

# WISH

World Integrated Systems in Health

Dr. Sandra J. Bevacqua

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## **Blood Work Request**

Prior to your consultation, have your primary care provider fax your recent blood work results to our office: Fax: (520) 743-4252.

### **Getting Blood Work**

For all clients over 12 years old, please request the following blood work from your primary care physician if you have not had blood taken during the past year:

- CBC
- Lipid Profile (including VLDL)
- Comprehensive Metabolic Panel
- Magnesium
- Thyroid Panel with TSH, free T3, and free T4. (Those having trouble with thyroid may want to request a complete thyroid panel which would include these additional tests: Total T3, Total T4, rT3, Anti-TG, and Anti-TPO)
- Hemoglobin A1C
- Homocysteine
- hs-CRP
- 25-OH Vitamin D
- DHEA
- Urinalysis

⇒ Make sure you **fast** (at least 12hrs) before giving blood for the above tests, but remember to drink plenty of water to stay hydrated during the fast.

### **Women**

If you are still menstruating, please get your blood drawn on day 18-22 of your cycle.

- Estradiol (for menstruating women)
- Total Estrogen (for non-menstruating women)
- Progesterone
- Total Testosterone
- Free Testosterone
- Prolactin, FSH, LH (for women having difficulty conceiving)
- CA 15-3
- CA 125
- CEA

### **Men**

- PSA
- Total Testosterone
- Free Testosterone
- CEA
- CA 15-3

### **For Individuals Under Stress**

- Cortisol

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## Informed Consent

For Nutritional Consultation & Blood Chemistry Analysis

### Advanced Nutritional Programs

I acknowledge that Sandra J. Bevacqua, Ph.D. and staff members of World Integrated Systems in Health (WISH) are not medical doctors. I request that Dr. Sandra Bevacqua perform an evaluation or interview and work with me to set up a program for the purpose of enhancing my health and/or education in an area of requested interest. I understand that Dr. Sandra Bevacqua has a Ph.D. in Molecular and Cellular Biology from the University of Arizona. I understand that Dr. Sandy and staff members provide blood chemistry analysis, nutritional and other health related information to help me attain and maintain my best health. Dr. Bevacqua will help determine which nutrients my body needs bolstered. All recommendations are designed to help me move towards my best state of health through personalized recommendations in lifestyle, exercise, health habits and advanced nutrition. I understand that Dr. Bevacqua and staff members of World Integrated Systems in Health (WISH) do NOT diagnose, treat or claim to cure any illness or disease.

### Time Allotment

**It is your responsibility to observe the length of time your consultation is taking.** Although Dr. Bevacqua is glad to answer your questions as your consultation proceeds, it naturally extends the length of time of your consultation takes. You are responsible for any additional fees you may incur should your consultation extend beyond the time allotted for your consultation. If you do not wish to go beyond the time allotted for your consultation please make sure Dr. Bevacqua is aware of this at the beginning of your consult.

### Emergencies

If you feel you have a medical emergency, please call 911 or consult with your medical care professional. If you would like to talk with Dr. Bevacqua regarding your health program, please call our office to schedule a 15 minute (or longer) emergency consultation. Dr. Bevacqua will call you back as soon as she is able. Fees for urgent consultations by phone or email are calculated at \$125 per 15 minutes.

### Recording Consultations

I hereby agree that if I wish to record my consultation with Dr. Bevacqua or any other practitioner at WISH, that I will notify them at the beginning of the consultation of my desire to record the conversation. **I will not record the conversation without verbal consent from the practitioner.** Consent must be obtained prior to recording any consultation including initial consultations and follow up appointments.

I certify that I am not a minor (under the age of 18) and I have read this informed consent and understand it. For consultations regarding minors, a parent or legal guardian must be present during the consultation and sign the document on behalf of the minor.

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Signature (Client or Legal Guardian)

Date

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Printed Name

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4627 N. 1<sup>st</sup> Ave., Suite 2 • Tucson, Arizona 85718  
(520) 743-0575 • Fax (520) 743-4252

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## **-Notice of Privacy Practices-**

WISH is not a HIPAA office. This means WISH is not ruled by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996. Although this is true, our commitment at WISH is to serve you, our client, with professionalism and confidentiality. In conducting our business, records are created regarding you and the services we provided you. We are dedicated to maintaining the privacy of this information.

This notice describes how your records may be used and/or disclosed and how you can get access to this information. Please review the following carefully. During the course of serving your interest, it may be necessary to share information with other providers or business associates. The following are examples of instances where information may be shared:

- In order to best serve you, we may need to use your record in the process of gathering additional information from previous or current healthcare providers and/or obtaining a second opinion from one or more of the specialists with which we partner.
- For payment purposes, we use your record to create invoices as is appropriate.
- We may release information to you and to others (health care providers, family, etc.) per your written request.

