

When were you divorced? _____ N/A _____

When were you remarried? _____ N/A _____ Spouse's occupation _____

37. Hobbies and leisure activities:_____

_____

_____

38. Do you exercise regularly? ____ Yes ____ No

If so, how many times a week?
____ 1x
____ 2x
____ 3x
____ 4x or more

When you exercise, how long is each session?
____ Less than 15 minutes
____ 16-30 minutes
____ 31-45 minutes
____ +45 minutes

What type of exercise is it? ____ Jogging/Walking ____ Cardio ____ Running
____ Weight Training ____ Curves or Similar ____ Other

Family History: For each family member, check the appropriate box that applies to their past and present health conditions.

	Father	Mother	Brother or Sister	Brother or Sister	Child 1	Child 2	Maternal Grand-mother	Maternal Grand-father	Paternal Grand-mother	Paternal Grand-father
Write in Family Names										
Good Health										
Poor Health										
Deceased										
Write in Age & Cause of Death (Include accidents & suicides)										
Alcoholism										
Allergies & Asthma										
Alzheimer's or Dementia										
Anemia										
Blood Clotting Problems										
Diabetes										
Cancer or Tumor										
Epilepsy / Seizures										
Genetic Disease										
Heart Disease										
High Blood Pressure										
Kidney or Bladder										
Anxiety or Depression										
Rheumatism or Arthritis										
Stomach or Bowel										
High Cholesterol										
Thyroid										
Health patterns among extended family										
Other Significant Issues										

39. Any other family history we should know about? ____ Yes ____ No

If so, please comment: _____

40. What is the attitude of those close to you about your illness? ____ Supportive ____Non-Supportive

For Women Only (questions 45 - 48)

41. Have you ever been pregnant? ____ Yes ____ No

____ # of Miscarriages ____ # of Abortions ____ # of Pre-Mature Births

____ # of Term Births ____ Birth weight of largest baby ____ Birth weight of smallest baby

Did you develop toxemia (high blood pressure)? ____ Yes ____ No

Have you had other problems with pregnancy? ____ Yes ____ No

If so, please comment: _____

42. Age at first period _____ Date of last pap smear _____ Date of last mammogram _____

Pap Smear _____ Normal _____ Abnormal

Mammogram _____ Normal _____ Abnormal

Bone mineral density testing _____ Normal _____ Abnormal
_____ Osteopeonia _____ Osteoporosis

43. Have you ever used birth control pills? ____ Yes (when _____) ____ No

44. Are you taking the pill now? ____ Yes ____ No

45. Did taking the pill agree with you? ____ Yes ____ No ____ N/A

46. Do you currently use contraception? ____ Yes ____ No

If yes, what type of contraception do you use? _____

47. Are you in menopause? ____ Yes ____ No

Date of last menstrual period _____

Have you used HRT (hormone replacement therapy)?____ Yes ____ No

What did you take? List all Rx's and O.T.C. drugs _____

48. How long have you been on hormone replacement therapy (if applicable)? _____

History of breast implants / reconstruction ____ Yes ____ No

Fibrocystic breasts ____ Yes ____ No

IUD ____ Yes ____ No

Data Sheet for Hormone Replacement

Patient Name _____ Age _____ Weight _____

Age and Date Menopause Started (if applicable) _____ Age Mother Started _____

Current Hormone Replacement? ____ Yes ____ No If Yes, for how long? _____

If Yes, which medications? _____

Dosage of each: _____

Other Rx medications: _____

OTC medications: _____

Family History of Cancer? (women's side) ____ Yes ____ No Body Type (shape) _____

Yes	No	Hot flashes?	If Yes, Frequency: ____/night ____/week ____/day
Yes	No	Sleeplessness?	
Yes	No	Having Periods?	If Yes, are they regular? ____ Yes ____ No
Yes	No	Recent Weight Gain?	
Yes	No	Acne?	
Yes	No	Frequent Urinary Infections?	If Yes, how often: _____
Yes	No	Thinning Hair?	
Yes	No	High Cholesterol?	
Yes	No	Adequate Libido?	
Yes	No	Hysterectomy?	If Yes, at what age? _____
Yes	No	Exercise?	How often: ____/day ____/weekday ____/weekend
Yes	No	Stress?	How do you feel? _____
Yes	No	Pregnancies?	If Yes, how many? _____
			How did you feel when pregnant? _____

What age did you start menses? _____ How did you feel? _____

If peri-menopausal, when 33 years old, how long was your cycle? _____

Yes No Goal to keep cycle the same now?

Current Complaints / Symptoms: _____

_____

_____

Suggested Changes: _____

_____

_____

49. Please check if you experience these symptoms (N) now or if you previously had them in the (P) past 6 months. Please rate the following (N) for now or (P) past 6 months.

