Intake:

New Patient Information

Minds in Motion
1041 Lincoln Ave #310
Steamboat Springs CO 80487

Phone 970-846-1598
Fax 970-875-7738

Mindsinmotionco.com
Email: angela.mindsinmotion@gmail.com

Dear Patient,

Welcome to Minds in Motion. Please review the information below to get an idea of what to expect during your initial appointment.

You must be an existing client with a referring therapist at Minds in Motion to make an appointment with Dr. Fegley

THESE FORMS AND ALL MEDICAL RECORDS MUST BE SUBMITTED TO OUR OFFICE AT LEAST 7 DAYS PRIOR TO YOUR FIRST APPOINTMENT
Please print these out and fax (970-875-7738)
Or email Phaedra.mindsinmotion@gmail.com
Or drop by our office

FILL OUT AND /OR SIGN THE FOLLOWING FORMS

1. Fill out the attached forms and email the completed questionnaire to Phaedra.mindsinmotionco@gmail.com or fax to (970-875-7738) at LEAST 7 days prior to your scheduled appointment.

* Male or Female Intake Questionnaire
* 3-Day Diet Diary
* MSQ – Medical Symptom/Toxicity Questionnaire
* Thyroid Questionnaire
* Toxin Exposure Questionnaire

2. Obtain previous medical records from other physicians or health care providers who are not affiliated with Minds in Motion.

Instruct outside healthcare

Thank you,

We are looking forward to working with you and helping you achieve optimal health.

PLEASE KEEP PAGES 1-7 FOR YOUR RECORDS

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WHAT TO EXPECT DURING YOUR CONSULTATION AT MINDS IN MOTION

YOU ARRIVE TO THE OFFICE (PLEASE ARRIVE 15 MINUTES BEFORE SCHEDULED APPOINTMENT)

Update personal forms and sign consent forms if not done previously

FUNCTIONAL MEDICINE INITIAL CONSULTATION:

Consult with Dr. Fegley (90 min).

Please plan 2 hours for your initial consultation. Bring a snack if you'd like.

Functional Medicine Initial **Follow Up Consults**:

Consult with Dr. Fegley to review labs and progress (50 min)

WRAP UP AND CHECK OUT

Pay for consult, and labs.

Schedule follow-up appointment

Any supplements purchased that day will be paid for separately at the front desk.

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PRACTICE POLICIES FOR PATIENTS

Our goal is to provide you with the highest level of personalized care possible. We are committed to helping you achieve optimal health

It is important to read all of the enclosed information carefully and return it to our office least 7 days prior to your appointment. You can return it to our office by mail, email, fax or drop it by our office. Our system is not interactive, so you will need to print out the documents and then rescan them if you choose to email, mail or fax them to us.

Having these forms 7 days in advance will allow Dr. Fegley to help solve your problems more efficiently and enhance the quality of your care. If your Intake Form and Medical Records have not been received at least 7 days prior to your initial appointment, it may take Dr. Fegley up to 30 minutes of your appointment time to review your chart.

WEBSITE

Information about Minds in Motion (mindsinmotionco.com) and all relevant patient forms are available through the website:

Mindsinmotionco.com and may be found on the tab Appointments/forms

MEDICAL RECORDS FROM OTHER DOCTORS/CLINICS/HOSPITALS

Medical records can only be released with your authorization.

It is your responsibility to obtain previous medical records from other physicians, or health care providers that you wish Dr. Fegley to review. Please contact your physician or other health care provider to obtain these records and make sure that we have received them at least 7 days prior to your initial appointment.

Your medical records should be mailed or faxed to:
Minds in Motion 1041 Lincoln Ave #310 Steamboat Springs CO 80487

Fax #: 970-875-7738

COPIES OF LABS FROM OUR OFFICE

You will be given a copy of your labs at each visit to keep for your records. [Should you need additional copies of your medical records; a $25 fee will be charged for copies and postage.]

FUNCTIONAL MEDICINE CONSULTATION FEES

Initial Consultation is $300. (Initial Appointment 1 ½ hr)
Initial follow up appointment is $150. (50 Minute). This includes visits with Dr. Fegley and review of all new lab results. All other consultations with Dr. Fegley are $150 (50 min).

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LAB TESTS

Lab kits for various testing will be given to you at the time of your first appointment.

If you require blood to be drawn, you will need to return to the office on the following Monday morning at your scheduled blood draw appointment time. This will be scheduled with you at the time of your initial visit. The cost of the blood draw is $25.00.Please arrive fasting unless Dr. Fegley instructs you otherwise.

SUPPLEMENTS

All of the supplements that are recommended at Minds in Motion are available for purchase in our office. You are not obligated to purchase supplements from our office.

Supplements may be purchased in our office. You can also sign up for home **delivery**

on our web site mindsinmotionco.com

CREDIT CARDS

We require a credit card number at the time of scheduling your first appointment. This credit card will be used to hold your appointment and will be kept on file to use for all appointments, labs and supplements unless otherwise specified by you at the time of check out.

CANCELLATION AND RESCHEDULING OF APPOINTMENTS

There is a 72 hours (3 business days) cancellation and rescheduling policy. Your appointment must be cancelled or rescheduled at least 72 hours (3 business days) prior to your consultation time or you will be charged a cancellation fee, unless we are able to fill your appointment time. The cancellation fee for a new patient appointment is half the cost of the appointment; the cancellation fee for all other appointments is the full cost of the appointment. You may cancel your appointment by calling the office 970-846-1598 or emailing at Phaedra.mindsinmotion.com

LATE ARRIVAL APPOINTMENTS

We are committed to being on time with patient's appointments in order to prevent clients from waiting. If you arrive late to the office for your consult your appointment will end at the scheduled time and you will be charged for the length of the originally scheduled visit.

FOLLOW UP APPOINTMENTS

At the time of check out you will be scheduled for a follow up appointment. We will assume you will honor this appointment time unless you notify us otherwise at least 72 hours/ 3-business days prior to your scheduled appointment.

PAYMENT OPTIONS

Cash, checks or credit cards (MasterCard, Visa, Discover, American Express, HSA) are all accepted methods of payment for services. When you schedule the initial visit, we request a credit card on file to hold the appointment for you. No charges will be applied to your credit card unless you miss or cancel an appointment without proper notice. On the day of your scheduled appointment, all charges for consultations, laboratory testing and nutritional supplements will be itemized and payment is due on the day of service.

Follow-up phone, or in person consultations will be billed to your credit card on file unless you provide other payment information and instructions prior to your appointment. If additional lab tests are required and our office sends test kits, the appropriate fees will be charged to you

INSURANCE INFORMATION

Medical insurance is not accepted and our office cannot assist you with claim resolution. In addition, Dr. Fegley is not a Medicare provider. You will be provided with a billing summary that you can submit to your insurance carrier. Dr. Fegley does not submit her medical notes to insurance companies.