At WISH we are committed to your best interest. If any other uses or disclosures than the ones listed above are needed, you will be notified and the information will only be released with your written authorization or that of a legal guardian/parent. This written authorization may be revoked at any time in writing.

Should WISH be contacted by an Insurance Provider, we will not release any information to them, including whether or not you have been a client with WISH. We will instead contact you to let you know of the Insurance Company's inquiry.

If you have any questions or comments regarding your records or our policies, feel free to contact our office.

I have read and understand the above Notice of Privacy Practices:

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_




# WISH

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## Client Information

Name:	
Street Address:	
City, State, Zip:	
Phone (home):	
Phone (cell):	
Email:	

## Payment Information

Credit card # _____ - _____ - _____ - _____ Exp. ____/____ Security Code:* _____ Please Circle One: 	*Security Code Location: American Express      Visa, MasterCard, Discover  4 Digit Verification Number  3 Digit Verification Number
Signature:	Date:
If paying by check or money order please submit payment along with the wellness packet at least one week prior to your consultation. Checks payable to WISH.	
Check #:	

## Referrals

How did you learn of this office? Referred by?
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### Referral Policy -

If you refer someone to this office have them mention your name. If they book and pay for a full initial consultation (1 ½ hour consult), you will receive a \$50 credit that you may use towards your own consultation expenses or you may gift it to someone else.



# WISH

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**Daily Food Log for:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Breakfast:** Time you ate \_\_\_\_\_ Everything you consumed:

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**A.M. Snack:** Time you ate \_\_\_\_\_ Everything you consumed:

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**Lunch:** Time you ate \_\_\_\_\_ Everything you consumed:

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**Afternoon Snack:** Time you ate \_\_\_\_\_ Everything you consumed:

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**Dinner:** Time you ate \_\_\_\_\_ Everything you consumed:

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**P.M. Snack:** Time you ate \_\_\_\_\_ Everything you consumed:

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**Daily Food Log for:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Breakfast:** Time you ate \_\_\_\_\_ Everything you consumed:

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**A.M. Snack:** Time you ate \_\_\_\_\_ Everything you consumed:

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**Lunch:** Time you ate \_\_\_\_\_ Everything you consumed:

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**Afternoon Snack:** Time you ate \_\_\_\_\_ Everything you consumed:

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**Dinner:** Time you ate \_\_\_\_\_ Everything you consumed:

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**P.M. Snack:** Time you ate \_\_\_\_\_ Everything you consumed:

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# WISH

## World Integrated Systems in Health

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**Name:** \_\_\_\_\_ **Spouse's Name:** \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Occupation: \_\_\_\_\_

Do you or anyone in your household or are you around anyone who smokes tobacco? Who? \_\_\_\_\_

Do you consume alcohol? How much? How often? \_\_\_\_\_

Blood Pressure: \_\_\_\_\_/\_\_\_\_\_ Pulse rate: \_\_\_\_\_ (Visit your local pharmacy, most have BP machines available)

**Please include a recent photograph if available.** Additional photos of nails, and tongue are helpful if you'd like to include them. Also, one of our practitioners is enrolled in a course in Iridology (the study of the iris), if you'd like to submit an in focus close up of your eyes for educational purposes, please feel free to do so.

**Please list your major health concerns:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do your gums bleed? Yes/No Frequency: \_\_\_\_\_

Do you floss? Yes/No Frequency: \_\_\_\_\_

Any additional comments about oral health? \_\_\_\_\_

**How much water do you drink each day:** \_\_\_\_\_ Please circle one:  
Tap water  
Filtered water

**Please answer the following:** (check all that apply)

**Number of bowel movements/day?**

- None
- One
- Two
- Three
- \_\_\_\_\_

**Density of Bowel Movements?**

- Breaks up when hits the water
- Fluffy floaters
- Formed sinkers
- Greasy
- Occasional mucous
- Occasional blood

**Pain Level?**

- Extreme
- Severe
- Moderate
- Low
- No Pain

**Form of bowel movements?**

- Liquid only
- Diarrhea - no form
- Formed - soft & thin
- Formed - soft & wide
- Formed - hard
- Small hard balls

**Color of bowel movements?**

- Yellow
- Yellow/Green
- Light Brown
- Medium Brown
- Dark Brown
- Reddish
- Black
- Greenish-brown
- Other \_\_\_\_\_

**Do you experience any of these symptoms?**

- White coating on tongue
- Itchy ears
- Ringing in the ears
- Acne or pimples
- Bloating
- Gas
- Persistent cough
- Sore throat
- Athlete's Foot
- Cravings for sweets
- Vertical ridges on fingernails
- Inability to tolerate certain raw vegetables
- Vaginal discharge w/odor
- Jock Itch

Have you used antibiotics in the last year? \_\_\_\_\_

Have you used antibiotics within the last three years? \_\_\_\_\_

4627 N. 1<sup>st</sup> Avenue, Suite #2 \* Tucson, Arizona 85718

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# WISH

## World Integrated Systems in Health

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Do you have any allergies? Do you have any food sensitivities or allergies?