General	mild	moderate	severe
cold hands & feet	___	___	___
daytime sleepiness	___	___	___
early waking	___	___	___
fever	___	___	___
heat intolerance	___	___	___
nightmares	___	___	___

General	mild	moderate	severe
cold intolerance	___	___	___
difficulty falling asleep	___	___	___
fatigue	___	___	___
flushing	___	___	___
night waking	___	___	___
no dream recall	___	___	___

Head, Eyes & Ears	mild	moderate	severe
conjunctivitis	___	___	___
distorted taste	___	___	___
ear noises	___	___	___
ear ringing/buzzing	___	___	___
eye pain	___	___	___
hearing loss	___	___	___
lid margin redness	___	___	___
sensitivity to loud noises	___	___	___

Head, Eyes & Ears	mild	moderate	severe
distorted sense of smell	___	___	___
ear fullness	___	___	___
ear pain	___	___	___
eye crusting	___	___	___
headache	___	___	___
hearing problems	___	___	___
migraine	___	___	___
vision problems	___	___	___

Musculoskeletal	mild	moderate	severe
Back muscle spasm	___	___	___
Chest tightness	___	___	___
Joint deformity	___	___	___
Joint redness	___	___	___
muscle pain	___	___	___
muscle spasms	___	___	___
muscle stiffness	___	___	___
neck muscle spasm	___	___	___
tension headache	___	___	___

Musculoskeletal	mild	moderate	severe
calf cramps	___	___	___
foot cramps	___	___	___
joint pain	___	___	___
joint stiffness	___	___	___
muscle twitches			
around eyes	___	___	___
arms or legs	___	___	___
muscle weakness	___	___	___
tendonitis	___	___	___
TMJ problems	___	___	___

Mood/Nerves	mild	moderate	severe
agoraphobia	___	___	___
auditory hallucinations	___	___	___
depression	___	___	___
difficulty w/balance	___	___	___
difficulty w/judgment	___	___	___
difficulty w/memory	___	___	___
fainting	___	___	___
irritability	___	___	___
numbness	___	___	___
panic attacks	___	___	___
seizures	___	___	___
tingling	___	___	___
visual hallucinations	___	___	___

Mood/Nerves	mild	moderate	severe
anxiety	___	___	___
black-out	___	___	___
difficulty concentrating	___	___	___
difficulty w/thinking	___	___	___
difficulty w/speech	___	___	___
dizziness (spinning)	___	___	___
fearfulness	___	___	___
light-headedness	___	___	___
other phobias	___	___	___
paranoia	___	___	___
suicidal thoughts	___	___	___
tremor/trembling	___	___	___

Eating	mild	moderate	severe
Binge eating	___	___	___
Can't gain weight	___	___	___
Carbohydrate craving	___	___	___
Poor appetite	___	___	___

Eating	mild	moderate	severe
bulimia	___	___	___
can't lose weight	___	___	___
carbohydrate intolerance	___	___	___
salt craving	___	___	___

Digestion	mild	moderate	severe
anal spasms	___	___	___
bleeding gums	___	___	___
bloating of whole abdomen	___	___	___
burping	___	___	___
cold sores	___	___	___
cracking corner of lips	___	___	___
diarrhea	___	___	___
dry mouth	___	___	___
fissures	___	___	___
heart burn	___	___	___
intolerance to lactose	___	___	___
intol. to gluten (wheat)	___	___	___
intolerance to eggs	___	___	___
intolerance to yeast	___	___	___
lower abdominal pain	___	___	___
nausea	___	___	___
sore tongue	___	___	___
undigested food stools	___	___	___
vomiting	___	___	___

Digestion	mild	moderate	severe
bad teeth	___	___	___
bloating of lower abdomen	___	___	___
blood in stools	___	___	___
canker sores	___	___	___
constipation	___	___	___
dentures w/poor chewing	___	___	___
difficulty swallowing	___	___	___
farting	___	___	___
foods "repeat" (reflux)	___	___	___
hemorrhoids	___	___	___
intolerance all milk prod.	___	___	___
intolerance to corn	___	___	___
intolerance fatty foods	___	___	___
liver disease/jaundice	___	___	___
mucus in stools	___	___	___
periodontal disease	___	___	___
strong stool odor	___	___	___
upper abdominal pain	___	___	___

Skin Problems	mild	moderate	severe
acne on back	___	___	___
acne on face	___	___	___
athlete's foot	___	___	___
cellulite	___	___	___
ears get red	___	___	___
eczema	___	___	___
hives	___	___	___
lackluster skin	___	___	___
oily skin	___	___	___
patchy dullness	___	___	___
rash	___	___	___
sensitive to bites	___	___	___
shingles	___	___	___
skin darkening	___	___	___
thick calluses	___	___	___

Skin Problems	mild	moderate	severe
acne on chest	___	___	___
acne on shoulders	___	___	___
bumps back of upper arm	___	___	___
dark circles under eyes	___	___	___
easy bruising	___	___	___
herpes - genital	___	___	___
jock itch	___	___	___
moles w/color size change	___	___	___
pale skin	___	___	___
psoriasis	___	___	___
red face	___	___	___
sensitive poison ivy/oak	___	___	___
skin cancer	___	___	___
strong body odor	___	___	___
vitiligo	___	___	___