DISABILITY FORMS

Dr. Fegley does not fill out medical disability forms for patients. Dr. Fegley does not submit her medical notes to support disability claims.

OFFICE HOURS

Our office hours are Monday – Thursday, 8 am to 5 pm CST.

Dr. Fegley office hours are Monday and Thursday mornings 9-noon

PHONE CALLS AND MESSAGES

- Phone messages left will be responded to within 48 hours (during business hours).

- To reach the office, please call (970-846-1598)
- If you call after hours, the office staff will return your call within the next 2-business days
- If you have a medical emergency, call 911 or go directly to the nearest ER.
- When leaving a message, please be brief and include the following information:

✓Full name, spell your last name, and date of birth

✓Reason for call
✓Phone number(s)
✓E-mail address (if desired)

PRESCRIPTION REFILL REQUESTS

For prescription refills, we ask that you contact your pharmacy and have them fax over the medication refill request. Our fax number is (970) 875-7738. It may take up to 72 business hours to process a prescription refill. Please note that Dr. Fegley is generally not in the office on Fridays to authorize refills. Please plan ahead to avoid any interruptions in your medications.

EMAIL

If you would like to schedule an appointment please do so on our web site mindsinmotionco.com. If you need to cancel an appointment please call 970-846-1598, questions or administrative questions, please email office.mindsinmotion@gmail.com.

If you have a medical question for Dr. Fegley please email her at Phaedra.mindsinmotion@gmail.com. Please note that it can take Dr. Fegley up to 72 hours to respond to emails.

If you need immediate assistance please call the office. If you have a medical emergency please call 911.

Thank You

The Minds in Motion Team

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FREQUENTLY ASKED QUESTIONS

What is your website address?

Information about the practice can be found at mindsinmotionco.com

How may I purchase supplements?

Dr. Fegley has extensively researched supplements and recommends only the highest quality nutritional supplements. Most of the supplements that are recommended at Minds in Motion are available for purchase in our office. You may purchase supplements after each visit or if you need something in the interim you are welcome to come by the office. You can also order supplements from our web site via the supplement tab on the main page (mindsinmotionco.com).

How can a functional medicine consult help my mental health issues?

Dr. Fegley uses an innovative systems approach to assess and treat your health care concerns. The team at Minds in Motion believes that mental wellness is directly influenced by chronic stress, poor nutrition, lack of exercise, social isolation and substance abuse. The fundamental goal of using an integrated approach to mental health is to find the most appropriate treatment, conventional or complementary, that can effectively treat mental health symptoms by addressing underlying causes.

How will lab tests be performed at Minds in Motion?

Some testing can be done through conventional laboratories and others are only available through functional medicine laboratories. During your medical consultation, Dr. Fegley will determine which tests are needed and review with you testing recommendations, instructions (ex. fasting or non- fasting, etc.) and costs. Some testing requires collecting urine, saliva or stool at home. Others may require you make a blood draw appointment at our office to have blood drawn. In all cases, we will assist you in coordinating initial and follow-up testing.

Do you take insurance?

Minds in Motion does not accept insurance or Medicare; we do not file insurance claims on your behalf; nor do we assist with claim resolution. However, we will provide a detailed receipt of services performed and you can submit this to your insurance carrier. For assistance with your reimbursement you may want to contact your insurance provider. We expect payment in full by check, cash or credit card due at the time services are provided.

What credit cards do you accept?

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We accept the following credit cards: MasterCard, Visa and Discover, and American Express. We also accept health savings account cards (HSA). It is important to maintain an active credit card on file with our office for billing of follow-up consultations, laboratory testing, and supplement orders.

Is Dr. Fegley a primary care physician?

Dr. Fegley is trained as a board certified family practice physician as well as certified in functional medicine and can handle many of your primary care needs, however she requests that you maintain a primary care doctor for an annual physical exam, Pap smear, prostate exam, etc. Dr. Fegley also does not provide acute care services. She is happy to work with you closely as a consultant and coach in preventive, nutritional and functional medicine to help you address the roots of chronic health problems. Dr. Fegley is also happy to confer with your primary care doctor if desired.

Email Policy/Disclaimer

Minds in Motion provides patients the opportunity to communicate with them by e-mail. Transmitting confidential health information by e-mail, however, has a number of risks, both general and specific, that should be considered before using e-mail.

1. Risks:

A. General e-mail risks are the following: e-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward e-mail to other recipients without the original sender(s) permission, or knowledge; users can easily misaddress an e-mail; e-mail is easier to falsify than handwritten, or signed documents; backup copies of e-mail may exist even after the sender, or recipient has deleted his/her history.

B. Specific e-mail risks are the following: e-mail containing information pertaining to diagnosis and/or treatment must be included in the protected personal health information; all individuals who have access to the protected personal health information will have access to the e-mail messages; patients who send, or receive e-mail from their place of employment risk having their employer read their e-mail.

2. It is the policy of Minds in Motion that all e-mail messages sent or received, which concern the diagnosis, or treatment, of the patient will be a part of that patient's protected personal health information and we will treat such e-mail messages, or internet communications, with the same degree of confidentiality as afforded other portions of the protected personal health information Minds in Motion will use reasonable means to protect the security and confidentiality of e-mail, or internet communication. Because of the risks outlined above, we cannot, however, guarantee the security and confidentiality of e-mail, or internet communications.
3. Patients must consent to the use of e-mail for confidential medical information after having been informed of the above risks. Consent to the use of e-mail includes agreement with the following conditions:
    1. All e-mail to, or from, patients concerning diagnosis and/or treatment will be made a part of the protected personal health information. As a part of the protected personal health information, other individuals, Dr. Fegley, physicians, nurses, other healthcare practitioners, insurance coordinators, and upon written authorization other healthcare providers and insurers will have access to e-mail messages contained in protected personal health information.
    2. Mind in Motion practitioners may forward e-mail messages within the practice as necessary for diagnosis and treatment. We will not, however, forward the e-mail outside the practice without the consent of the patient as required by law.
    3. We at Minds in Motion will endeavor to read e-mail promptly, but can provide no assurance that the recipient of the particular e-mail will read the e-mail message promptly. Therefore, e-mail must not be used in a medical emergency.
    4. It is the responsibility of the sender to determine whether the intended recipient received the e-mail and when the recipient will respond.
    5. Because some medical information is so sensitive that unauthorized disclosure can be very damaging, e-mail should not be used for communications concerning diagnosis, or treatment of AIDS/HIV infection; other sexually transmissible, or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; Behavioral health, Mental health, or developmental disability; or alcohol and drug abuse.
    6. Minds in Motion cannot guarantee that electronic communications will be private. However, we will take reasonable steps to protect the confidentiality of the e-mail, or internet communication. However, Dr. Fegley is not liable for improper

disclosure of confidential information not caused by its employee's gross negligence, or wanton misconduct.