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What do you do for exercise each day? What type of movement do you engage in?

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What are your sleep patterns? \_\_\_\_\_  
Do you sleep through the night? \_\_\_\_\_  
How many hours do you sleep at night? \_\_\_\_\_  
Do you nap during the day? \_\_\_\_\_  
Do you find it difficult to fall asleep? \_\_\_\_\_  
Do you find it easy to fall asleep but wake up during the night? \_\_\_\_\_  
Do you know the reason for waking? \_\_\_\_\_ Are you able to fall back asleep easily? \_\_\_\_\_  
Do you feel well rested in the morning? \_\_\_\_\_  
Do you feel fatigued during the day? \_\_\_\_\_  
Other comments? \_\_\_\_\_

What are your intentions or expectations for this consultation? What is your most pressing health concern that you would like assistance with?

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Any thing else you feel Dr. Bevacqua should know about your current situation?

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What are your long-term health care goals?

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### **Family Health History:**

Please list any major health conditions, diseases or illnesses family members have had. (Parents, grandparents, etc)

<b>Family Member:</b>	<b>Condition:</b>

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## *Symptom Check Lists*

**Instructions:** Please indicate any of these symptoms that you may experience on a regular basis. There may be some repetition in various sections, please mark all that apply even if previously marked in another section.

### **Section 1:**

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Inability to focus    | <input type="checkbox"/> Low blood sugar       | <input type="checkbox"/> Intestinal bloating                            | <input type="checkbox"/> High blood pressure                  |
| <input type="checkbox"/> Poor memory           | <input type="checkbox"/> Carbohydrate cravings | <input type="checkbox"/> Weight gain                                    | <input type="checkbox"/> High Triglycerides                   |
| <input type="checkbox"/> Loss of creativity    | <input type="checkbox"/> Feelings of agitation | <input type="checkbox"/> Increased fat storage                          | <input type="checkbox"/> Depression                           |
| <input type="checkbox"/> Fuzzy thinking        | <input type="checkbox"/> Feeling jittery       | <input type="checkbox"/> Extra weight carried in the abdominal area     | <input type="checkbox"/> Extra weight carried in the buttocks |
| <input type="checkbox"/> Learning disabilities | <input type="checkbox"/> Feeling moody         | <input type="checkbox"/> Gas, especially following consumption of carbs | <input type="checkbox"/> Sleepiness following meals           |

### **Section 2:**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Low metabolism                          | <input type="checkbox"/> Memory loss                                     | <input type="checkbox"/> Brittle, coarse dry hair                                      | <input type="checkbox"/> Depression                                     |
| <input type="checkbox"/> Weight gain                             | <input type="checkbox"/> Decreased libido                                | <input type="checkbox"/> Dry rough pale skin   | <input type="checkbox"/> Fatigue  |
| <input type="checkbox"/> Insulin resistance                      | <input type="checkbox"/> Cold intolerance                                | <input type="checkbox"/> Constipation  | <input type="checkbox"/> Irritability                                   |
| <input type="checkbox"/> Loss of outside portion of eyebrow hair | <input type="checkbox"/> Difficulty losing weight                        | <input type="checkbox"/> Muscle cramps, frequent muscle aches                          | <input type="checkbox"/> Abnormal menstrual cycles                      |
| <input type="checkbox"/> Elevated cholesterol                    | <input type="checkbox"/> Aches & pains                                   | <input type="checkbox"/> Slow wound healing  | <input type="checkbox"/> Brittle nails                                  |
| <input type="checkbox"/> Ringing in the ears                     | <input type="checkbox"/> Cold hands & feet                               | <input type="checkbox"/> Thinning hair   | <input type="checkbox"/> Sleep disturbances                             |
| <input type="checkbox"/> Anxiety                                 | <input type="checkbox"/> Weakness  | <input type="checkbox"/> Hair falls out easily   | <input type="checkbox"/> Infertility                                    |
| <input type="checkbox"/> Edema, esp. facial                      | <input type="checkbox"/> Frequent colds & flu                            | <input type="checkbox"/> Breast or ovarian cysts                                       | <input type="checkbox"/> Uterine fibroids                               |
| <input type="checkbox"/> Increased or decreased blood pressure   | <input type="checkbox"/> Low basal body temperature (resting body temps) | <input type="checkbox"/> Decreased cognitive function, reduced initiative, poor memory | <input type="checkbox"/> Morning headaches that wear off as day goes on |