Skin Itching	mild	moderate	severe
anus	___	___	___
ear canals	___	___	___
feet	___	___	___
legs	___	___	___
nose	___	___	___
roof of mouth	___	___	___
skin in general	___	___	___

Skin Itching	mild	moderate	severe
arms	___	___	___
eyes	___	___	___
hands	___	___	___
nipples	___	___	___
penis	___	___	___
scalp	___	___	___
throat	___	___	___

Skin Dryness	mild	moderate	severe
eyes	___	___	___
feet - cracking	___	___	___
hair	___	___	___
hands	___	___	___
hands - peeling	___	___	___
scalp	___	___	___
skin in general	___	___	___

Skin Dryness	mild	moderate	severe
feet	___	___	___
feet - peeling	___	___	___
hair unmanageable	___	___	___
hands - cracking	___	___	___
mouth/throat	___	___	___
dandruff	___	___	___

Lymph Nodes	mild	moderate	severe
Enlarged/neck	___	___	___
Other enlarged/ tender lymph nodes	___	___	___

Lymph Nodes	mild	moderate	severe
tender/neck	___	___	___

Nails	mild	moderate	severe
bitten	___	___	___
curve up	___	___	___
fungus - fingers	___	___	___
pitting	___	___	___
ridges	___	___	___
thickening finger nails	___	___	___
white spots/lines	___	___	___

Nails	mild	moderate	severe
brittle	___	___	___
frayed	___	___	___
fungus - toes	___	___	___
ragged cuticles	___	___	___
soft	___	___	___
thickening of toe nails	___	___	___

Respiratory	mild	moderate	severe
bad breath	___	___	___
cough - dry	___	___	___
hay fever spring	___	___	___
hay fever fall	___	___	___
hoarseness	___	___	___
nose bleeds	___	___	___
sinus fullness	___	___	___
snoring	___	___	___
wheezing	___	___	___

Respiratory	mild	moderate	severe
bad odor in nose	___	___	___
cough - productive	___	___	___
hay fever summer	___	___	___
hay fever change seasons	___	___	___
nasal stuffiness	___	___	___
post nasal drip	___	___	___
sinus infection	___	___	___
sore throat	___	___	___
winter stuffiness	___	___	___

Cardiovascular	mild	moderate	severe
angina/chest pain	___	___	___
heart attack	___	___	___
high blood pressure	___	___	___
mitral valve prolapse	___	___	___
phlebitis	___	___	___
varicose veins	___	___	___

Cardiovascular	mild	moderate	severe
breathlessness	___	___	___
heart murmur	___	___	___
irregular pulse	___	___	___
palpitations	___	___	___
swollen ankles/feet	___	___	___

Urinary	mild	moderate	severe
bed wetting	___	___	___
infection	___	___	___
kidney stone	___	___	___
pain/burning	___	___	___
prostate infection	___	___	___

Urinary	mild	moderate	severe
hesitancy	___	___	___
kidney disease	___	___	___
leaking/incontinence	___	___	___
prostate enlargement	___	___	___
urgency	___	___	___

Male Reproductive	mild	moderate	severe
discharge from penis	___	___	___
genital pain	___	___	___
infection	___	___	___
poor libido (sex drive)	___	___	___

Male Reproductive	mild	moderate	severe
ejaculation problem	___	___	___
impotence	___	___	___
lumps in testicles	___	___	___

Female Reproductive	mild	moderate	severe
breast cysts	___	___	___
breast tenderness	___	___	___
poor libido (sex drive)	___	___	___
fibroids	___	___	___
vaginal discharge	___	___	___
vaginal itch	___	___	___

Female Reproductive	mild	moderate	severe
breast lumps	___	___	___
ovarian cyst	___	___	___
endometriosis	___	___	___
infertility	___	___	___
vaginal odor	___	___	___
vaginal pain	___	___	___

Premenstrual	mild	moderate	severe
bloating	___	____	____
carbohydrate craving	___	____	____
constipation	___	____	____
diarrhea	___	____	____
increased sleep	___	____	____

Premenstrual	mild	moderate	severe
breast tenderness	___	____	____
chocolate craving	___	____	____
decreased sleep	___	____	____
fatigue	___	____	____
irritability	___	____	____

Menstrual	mild	moderate	severe
cramps	___	____	____
irregular periods	___	____	____
scanty periods	___	____	____

Menstrual	mild	moderate	severe
heavy periods	___	____	____
no periods	___	____	____
spotting between	___	____	____

Optional

Have you had HIV testing? ____ Yes ____ No

Do suspect that you are at risk for HIV/AIDS? ____ Yes ____ No

Thank you for your time and attention to this questionnaire. Please contact us should you have any questions prior to your first visit with us. We look forward to working with you!

The Staff of The Northeast Ohio Institute of Functional Medicine: Center for Hope and Healing

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