7. If consent is given for the use of e-mail, it is the responsibility of the patient to inform Minds in Motion staff of any type of information you do not want to be sent by e-mail.
8. It is the responsibility of the patient to protect their password or other means of access to e- mail sent, or received, from Minds in Motion, to protect confidentiality. Minds in Motion is not liable for breaches of confidentiality caused by the patient.

Any further use of e-mail initiated by the patient that discusses diagnosis, or treatment, constitutes informed consent to the foregoing.

I understand that my consent to the use of e-mail may be withdrawn at any time by e-mail, or written communication, to Minds in Motion.

I have read this form carefully and understand the risks and responsibilities associated with the use of e- mail. I agree to assume all risks associated with the use of e-mail.

NAME PRINTED:____

SIGNATURE____

DATE____

COMPREHENSIVE HEALTH HISTORY

Thank you for choosing our office to assist you with your health care. Our ability to draw effective conclusions about your state of health and how to optimize its improvement depends largely on the accuracy of the information in which you provide, including symptoms that you may consider minor. Health issues may be influenced by many factors; therefore, it is important that you carefully consider the questions asked in this form as well as those posed by the doctor during your consultation. This will assist our goal to

provide you with an optimal plan of health care, enhance our efficiency, and will provide effective use of your scheduled time.

Date:____________

First Name:_______________________ Middle:___________________________Last:________________
____

Address ____________________________ City _______________ State ____ Zip Code_

Home Phone (___) ____-______ Work (___) ____-______ Cell (___) ____-______

Email ________________________________

Age ____ Date of Birth ___/___/____ Place of birth______________ Gender: Female__Male__

City or town & country, if not US

Referred by:____

Name, address, & phone number of primary care physician:________________________________
____

Marital Status:

Single___ Married___ Divorced___ Widowed___ Long Term Partnership___

Emergency Contact: ____

Relationship Name Phone
____

Address

Occupation __________________________________ Hours per week _______ Retired _____

Nature of Business____

Genetic Background: Please check appropriate box(es):

- ❑ African American
- ❑ Hispanic
- ❑ Mediterranean
- ❑ Asian
- ❑ Native American
- ❑ Caucasian
- ❑ Northern European
- ❑ Other___________

CURRENT HEALTH STATUS/CONCERNS

Please provide us with current and ongoing problems

Problem	Date of Onset	Severity/Frequency	Treatment Approach	Success
Example:	May 2006	2 times per week	Acupuncture/Aspirin	Mild improvement

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Headaches				

What diagnosis or explanation(s), if any, have been given to you for these concerns?

____

____

____

When was the last time that you felt well?______________________________________

What seems to trigger your symptoms?____

____

What seems to worsen your symptoms?____

____

What seems to make you feel better?____

____

What physician or other health care provider (including alternative or complimentary practitioners) have you seen for these conditions?________________________________

____

____

____

How much time have you lost from work or school in the past year due to these conditions?_

____

PAST MEDICAL AND SURGICAL HISTORY

If you have experienced reoccurrence of an illness, please indicate when or how often under comments.

ILLNESSES	WHEN /ONSET	COMMENTS
Anemia		
Arthritis		
Asthma		
Bronchitis		

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Cancer		
Chicken Pox		
Chronic Fatigue Syndrome		
Crohn's Disease or Ulcerative Colitis		
Diabetes		

ILLNESS	WHEN/ONSET	COMMENTS
Emphysema		
Epilepsy, convulsions, or seizures		
Gallstones		
German Measles		
Gout		
Heart Attack, Angina		
Heart Failure		
Hepatitis		
Herpes Lesions/Shingles		
High blood fats (cholesterol, triglycerides)		
High blood pressure (hypertension)		
Irritable bowel (or chronic diarrhea)		
Kidney stones		
Measles		
Mononucleosis		
Mumps		
Pneumonia		
Rheumatic Fever		
Sinusitis		
Sleep Apnea		
Stroke		
Thyroid disease		

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Whooping Cough		
Other (describe)		
Other (describe)		
INJURIES	**WHEN**	**COMMENTS**
Back injury		
Broken bones or fractures (describe)		
Head injury		
Neck injury		
Other (describe)		
Other (describe)		

DIAGNOSTIC STUDIES	**WHEN**	**COMMENTS**
Blood Tests		
Bone Density Test		
Bone Scan		
Carotid Artery Ultrasound		
CAT Scan (Please indicate type)		
Colonoscopy		
EKG		
Liver Scan		
Mammogram		
Neck X-Ray		
MRI		
X-Ray (Please indicate type)		
Other (describe)		
Other (describe)		
SURGERIES	**WHEN**	**COMMENTS**
Appendectomy		
Dental Surgery		

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Gall Bladder		
Hernia		
Hysterectomy		
Tonsillectomy		
Tubes in Ears		
Other (describe)		
Other (describe)		

HOSPITALIZATIONS

WHERE HOSPITALIZED	WHEN	REASON

MEDICATIONS

How often have you taken antibiotics?	Less than 5 times	More than 5 times	Comments
Infancy/Childhood			
Teen			
Adulthood			

How often have you taken oral steroids? (e.g. Prednisone,	Less than 5	More than 5	Comments

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Cortisone, etc)	times	times	
Infancy/Childhood			
Teen			
Adulthood			

List all medications. Include all over the counter non-prescription drugs.

Medication Name	Date started	Date stopped	Dosage

List all vitamins, minerals, and any nutritional supplements that you are taking now. If possible, indicate whether the dosage.

Type	Date Started	Date Stopped	Dosage

Are you allergic to any medication, vitamin, mineral, or other nutritional supplement?
Yes___ No ___
If yes, please list:____
____

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CHILDHOOD HISTORY

Please answer to the best of your knowledge.

	Yes	No	Don't Know	Comment
Where you a full term baby?				
A premature birth? ('preemie')				
Breast fed?				
Bottle fed?				
When pregnant with you, did your mother:				
Smoke tobacco?				
Use recreational drugs?				
Drink alcohol?				
Use estrogen?				
Other prescription or non-prescription medications?				