### **Section 3:**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Increased metabolism | <input type="checkbox"/> Insomnia                   | <input type="checkbox"/> Fatigue                                | <input type="checkbox"/> Loss of scalp hair             |
| <input type="checkbox"/> Heart palpitations   | <input type="checkbox"/> Breathlessness             | <input type="checkbox"/> Hair loss                              | <input type="checkbox"/> Sleep disturbances             |
| <input type="checkbox"/> Warm moist skin      | <input type="checkbox"/> Weight loss without trying | <input type="checkbox"/> Increased bowel movements              | <input type="checkbox"/> Light or absent menstruation   |
| <input type="checkbox"/> Heat intolerance     | <input type="checkbox"/> Fast heart rate            | <input type="checkbox"/> Nervousness                            | <input type="checkbox"/> Increased appetite             |
| <input type="checkbox"/> Always warm          | <input type="checkbox"/> Bulging eyes               | <input type="checkbox"/> Excessive & inappropriate perspiration | <input type="checkbox"/> Tremor of outstretched fingers |

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## *Symptom Check Lists*

**Instructions:** Please indicate any of these symptoms that you may experience on a regular basis. There may be some repetition in various sections, please mark all that apply even if previously marked in another section.

**Section 4:** Note which of the following symptoms are troublesome and/or persistent over time.

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Persisting fatigue | <input type="checkbox"/> Dry eyes        | <input type="checkbox"/> Anxiety                   | <input type="checkbox"/> Loss of libido                      |
| <input type="checkbox"/> Depression         | <input type="checkbox"/> Dry skin & hair | <input type="checkbox"/> Hypersensitivity to noise | <input type="checkbox"/> Loss of head, armpit and pubic hair |

**Section 5:**

Note which of the following symptoms are troublesome and/or persistent over time.

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Hot flashes         | <input type="checkbox"/> Mood swings (PMS) | <input type="checkbox"/> Urinary incontinence          | <input type="checkbox"/> Night sweats   |
| <input type="checkbox"/> Heart palpitations  | <input type="checkbox"/> Cystic ovaries    | <input type="checkbox"/> Vaginal dryness               | <input type="checkbox"/> Acne           |
| <input type="checkbox"/> Heavy menses        | <input type="checkbox"/> Foggy thinking    | <input type="checkbox"/> Weight gain                   | <input type="checkbox"/> Depressed mood |
| <input type="checkbox"/> Fibrocystic breasts | <input type="checkbox"/> Irritability      | <input type="checkbox"/> Increased body or facial hair | <input type="checkbox"/> Headaches      |
| <input type="checkbox"/> Thinning skin       | <input type="checkbox"/> Uterine fibroids  |  | <input type="checkbox"/> Bone loss      |

**Section 6:**

Note which of the following symptoms are troublesome and/or persistent over time.

Part 1:

- |   |   |
|---|---|
| <input type="checkbox"/> Can't stay asleep                | <input type="checkbox"/> Weight loss                      |
| <input type="checkbox"/> Crave salty foods                | <input type="checkbox"/> Weak nails                       |
| <input type="checkbox"/> Afternoon fatigue                | <input type="checkbox"/> Afternoon headache               |
| <input type="checkbox"/> Can't get started in the morning | <input type="checkbox"/> Headache with stress or exertion |

Part 2:

- |  |  |
|--|--|
| <input type="checkbox"/> Can't fall asleep                                 | <input type="checkbox"/> Increased hunger                            |
| <input type="checkbox"/> Increased stress levels                           | <input type="checkbox"/> Trauma                                      |
| <input type="checkbox"/> Do best work late at night                        | <input type="checkbox"/> Excessive perspiration with little activity |
| <input type="checkbox"/> Wake up tired even after 6 or more hours of sleep | <input type="checkbox"/> Hair loss                                   |
| <input type="checkbox"/> Low libido  |  |

Part 3:

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> General fatigue                           | <input type="checkbox"/> Allergic conditions                               | <input type="checkbox"/> Chronic illness                                 | <input type="checkbox"/> Bone loss  |
| <input type="checkbox"/> Eating relieves fatigue                   | <input type="checkbox"/> Depression  | <input type="checkbox"/> Anxiety   | <input type="checkbox"/> Blood sugar imbalance                                    |
| <input type="checkbox"/> Afternoon headache                        | <input type="checkbox"/> Nervousness                                       | <input type="checkbox"/> Chemical sensitivities                          | <input type="checkbox"/> Irritable before meals                                   |
| <input type="checkbox"/> Infertility                               | <input type="checkbox"/> Gastric ulcer                                     | <input type="checkbox"/> Autoimmune illness                              | <input type="checkbox"/> Elevated triglycerides                                   |
| <input type="checkbox"/> Headache with mental or physical exertion | <input type="checkbox"/> Can't stay asleep or difficulty in falling asleep | <input type="checkbox"/> Susceptibility to infections/weak immune system | <input type="checkbox"/> Get shaky or light-headed if meals are missed or delayed |
| <input type="checkbox"/> Hard to get going in the morning          | <input type="checkbox"/> Blurred vision, unstable behavior                 | <input type="checkbox"/> Crave sweets, caffeine or cigarettes            | <input type="checkbox"/> Fullness or bloated feeling                              |