FEMALE MEDICAL HISTORY

(For women only)

OBSTETRICS HISTORY

Check box if yes, and provide number of pregnancies and/or occurrences of conditions

- ❑ Pregnancies___________
- ❑ Caesarean ____________
- ❑ Vaginal deliveries________
- ❑ Miscarriage ___________
- ❑ Abortion ______________
- ❑ Living Children__________
- ❑ Post partum depression___
- ❑ Toxemia _____________
- ❑ Gestational diabetes_____

GYNECOLOGICAL HISTORY

Age at first menses?_____ Frequency:________________ Length:____________________

Painful: Yes____ No____ Clotting: Yes___ No___

Date of last menstrual period:___/___/_____

Do you currently use contraception? Yes___ No___ If yes, what please indicate which form:

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Non-hormonal

- ❑ Condom
- ❑ Diaphragm
- ❑ IUD
- ❑ Partner vasectomy
- ❑ Other (non-hormonal-please describe)____

Hormonal

- ❑ Birth control pills
- ❑ Patch
- ❑ Nuva Ring
- ❑ Other (please describe)____

Even if you are *not* currently using conception, but have used hormonal birth control in the past, please indicate which type and for how long.______________________________________ ____________________

Do you experience breast tenderness, water retention, or irritability (PMS) symptoms in the second half of your cycle? Yes ____ No ____

Please advise of any other symptoms that you feel are significant.______________________ ____ ____ ______

Are you menopausal? Yes____ No____ If yes, age of menopause____________________

Do you currently take hormone replacement? Yes___ No___ If yes, what type and for how long?______

❑ Estrogen ❑ Ogen ❑ Estrace ❑ Premarin ❑ Progesterone ❑ Provera ❑ Other ________________________________

DIAGNOSTIC TESTING

Last PAP test:____/____/_____ Normal:__________Abnormal_________

Last Mammogram____/____/____ Breast biopsy? Date:____/____/_____

Date of last bone densitiy____/____/_____ Results: High___ Low___ Within normal range___

MALE MEDICAL HISTORY

(*for males only*)

(Check if applicable)

___Testicular mass ___Testicular pain ___Prostate enlargement

___Prostate infection ___Change in sex drive ___Impotence ___Change in sex drive

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___Premature ejaculation ___Difficulty obtaining an erection ___Vasectomy

___Difficulty maintaining and erection ___Loss of control of urine

___Urinary urgency/hesitancy/change in stream ___Nocturia (urination at night) #times__

___Sexually transmitted diseases (describe)____

Screening/Procedures

Last PSA test ________________________ PSA level: ___0-2 ___2-4 ___5-10 ___>10

Other tests/procedures (list type and date)____

FAMILY HEALTH HISTORY

Please indicate current and past history to the best of your knowledge

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Age (if still living)									
Age at death (if deceased)									
Heart Attack									
Stroke									
Uterine Cancer									
Colon Cancer									
Breast Cancer									
Ovarian Cancer									
Prostate Cancer									
Skin Cancer									
ADD/ADHD									
ALS or other Motor Neuron Diseases									
Alzheimer's									
Anemia									
Anxiety									

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Arthritis									
Asthma									
Autism									
Autoimmune Diseases (such as Lupus)									
Bipolar Disease									
Bladder disease									
Blood clotting problems									
Celiac disease									
Dementia									
Depression									
Diabetes									
Eczema									
Emphysema									
Environmental Sensitivities									
Check Family Members that Apply	**Father**	**Mother**	**Brother(s)**	**Sister(s)**	**Children**	**Maternal Grandmother**	**Maternal Grandfather**	**Paternal Grandmother**	**Paternal Grandfather**
Epilepsy									
Flu									
Genetic Disorders									
Glaucoma									
Headache									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing spondylitis)									
Inflammatory Bowel Disease									
Insomnia									
Irritable Bowel Syndrome									
Kidney disease									
Multiple Sclerosis									
Nervous breakdown									
Obesity									
Osteoporosis									

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Other									
Parkinson's									
Pneumonia/Bronchitis									
Psoriasis									
Psychiatric disorders									
Schizophrenia									
Sleep Apnea									
Smoking addiction									
Stroke									
Substance abuse (such as alcoholism)									
Ulcers									

REVIEW OF SYMPTOMS

Check (√) those items that applied to you in the ***past***. **Circle** those that ***presently*** apply

GENERAL

- ❑ Fever
- ❑ Chills/Cold all over
- ❑ Aches/Pains
- ❑ General Weakness
- ❑ Difficulty sweating
- ❑ Excessive Sweating
- ❑ Swollen Glands
- ❑ Cold hands & Feet
- ❑ Fatigue
- ❑ Difficulty falling asleep
- ❑ Sleepwalker
- ❑ Nightmares
- ❑ No dream recall
- ❑ Early waking
- ❑ Daytime sleepiness
- ❑ Distorted vision

SKIN:

- ❑ Cuts heal slowly
- ❑ Bruise easily
- ❑ Rashes
- ❑ Pigmentation
- ❑ Changing Moles
- ❑ Calluses
- ❑ Eczema
- ❑ Psoriasis
- ❑ Dryness/cracking skin
- ❑ Oiliness
- ❑ Itching
- ❑ Acne
- ❑ Boils
- ❑ Hives
- ❑ Fungus on Nails
- ❑ Peeling Skin
- ❑ Shingles
- ❑ Nails Split
- ❑ White Spots/Lines on Nails
- ❑ Crawling Sensation
- ❑ Burning on Bottom of Feet
- ❑ Athletes Foot
- ❑ Cellulite
- ❑ Bugs love to bite you
- ❑ Bumps on back of arms & front of thighs
- ❑ Skin cancer
- ❑ Strong body odor

Is your skin sensitive to:

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- Sun
- Fabrics
- Detergents
- Lotions/Creams

HEAD:

- Poor Concentration
- Confusion
- Headaches:
  - After Meals
  - Severe
  - Migraine
  - Frontal
  - Afternoon
  - Occipital
  - Afternoon
  - Daytime
  - Relieved by:
    - Eating Sweets
- Concussion/Whiplash
- Mental sluggishness
- Forgetfulness
- Indecisive
- Face twitch
- Poor memory
- Hair loss

EYES:

- Feeling of sand in eyes
- Double vision
- Blurred vision
- Poor night vision
- See bright flashes
- Halo around lights
- Eye pains
- Dark circles under eyes
- Strong light irritates
- Cataracts
- Floaters in eyes
- Visual hallucinations

EARS:

- Aches
- Discharge/Conjunctivitis
- Pains
- Ringing
- Deafness/Hearing loss
- Itching
- Pressure
- Hearing aid
- Frequent infections
- Tubes in ears
- Sensitive to loud noises
- Hearing hallucinations

NOSE/SINUSES

- Stuffy
- Bleeding
- Running/Discharge
- Watery nose
- Congested
- Infection
- Polyps
- Acute smell
- Drainage
- Sneezing spells
- Post nasal drip
- No sense of smell
- Do the change of seasons tend to make your symptoms worse? Yes/No

  If yes, is it worse in the:
  - Spring
  - Summer
  - Fall
  - Winter

MOUTH:

- Coated tongue
- Sore tongue
- Teeth problems
- Bleeding gums
- Canker sores
- TMJ
- Cracked lips/ corners
- Chapped lips
- Fever blisters
- Wear dentures
- Grind teeth when sleeping
- Bad breath
- Dry mouth

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THROAT:

- ❑ Mucus
- ❑ Difficulty swallowing
- ❑ Frequent hoarseness
- ❑ Tonsillitis
- ❑ Enlarged glands
- ❑ Constant clearing of throat
- ❑ Throat closes up

NECK:

- ❑ Stiffness
- ❑ Swelling
- ❑ Lumps
- ❑ Neck glands swell

CIRCULATION/RESPIRATION:

- ❑ Swollen ankles
- ❑ Sensitive to hot
- ❑ Sensitive to cold
- ❑ Extremities cold or clammy
- ❑ Hands/Feet go to sleep/numbness/tingling
- ❑ High blood pressure
- ❑ Chest pain
- ❑ Pain between shoulders
- ❑ Dizziness upon standing
- ❑ Fainting spells
- ❑ High cholesterol
- ❑ High triglycerides
- ❑ Wheezing
- ❑ Irregular heartbeat
- ❑ Palpitations
- ❑ Low exercise tolerance
- ❑ Frequent coughs
- ❑ Breathing heavily
- ❑ Frequently sighing
- ❑ Shortness of breath
- ❑ Night sweats
- ❑ Varicose veins/spider veins
- ❑ Mitral valve prolapse
- ❑ Murmurs
- ❑ Skipped heartbeat
- ❑ Heart enlargement
- ❑ Angina pain
- ❑ Bronchitis/Pneumonia
- ❑ Emphysema
- ❑ Croup
- ❑ Frequent colds
- ❑ Heavy/tight chest
- ❑ Prior heart attack ? When___/___/_____
- ❑ Phlebitis

GASTROINTESTINAL

- ❑ Peptic/Duodenal Ulcer
- ❑ Poor appetite
- ❑ Excessive appetite
- ❑ Gallstones
- ❑ Gallbladder pain
- ❑ Nervous stomach
- ❑ Full feeling after small meal
- ❑ Indigestion
- ❑ Heartburn
- ❑ Acid Reflux
- ❑ Hiatal Hernia
- ❑ Nausea
- ❑ Vomiting
- ❑ Vomiting blood
- ❑ Abdominal Pains/Cramps
- ❑ Gas
- ❑ Diarrhea
- ❑ Constipation
- ❑ Changes in bowels

- ❑ Rectal bleeding
- ❑ Tarry stools
- ❑ Rectal itching
- ❑ Use laxatives
- ❑ Bloating
- ❑ Belch frequently
- ❑ Anal itching
- ❑ Anal fissures
- ❑ Bloody stools
- ❑ Undigested food in stools

KIDNEY/URINARY TRACT:

- ❑ Burning
- ❑ Frequent urination
- ❑ Blood in urine
- ❑ Night time urination
- ❑ Problem passing urine
- ❑ Kidney pain
- ❑ Kidney stones
- ❑ Painful urination
- ❑ Bladder infections
- ❑ Kidney infections
- ❑ Syphilis
- ❑ Bedwetting
- ❑ Have trichomonas

WOMEN'S HISTORY (for women only)

- ❑ Fibrocystic breasts
- ❑ Lumps in breast
- ❑ Fibroid Tumors/Breast
- ❑ Spotting
- ❑ Heavy periods
- ❑ Fibroid Tumors/Uterus

WOMEN'S HISTORY (for women only)

- ❑ Painful periods
- ❑ Change in period
- ❑ Breast soreness before period
- ❑ Endometriosis
- ❑ Non-period bleeding
- ❑ Breast soreness during period
- ❑ Vaginal dryness
- ❑ Vaginal discharge
- ❑ Partial/total hysterectomy
- ❑ Hot flashes
- ❑ Mood swings
- ❑ Concentration/Memory Problems
- ❑ Breast cancer
- ❑ Ovarian cysts
- ❑ Pregnant
- ❑ Infertility
- ❑ Decreased libido
- ❑ Heavy bleeding
- ❑ Joint pains
- ❑ Headaches
- ❑ Weight gain
- ❑ Loss of bladder control
- ❑ Palpitations

MEN'S HISTORY (for men only)

Have you had a PSA done?

Yes _____ No _____

PSA Level:

- ❑ 0 – 2
- ❑ 2 – 4
- ❑ 4 – 10
- ❑ >10

- ❑ Prostate enlargement
- ❑ Prostate infection
- ❑ Change in libido
- ❑ Impotence
- ❑ Diminished/poor libido
- ❑ Infertility
- ❑ Lumps in testicles
- ❑ Sore on penis
- ❑ Genital pain
- ❑ Hernia
- ❑ Prostate cancer
- ❑ Low sperm count
- ❑ Difficulty obtaining erection
- ❑ Difficulty maintaining an erection
- ❑ Nocturia (urination at night)
  - ❑ How many times at night? ____
- ❑ Urgency/Hesitancy/Change in Urinary Stream
- ❑ Loss of bladder control

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JOINT/MUSCLES/TENDONS

- ❑ Pain wakes you
- ❑ Weakness in legs and arms
- ❑ Balance problems
- ❑ Muscle cramping
- ❑ Head injury
- ❑ Muscle stiffness in morning
- ❑ Damp weather bothers you

EMOTIONAL:

- ❑ Convulsions
- ❑ Dizziness
- ❑ Fainting Spells
- ❑ Blackouts/Amnesia
- ❑ Had prior shock therapy
- ❑ Frequently keyed up and jittery
- ❑ Startled by sudden noises
- ❑ Anxiety/Feeling of panic
- ❑ Go to pieces easily
- ❑ Forgetful
- ❑ Listless/groggy
- ❑ Withdrawn feeling/Feeling 'lost'
- ❑ Had nervous breakdown
- ❑ Unable to concentrate/short attention span
- ❑ Vision changes
- ❑ Unable to reason
- ❑ Considered a nervous person by others
- ❑ Tends to worry needlessly
- ❑ Unusual tension

EMOTIONAL (CONTINUED)