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## *Questions for Women*

Date of Last Menstrual Period: \_\_\_\_\_ Average length of period: \_\_\_\_\_ Pain level: \_\_\_\_\_  
Average length of cycle: \_\_\_\_\_ Menstrual flow: very heavy/heavy/medium/light  
**Day of cycle blood was drawn on:** \_\_\_\_\_ (Day 1 is first day of menses; if in menopause disregard)  
Are you Nursing? \_\_\_\_\_ Date of Last Pregnancy: \_\_\_\_\_  
# of Children: \_\_\_\_\_ Ages: \_\_\_\_\_

Do you experience PMS symptoms? \_\_\_\_\_  
Please Describe: \_\_\_\_\_  
\_\_\_\_\_

Have you experienced symptoms of peri-menopause? \_\_\_\_\_ What age did the symptoms begin? \_\_\_\_\_  
Have you completed menopause? \_\_\_\_\_ Age of last menstrual period: \_\_\_\_\_

Date of last pap smear: \_\_\_\_\_ Result: \_\_\_\_\_  
Do you do self-breast exams? \_\_\_\_\_ How often? \_\_\_\_\_

History of Bladder infections? \_\_\_\_\_ Frequency: \_\_\_\_\_

### **Section 7:**

Note which of the following symptoms that are troublesome and/or persistent over time.

<input type="checkbox"/> Headaches	<input type="checkbox"/> Water retention	<input type="checkbox"/> Moodiness	<input type="checkbox"/> Acne
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Weight gain	<input type="checkbox"/> Depression	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Swollen breasts	<input type="checkbox"/> Low sex drive	<input type="checkbox"/> Irritability	<input type="checkbox"/> Infertility
<input type="checkbox"/> Painful breasts	<input type="checkbox"/> Fuzzy thinking	<input type="checkbox"/> PMS symptoms	<input type="checkbox"/> History of miscarriage
<input type="checkbox"/> Cramps	<input type="checkbox"/> Inability to concentrate	<input type="checkbox"/> Emotional swings	
<input type="checkbox"/> Painful joints	<input type="checkbox"/> Food cravings		

### **Section 8:**

Note which of the following symptoms that are troublesome and/or persistent over time.

<input type="checkbox"/> Hot flashes	<input type="checkbox"/> Vaginal dryness	<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Night sweats	<input type="checkbox"/> Low libido	<input type="checkbox"/> Dry hair/Hair Loss	<input type="checkbox"/> Depression
<input type="checkbox"/> Sleep disturbances	<input type="checkbox"/> Painful intercourse	<input type="checkbox"/> Dry Skin	<input type="checkbox"/> Headaches
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Vaginal atrophy	<input type="checkbox"/> Bone loss	<input type="checkbox"/> Foggy thinking
<input type="checkbox"/> Mood swings	<input type="checkbox"/> Frequent yeast infections	<input type="checkbox"/> Frequent urinary tract infections	<input type="checkbox"/> Short-term memory loss

### **Section 9:**

Note which of the following symptoms that are troublesome and/or persistent over time.

<input type="checkbox"/> Fatigue	<input type="checkbox"/> Cravings for sweets	<input type="checkbox"/> Weight gain	<input type="checkbox"/> Loss of scalp hair
<input type="checkbox"/> Headaches	<input type="checkbox"/> Decreased libido	<input type="checkbox"/> Fibrocystic breasts	<input type="checkbox"/> Sleep disturbances
<input type="checkbox"/> Fluid retention	<input type="checkbox"/> Heavy or irregular periods	<input type="checkbox"/> Uterine fibroids	<input type="checkbox"/> Mood swings
<input type="checkbox"/> Nervousness, anxiety, irritability		<input type="checkbox"/> Breast tenderness/swelling	<input type="checkbox"/> Symptoms of low thyroid function

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<b>Please Answer the Following Questions:</b>	<b>Yes</b>	<b>No</b>
Weak fingernails—brittle, peeling or ridges?		
I often have gas, bloating, or belching after meals		
I tend to feel full for quite some time after meals, or feel like food just sits in my stomach after meals		
I usually have bad breath		
I seem to be aging prematurely, even though I do everything right (eat well , exercise, avoid sun exposure, etc)		
I have a strong appetite		
I often have constipation or diarrhea		
I have or have had iron deficiency anemia		
My hair is thin, brittle or weak		
I don't digest food well. I often feel uncomfortable or unwell after eating.		
My skin tends to be dry and/or weak		
I have a history of one or more of the following conditions: acne, eczema, rosacea, psoriasis, vitiligo, autoimmune disease, rheumatoid arthritis, bacterial overgrowth, candida, and food allergies.		