- ❑ Frustration
- ❑ Emotional numbness
- ❑ Often break out in cold sweats
- ❑ Profuse sweating
- ❑ Depressed
- ❑ Previously admitted for psychiatric care
- ❑ Often awakened by frightening dreams
- ❑ Family member had nervous breakdown
- ❑ Use tranquilizers
- ❑ Misunderstood by others
- ❑ Irritable/
- ❑ Feeling of hostility/volatile or aggressive
- ❑ Fatigue
- ❑ Hyperactive
- ❑ Restless leg syndrome
- ❑ Considered clumsy
- ❑ Unable to coordinate muscles
- ❑ Have difficulty falling asleep
- ❑ Have difficulty staying asleep
- ❑ Daytime sleepiness
- ❑ Am a workaholic
- ❑ Have had hallucinations
- ❑ Have considered suicide
- ❑ Have overused alcohol
- ❑ Family history of overused alcohol
- ❑ Cry often
- ❑ Feel insecure
- ❑ Have overused drugs
- ❑ Been addicted to drugs
- ❑ Extremely shy

DENTAL HISTORY

	Yes	No
Problem with sore gums (gingivitis)?	______	______
Ringing in the ears (tinnitus)?	______	______
Have TMJ (temporal mandibular joint) problems?	______	______
Metallic taste in mouth?	______	______

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Problems with bad breath (halitosis) or white tongue (thrush)?	______	______
Previously or currently wear braces?	______	______
Problems chewing?	______	______
Floss regularly?	______	______
Do you have amalgam dental fillings? How many?	______	______
Did you receive these fillings as a child?	______	______

List your approximate age and the type of dental work done from childhood until present:

Age	Type of dental work:	Health Problems following dental work? (describe)

NUTRITIONAL HISTORY

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

FOOD DIARY

Place a check mark next to the food/drink that applies to your current diet. (List continues on next page.)

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

How much of the following do you consume each week?

Candy	
Cheese	
Chocolate	

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Cups of coffee containing caffeine	
Cups of decaffeinated coffee or tea	
Cups of hot chocolate	
Cups of tea containing caffeine	
Diet soda	
Ice cream	
Salty foods	
Slices of white bread (rolls/bagels, etc)	
Soda with caffeine	
Soda without caffeine	

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

- ❑ Ovo-lacto
- ❑ Diabetic
- ❑ Dairy restricted
- ❑ Other (describe)____
- ❑ Vegetarian
- ❑ Vegan
- ❑ Blood type diet

Please tell us if there is anything special about your diet that we should know.______________

____

____

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

Yes___ No____

If yes, are these symptoms associated with any particular food or supplement?

Yes___ No____

If yes, please name the food or supplement and symptom(s). _________________________________

____

____

Do you feel that you have *delayed* symptoms after eating certain foods, such as fatigue, muscle aches, sinus congestion, etc? (symptoms may not be evident for 24 hours or more)

Yes___ No____

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

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

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

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

pasta, potatoes) ❑ Other_________________________

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

Has there ever been a food that you have craved or ‘binged’ on over a period of time?

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

____

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

If yes, what food(s) ____

____

Please complete the following chart as it relates to your bowel movements:

Frequency	√
More than 3x/day	
1-3x/ day	
4-6x/week	
2-3x/week	
1 or fewer x/week	

Consistency	√
Soft and well formed	
Often floats	
Difficult to pass	
Diarrhea	
Thin, long or narrow	
Small and hard	
Loose but not watery	
Alternating between hard and loose/watery	

Color	√
Medium brown consistently	
Very dark or black	
Greenish color	
Blood is visible	
Varies a lot	
Dark brown consistently	
Yellow, light brown	
Greasy, shiny appearance	

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Intestinal gas:

- ❑ Daily
- ❑ Occasionally
- ❑ Excessive
- ❑ Present with pain
- ❑ Foul smelling
- ❑ Little odor

LIFESTYLE HISTORY

TOBACCO HISTORY

Have you ever used tobacco? Yes ____ No _____

If yes, what type? Cigarette ___ Smokeless ___ Cigar ___ Pipe ___ Patch/Gum ___

How much?_______________________________

Number of years?__________If not a current user, year quit___________________

Attempts to quit: ________

Are you exposed to 2nd hand smoke regularly? If yes, please explain:_________________________

____

ALCOHOL INTAKE

Have you ever used alcohol? Yes____ No____

If yes, how often do you now drink alcohol?

- ❑ No longer drink alcohol
- ❑ Average 1-3 drinks per week
- ❑ Average 4-6 drinks per week
- ❑ Average 7-10 drinks per week
- ❑ Average >10 drinks per week

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

Have you ever had a problem with alcohol? Yes____ No____

If yes, indicate time period (month/year) From________ to ________

OTHER SUBSTANCES

Do you currently or have you previously used recreational drugs? Yes____ No____

If yes, what type(s) and method? (IV, inhaled, smoked, etc)_______________________________

____

To your knowledge, have you ever been exposed to toxic metals in your job or at home? Yes___No___

If yes, indicate which

- ❑ Lead
- ❑ Arsenic
- ❑ Aluminum
- ❑ Cadmium
- ❑ Mercury

SLEEP & REST HISTORY

Average number of hours that you sleep at night? Less than 10__ 8-10___ 6-8___ less than 6___

Do you:

- ❑ Have trouble falling asleep?
- ❑ Feel rested upon wakening?
- ❑ Have problems with insomnia?
- ❑ Snore?
- ❑ Use sleeping aids

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EXERCISE HISTORY

Do you exercise regularly? Yes____ No____

If yes, please indicate:

Type of exercise	Times/week				Length of session			
	1x	2x	3x	4x/+	≤15	16-30 min	31-45 min	>45
Jogging/Walking								
Aerobics								
Strength Training								
Pilates/Yoga/Tai Chi								
Sports (tennis, golf, water sports, etc)								
Other (please indicate)								

If no, please indicate what problems limit your activity (e.g., lack of motivation, fatigue after exercising, etc)

____

____

SOCIAL HISTORY

Because stress has a direct effect on your overall health and wellbeing that often leads to illness, immune system dysfunction, and emotional disorders, it is important that your health care provider is aware of any stressful influences that may be impacting your health. Informing your doctor allows him/her to offer you supportive treatment options and optimize the outcome of your health care.

STRESS/PSYCHOSOCIAL HISTORY

Are you overall happy? Yes____ No____

Do you feel you can easily handle the stress in your life? Yes ____ No _____

If no, do you believe that stress is presently reducing the quality of your life? Yes____ No____

If yes, do you believe that you know the source of your stress? Yes____ No____

If yes, what do you believe it to be?____

Have you ever contemplated suicide? Yes____ No____

If yes, how often? ____ When was the last time?__

Have you ever sought help through counseling? Yes____ No____

If yes, what type? (e.g., pastor, psychologist, etc)________________________________

Did it help?__________

How well have things been going for you?