Please describe your level and sources of stress: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# NEUROBEHAVIORAL SYMPTOM CHECKLIST

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

From time to time, everyone feels out of sorts, not themselves, nervous, depressed, irritable, or anxious. Illness and prescription medications can alter behavior, perception, and mood states as well. These questions are designed to assist you and your healthcare provider in identifying patterns of behavior and feelings that tend to affect the quality of your relationships with family and friends, performance at work, and your overall sense of well-being. By sharing this information, you participate as a partner in exploring some of the possible underlying causes of any emotional or mental discomfort you may be experiencing.

## Directions:

Please check the boxes that best describe your feelings and ability to function most of the time. When answering each question, consider the degree to which your daily life is affected.

### 1. Over the last year, I have experienced:

- Becoming forgetful
- Lapses in memory
- Becoming less attentive
- Less interest in normal activities
- Feeling less sharp
- Difficulty remembering people's names
- Difficulty making decisions
- Problems finding the right words to communicate
- Difficulty solving routine problems
- Difficulty learning new things
- Problems writing, reading, or organizing thoughts
- Difficulty following instructions

### 2. I experience:

- Lack of interest in normal activities
- Loss of energy
- Oversleeping or sleepiness
- Sense of sadness for no apparent reason
- Increased appetite, especially for carbohydrates
- Fatigue
- Symptoms that usually get worse in the winter
- Weight gain or weight loss
- Difficulty concentrating and processing information, especially in the afternoon
- Diminished sexual desire

### 3. I frequently:

- Feel tense and have trouble relaxing
- Have headaches and other aches and pains
- Get crabby or grouchy
- Have trouble falling asleep or staying asleep
- Sweat and have hot flashes in anticipation of events
- Feel irritable or short tempered
- Have trouble letting things go
- Get angry for no apparent reason
- Women only: Get worse symptoms prior to getting my period

### 4. I often:

- Feel overly active and compelled to do things, like being driven by a motor
- Have difficulty relaxing and unwinding when I have time to myself
- Misplace and have difficulty finding things
- Crave caffeine and stimulants to keep me going
- Delay getting started when I have a task or work that requires a lot of thought
- Get easily distracted by activity or noise around me
- Have difficulty keeping my attention when doing boring and repetitive work
- Fidget or squirm with my hands and feet when I have to sit down for a long time
- Leave my seat in meetings or other situations in which I am expected to remain seated
- Have problems remembering appointments or obligations
- Have difficulty concentrating on what people say to me, even when they are speaking to me directly
- Move around and kick in my sleep

**5. I experience:**

- Waking up frequently during the night with difficulty returning to sleep
- Looking forward to catching up on my sleep on the weekends
- Taking more than 30 minutes to fall asleep at night
- Stomach problems or nausea
- Waking up repeatedly throughout the night
- Waking up groggy and not well rested
- Preferring to go to sleep later than midnight and waking up late, after 10:00 A.M.
- Preferring an early bedtime—going to sleep between 7 P.M. and 9 P.M. and waking up early, around 5:00 A.M.
- Jet lag
- Difficulty turning off my thoughts when I lay down to sleep

**Additional Comments:**

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# Wellness Profile

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Age: \_\_\_\_\_ Sex (M/F) \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Total Cholesterol: \_\_\_\_\_ HDL: \_\_\_\_\_ LDL: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
List medications you take: \_\_\_\_\_

## Instructions

- 1) If statement does not apply, leave it blank. Otherwise place a 1, 2, or 3 on the line to the left of the statement.  
**-- 1 for Mild or Infrequent -- 2 for Moderate or Occasional -- 3 for Severe or Frequent**
- 2) Underline the particular part of the question that applies. Do not agonize over each question.
- 3) Some statements are repeated. It is important that you mark all appropriate statements, even if marked previously.
- 4) Mark YES or NO statements by checking the appropriate spot.

### Supplemental Information

<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Trying to lose weight	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Interested in preventing Cancer
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Exercise frequently	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Want to strengthen the immune system
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Eat vegetarian diet	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Are you overweight
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Eat less than 3 servings per day of milk, yogurt or cheese	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Eat fried and processed foods
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Eat less than 3-5 servings of vegetables daily	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Eat low fiber, high fat diet
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Eat less than 6-11 servings of whole grain daily	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Eat less than 2 servings of fruit daily
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Are you pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Interested in preventing Heart Disease

### Questionnaire

#### Yes or No section

Yes  No  Do you have High Blood Pressure?  
 Yes  No  Do you have Type I Diabetes or medically diagnosed Reactive Hypoglycemia?  
 Yes  No  Do you or does anyone in your immediate household smoke?  
 Yes  No  Do you have high cholesterol?  
 Do you have joint or muscle aches or tenderness, OR abnormal muscle aches from exercise, OR backache?