	Very well	**Fine**	**Poorly**	**Very poorly**	**Does not apply**
At school					
In your job					
In your social life					
With close friends					
With sex					
With your attitude					
With your boyfriend/girlfriend					
With your children					
With your parents					
With your spouse					

Which of the following provide you emotional support? *Check all that apply*

- ❑ Spouse
- ❑ Family
- ❑ Friends
- ❑ Religious/Spiritual
- ❑ Pets
- ❑ Other ___________

Have you ever been involved in abusive relationships in your life?
Yes ___ No___

Have you ever been abused, a victim of a crime, or experienced a significant trauma?
Yes ___ No___

Did you feel safe growing up? Yes ___
No___

Was alcoholism or substance abuse present in your childhood home?
Yes ___ No___

Is alcoholism or substance abuse present in your relationships now?
Yes ___ No__

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

a. _____ not at all important   b. _____ somewhat important   c. _____ extremely important

Do you practice meditation or relaxation techniques?
Yes ___ No ___

If yes, how often? _____________

Check all that apply:

❑ Yoga ❑ Meditation ❑ Imagery ❑ Breathing ❑ Tai Chi ❑ Prayer ❑ Other

Hobbies and leisure activities:
____
____

Is there anything that you would like to discuss with the doctor today that you feel you cannot indicate here? Yes_____ No_____

READINESS ASSESSMENT

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

In order to improve your health, how willing are you to:

Significantly modify your diet 5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Take nutritional supplements each day 5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Keep a record of everything you eat each day 5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Modify your lifestyle (e.g. work demands, sleep habits) 5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Practice relaxation techniques 5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Engage in regular exercise 5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Have periodic lab tests to assess progress 5 _____ 4 _____ 3 _____ 2 _____ 1 _____

Comments ____
____
____

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

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

If you are not confident in your ability, what aspects of yourself or your life lead you to question your capacity to follow through?____
____

Rate on a scale of 5 (very supportive) to 1 (very unsupportive)

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? 5___ 4____ 3____ 2____ 1____

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

How much ongoing support (e.g. telephone, consults, email, correspondence) from our professional staff would be helpful to you as you implement your personal health program? 5___ 4 ___ 3 ____ 2 ____ 1 ____

Comments____
____

HEALTH GOALS

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

When was the last time you felt well?____
____
____

Did something trigger your change in health?____
____
____

What makes you feel better?____
____
____

What makes you feel
worse?____
____
____

How does your condition affect
you?____
____
____

What do you think is happening and
why?____
____
____

What do you think needs to happen for you to get
better?____
____
____

Thank you for taking the time to complete this health history medical questionnaire. The information derived from all of these forms will provide invaluable data in identifying the underlying problems of your health concerns rather than simply treating the symptoms alone.

We look forward to helping you achieve lifelong health and well-being.

Sincerely,

Dr. Phaedra Fegley and the Minds in Motion Team

Medical Symptoms Questionnaire (MSQ)

Patient Name______________________________ Date______________

Rate each of the following symptoms based upon your typical health profile for the past 14 days.

Point Scale
- 0 – ***Never or almost never*** have the symptom
- 1 – ***Occasionally*** have it, effect is ***not severe***
- 2 – ***Occasionally*** have it, effect is ***severe***
- 3 – ***Frequently*** have it, effect is ***not severe***
- 4 – ***Frequently*** have it, effect is ***severe***

HEAD

_______ Headaches
_______ Faintness
_______ Dizziness
_______ Insomnia

Total _______

EYES

_______ Watery or itchy eyes
_______ Swollen, reddened or sticky eyelids
_______ Bags or dark circles under eyes
_______ Blurred or tunnel vision
(Does not include near or far-sightedness)

Total _______

EARS

_______ Itchy ears
_______ Earaches, ear infections
_______ Drainage from ear
_______ Ringing in ears, hearing loss

Total _______

NOSE

_______ Stuffy nose
_______ Sinus problems
_______ Hay fever
_______ Sneezing attacks
_______ Excessive mucus formation

Total _______

MOUTH/THROAT

_______ Chronic coughing
_______ Gagging, frequent need to clear throat
_______ Sore throat, hoarseness, loss of voice
_______ Swollen or discolored tongue, gums, lips
_______ Canker sores

Total _______

SKIN

_______ Acne
_______ Hives, rashes, dry skin
_______ Hair loss
_______ Flushing, hot flashes
_______ Excessive sweating

Total _______

HEART

_______ Irregular or skipped heartbeat
_______ Rapid or pounding heartbeat
_______ Chest pain

Total _______

MEDICAL SYMPTOMS QUESTIONNAIRE (MSQ)

LUNGS

__________ Chest congestion
__________ Asthma, bronchitis
__________ Shortness of breath
__________ Difficulty breathing

Total __________

DIGESTIVE TRACT

__________ Nausea, vomiting
__________ Diarrhea
__________ Constipation
__________ Bloated feeling
__________ Belching, passing gas
__________ Heartburn
__________ Intestinal/stomach pain

Total __________

JOINTS/MUSCLE

__________ Pain or aches in joints
__________ Arthritis
__________ Stiffness or limitation of movement
__________ Pain or aches in muscles
__________ Feeling of weakness or tiredness

Total __________

WEIGHT

__________ Binge eating/drinking
__________ Craving certain foods
__________ Excessive weight
__________ Compulsive eating
__________ Water retention
__________ Underweight

Total __________

ENERGY/ACTIVITY

__________ Fatigue, sluggishness
__________ Apathy, lethargy
__________ Hyperactivity
__________ Restlessness

Total __________

MIND

__________ Poor memory
__________ Confusion, poor comprehension
__________ Poor concentration
__________ Poor physical coordination
__________ Difficulty in making decisions
__________ Stuttering or stammering
__________ Slurred speech
__________ Learning disabilities

Total __________

EMOTIONS

__________ Mood swings
__________ Anxiety, fear, nervousness
__________ Anger, irritability, aggressiveness
__________ Depression

Total __________

OTHER

__________ Frequent illness
__________ Frequent or urgent urination
__________ Genital itch or discharge

Total __________

Grand Total __________

Thyroid Screening Questionnaire

Patient Name_______________________________ Date_______________

Put a check by the following statements that apply to your family history, your personal history, and the symptoms that you may have.