#### Points Section

<input type="checkbox"/> Acne, Blackheads or Warts	<input type="checkbox"/> Dry, Rough Skin
<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Permanent Goose Bumps on back of arms
<input type="checkbox"/> Inability to adjust eyes when entering a dark room. Difficulty seeing at night.	<input type="checkbox"/> Frequent Colds, Respiratory Infections

(1) \_\_\_\_\_

<input type="checkbox"/> Frequent Fatigue	<input type="checkbox"/> Irritability
<input type="checkbox"/> Depression	<input type="checkbox"/> Craving for Sweets
<input type="checkbox"/> Can't Concentrate	<input type="checkbox"/> Fits of Temper
<input type="checkbox"/> Hurt all over (general)	<input type="checkbox"/> Heart Palpitations
<input type="checkbox"/> Use antibiotics; eat red meat or chicken, drink milk	<input type="checkbox"/> Graying Hair

(2) \_\_\_\_\_

<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Bruise Easily
<input type="checkbox"/> Frequent Colds or Flu	<input type="checkbox"/> Varicose Veins or Broken Capillaries
<input type="checkbox"/> Slow Healing of Cuts or Scrapes	<input type="checkbox"/> Nose Bleeds
<input type="checkbox"/> Cuticles Tear Easily, Hang Nails	

(3) \_\_\_\_\_ (4) = 1+2+3 (auto entry)

<input type="checkbox"/> Poor Circulation	<input type="checkbox"/> Lack of Stamina
<input type="checkbox"/> Dark Circles under Eyes	<input type="checkbox"/> History of Anemia
<input type="checkbox"/> Heavy Menstrual Flow	<input type="checkbox"/> Thin, Fragile, Brittle Nails
<input type="checkbox"/> Pale Skin, Palms very Pale	

(5) \_\_\_\_\_

<input type="checkbox"/> Menstrual Cramps	<input type="checkbox"/> Muscle Twitching or Tics
<input type="checkbox"/> Fingernails won't Grow	<input type="checkbox"/> Foot or Leg Cramps
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Muscle Tension
<input type="checkbox"/> Joints Pop or Crack	<input type="checkbox"/> Frequent Backaches
<input type="checkbox"/> Aching Joints or Muscles	<input type="checkbox"/> Crave Chocolate

(6) \_\_\_\_\_

<input type="checkbox"/> Bad Breath	<input type="checkbox"/> White coated Tongue
<input type="checkbox"/> White Spots on Fingernails	<input type="checkbox"/> Diminished Smell or Taste
<input type="checkbox"/> Slow Healing of Wounds	<input type="checkbox"/> Stress
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Taking Estrogen (The Pill or Premarin)? If so, put a 2 on the line to the left.	

(7) \_\_\_\_\_ (8) = 5+6+7 (auto entry) (9) = 4+8 (auto entry)

<input type="checkbox"/> Nausea, Headache, Migraine	<input type="checkbox"/> History of Constipation
<input type="checkbox"/> Bad Breath, Bad taste in Mouth	<input type="checkbox"/> History of Hepatitis, Jaundice, Malaria
<input type="checkbox"/> Occasional Body Odor, Including Feet	<input type="checkbox"/> Undigested Food in Bowel Movement
<input type="checkbox"/> Gall Bladder or Stones Removed. Year _____	<input type="checkbox"/> Frequent Tension in Neck and Shoulders
<input type="checkbox"/> Occasional Abdominal Pain after big meal	<input type="checkbox"/> Coated Tongue
<input type="checkbox"/> Yellow-colored Bowel Movements	<input type="checkbox"/> Ingest alcohol (more than 1 oz. OR 1 beer per day)

(10) \_\_\_\_\_

History of Colitis, Diverticulitis  
 History of Hemorrhoids  
 Constipation during Menstruation  
 Painful, Hard Bowel Movements  
 Rarely have daily Bowel Movements

Desire to Eat often, Especially Starches  
 Alternating Constipation and Diarrhea  
 Thin, Pencil-like Bowel Movements  
 History of Rectal Fissure

(11)\_\_\_\_\_

Gas after Eating  
 Belching, Burping after Meals

Stomach Bloating after Eating

(12)\_\_\_\_\_

Heavy, Tired Feeling after Eating  
 Very Flabby Tissues  
 Chronic Fluid Retention

Drowsy after eating  
 Fingernails Break and Split

(12A)\_\_\_\_\_ (13) = 12+12A (auto entry)