HISTORY

- ☐ My family (parent, sibling, child) has a history of thyroid disease
- ☐ I've had a thyroid problem (i.e., hyperthyroidism, Graves' disease, Hashimoto's thyroiditis, post-partum thyroiditis, goiter, nodules, thyroid cancer) in the past
- ☐ A member of my family or I have currently or in the past been diagnosed with an autoimmune disease
- ☐ I have had radiation treatment to my head, neck, chest, tonsil area, etc.
- ☐ I grew up, live, or work near or at a nuclear plant
- ☐ Women: I have a history of infertility or miscarriage

SIGNS AND SYMPTOMS

- ☐ I am gaining weight for no clear reason or am unable to lose weight with a diet and exercise program
- ☐ My "normal" body temperature is low (below 98.2° when I take it)
- ☐ My hands and feet are cold to the touch and I frequently feel cold when others do not
- ☐ I feel fatigued or exhausted more than normal
- ☐ I have a slow pulse, and/or low blood pressure
- ☐ I have been told I have high cholesterol
- ☐ My hair is rough, coarse dry, breaking, brittle, or falling out
- ☐ My skin is rough, coarse, dry, scaly, itchy, and thick
- ☐ My nails have been dry and brittle, and break more easily
- ☐ My eyebrows appear to be thinning, particularly the outer portion
- ☐ My voice has become hoarse and/or 'gravelly'
- ☐ I have pains, aches, stiffness, or tingling in joints, muscles, hands and/or feet
- ☐ I have carpal tunnel syndrome, tendonitis, or plantar fasciitis
- ☐ I am constipated (less than 1 bowel movement daily)
- ☐ I feel depressed, restless, moody, sad
- ☐ I have difficulty concentrating or remembering things
- ☐ I have a low sex drive
- ☐ My eyes feel gritty, dry, light-sensitive
- ☐ My neck or throat feels full, with pressure, or larger than usual, and/or I have difficulty swallowing
- ☐ I have puffiness and swelling around the eyes, eyelids, face, feet, hands and feet
- ☐ Women: I am having irregular menstrual cycles (longer, or heavier, or more frequent)

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Toxin Exposure Questionnaire

Patient Name________________________________ Date______________

Please check the best response for each of the following questions. Your provider will discuss your answers with you.

FOOD & WATER	YES	SOMETIMES	IN THE PAST	NO
1. Do you consume conventionally-farmed (non-organic) or genetically-modified fruits and vegetables?	☐	☐	☐	☐
2. Do you consume conventionally-raised (non-organic) animal products (i.e., meat, poultry, dairy, eggs)	☐	☐	☐	☐
3. Do you consume canned or farmed fish and seafood?	☐	☐	☐	☐
4. Do you consume processed foods (i.e., foods with added artificial colors, flavors, preservatives, or sweeteners), deep-fried, or fast foods?	☐	☐	☐	☐
5. Do you drink water from a well, spring, or cistern, or from plumbing pipes or fixtures installed before 1986?	☐	☐	☐	☐
6. Do you drink sodas, juices, or other beverages with natural or refined sweeteners (i.e., high-fructose corn syrup, cane sugar, agave nectar, Stevia, undiluted fruit juice, etc.) or artificial sweeteners (i.e., NutraSweet/Equal/aspartame, Sweet'N Low/saccharine, Splenda/sucralose, Sunett/Sweet One/acesulfame K, neotame)?	☐	☐	☐	☐

HOME & WORK ENVIRONMENT	YES	SOMETIMES	IN THE PAST	NO
1. Do you live in an apartment or home built before 1978, or in a mobile home, boat, or RV?	☐	☐	☐	☐
2. Does your home or workplace contain new construction materials or furniture (i.e., paint, laminate flooring, particle board, new carpeting, bedding, furniture, etc.)?	☐	☐	☐	☐
3. Does your home or workplace show signs of mold or water damage (i.e., cracking paint, ceiling leaks, decaying insulation or foam, visible mold, or damp windows, basement, or crawlspaces, etc.)?	☐	☐	☐	☐
4. Are you exposed to toxic substances (i.e., treated lumber, lead paint, paint chips or dust, broken mercury thermometers or fluorescent bulbs, etc.) at home or work?	☐	☐	☐	☐
5. Are you exposed to conventional cleaning chemicals, disinfectants, hand sanitizers, air fresheners, scented candles, or other scented products at home or work?	☐	☐	☐	☐
6. Do you live or work near an industrial pollution source (i.e., highway, factory, incinerator, gas station, power plant, etc.)?	☐	☐	☐	☐
7. Do you live or work near a source of electromagnetic radiation (i.e., cell phone tower, high-voltage power lines, or other known source)?	☐	☐	☐	☐
8. Do you live or work in an agricultural area or another type of area where you are exposed to herbicides, pesticides, or fungicides?	☐	☐	☐	☐
9. Do you have wood-burning, propane, or gas stoves or appliances at home or work?	☐	☐	☐	☐
10. Do you live or work in a sealed building with recirculated air?	☐	☐	☐	☐

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TRAVEL & RECREATION	YES	SOMETIMES	IN THE PAST	NO
1. Do you frequent parks, golf courses, or other outdoor or recreational areas treated with herbicides, pesticides, or fungicides?	☐	☐	☐	☐
2. Do you travel by air?	☐	☐	☐	☐
3. Do you run or bike to work along busy streets?	☐	☐	☐	☐
4. Do you get sick while camping, hiking, or traveling (foreign or domestic)?	☐	☐	☐	☐
5. Are you exposed to toxic chemicals as a result of a hobby (i.e., paints, photo-developing chemicals, epoxy adhesives, glues, varnishes, etc.)?	☐	☐	☐	☐

MEDICAL & PERSONAL CARE	YES	SOMETIMES	IN THE PAST	NO
1. Are you sensitive to personal care products like lotions, moisturizers, toners, shampoos, conditioners, shaving creams, and soaps?	☐	☐	☐	☐
2. Are you sensitive to smoke, perfumes, fragrances, cleaning products, gasoline, or other fumes?	☐	☐	☐	☐
3. Do you smoke, or are you often exposed to second-hand smoke?	☐	☐	☐	☐
4. Do you have a history of heavy use of alcohol, or recreational or prescription drugs?	☐	☐	☐	☐
5. Do you have any unusual reactions to anesthesia or to prescription or over-the-counter medications?	☐	☐	☐	☐
6. Do you have root canals, extracted teeth, "silver" fillings, crowns, dental sealants, dentures, retainers, aligning trays, braces, mouth guards, dental implants, etc.?	☐	☐	☐	☐
7. Do you have food reactions, sensitivities, or intolerances? Do you have environmental allergies?	☐	☐	☐	☐
8. Do you have any artificial materials in your body (implants, pins, joints, etc.)?	☐	☐	☐	☐
9. Do you lead a high-stress lifestyle, or have you experienced a stressful or traumatic event?	☐	☐	☐	☐

Note: For more information on the questions included here, please see the **Toxin Exposure Questionnaire—Bibliography** in IFM's Clinical Practice Toolkit.

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