Stomach Pain 5-6 Hours after Meals, often at Night. Relieved by Drinking Cream or Milk  
 Above Complaints Aggravated by Worry and tension. Relieved by Vacating

History of Ulcers  
 Taking Pills or Vitamins Causes Stomach Discomfort

(14)\_\_\_\_\_ (15) = 10+11+13+14 (auto entry)

Puffy Eyes  
 History of Kidney or Bladder Infections  
 Infrequent Urination  
 Sleep Disturbed by Urge to Urinate 2 or More Times/Night

Ankles Swell Frequently  
 Difficult or Painful Urination  
 Legs often Feel Heavy  
 Severe Pre-Menstrual Bloating

(16)\_\_\_\_\_

Blood Pressure Fluctuates, Sometimes too Low  
 Overly Worried or Concerned about Things Left Undone  
 Constriction in Throat, Lump that Hurts when Emotionally Disturbed  
 Emotional Upsets cause Exhaustion. Must go and Lie Down  
 Easily Startled, Heart Pounds from Unexpected Noise

Craving for Salt  
 Occasional Cold Sweats  
 Perfectionist, Set High Standards  
 Eyes Sensitive to Headlights, Sun  
 Allergies, Skin Rash, Hay Fever, Sneezing Attacks

(17)\_\_\_\_\_

**FEMALE: Do this section then move to next section. MALE: Skip this section and move to next section**

Missing Periods  
 Menopause, Hot Flashes, night sweats  
 Diminished Sex Drive  
 Abnormal sleep patterns  
 Yes[ ] No[ ] Have had Ovaries or Uterus Removed (Hysterectomy)? If so, put a 2 on the line to the left. Year \_\_\_\_\_

Irregular or Uncomfortable Periods  
 Feel Nervous, Depressed before Periods  
 Mood changes

(18)\_\_\_\_\_

**MALE: Do this section then move to next section. FEMALE: Skip this section and move to next section**

Prostate Trouble  
 Diminished Sex drive  
 Back or Leg Pains

Difficulty Urinating, Starting, Burning  
 Get Up at Night to Urinate

(19)\_\_\_\_\_

Irritable if Late for a Meal or Missing a Meal  
 Wake Up at Night Feeling Hungry  
 Craving for Sweets, Alcohol or Coffee  
 Cold Sweat on Hands even when Warm  
 Nervous, Shaky Feeling, Headaches relieved by eating Sweets or Starches  
 Bouts of Faintness, Dizziness, Lack of Concentration \_\_ in Morning \_\_ in Mid-Afternoon \_\_ in Evening

Urinate a Lot  
 Emotional on Empty Stomach  
 Intense, Frequent Thirst  
 Irritable before Breakfast  
 Weak Spells, Tiredness in Mid-Afternoon

(20)\_\_\_\_\_

Crave Sweets and Starches, but Eating doesn't Provide Much Relief  
 History of Sores, Especially in Legs, Slow Healing  
 Chronic Fatigue, Lowered Resistance

Occasional Night Sweats  
 Diabetes in Family  
 Very Thirsty all the Time

(21)\_\_\_\_\_

Feel Better when Resting, Low Exercise Tolerance, Low Endurance  
 Bruise Easily, Black and Blue Spots  
 Cold Hands and Feet, Need Extra Covers at Night

Require Extra Amount of Sleep  
 Short of Breath when Climbing Stairs

(22)\_\_\_\_\_

Numbness or Heaviness in Arms or Legs  
 Tingling Sensation in Lips or Fingers  
 Short Walks Cause Aches and Pains

Hands Cramp when Writing  
 Memory Getting Worse  
 Arms and Legs Often go to Sleep

(22A)\_\_\_\_\_ (23) = 22+22A (auto entry)

Chest Pains, Sometimes Down Left Arm  
 Very Slow Heart Beat (under 50/minute)  
 Shortness of Breath on Exertion  
 Very Rapid Heart Beat (over 90/minute)

Heart Sometimes Flip-Flops  
 Unexplained Headache or Dizziness  
 Diabetes  
 History of Heart Disease in Family

(22B)\_\_\_\_\_ (24) = 23+22B (auto entry)

History of Bronchitis, Asthma, Pneumonia, Emphysema, Pleurisy  
 Working in a Factory, or with Chemicals or Fumes  
 Chronic Mucus in Throat or Sinus

Chronic Cough  
 History of Colds, Lung Problems

(25)\_\_\_\_\_

History of Cancer, Multiple Sclerosis, Parkinson's, Rheumatoid Arthritis  
 Swollen Glands in Groin, Tonsils, Throat, Armpits  
 Flu-like Symptoms often Occur

Unusual Number of Cavities  
 Very Susceptible to Infection

\_\_\_ Feel Puffiness in Throat (26)\_\_\_\_\_

- \_\_\_ Frequent Use of Antibiotics
- \_\_\_ Rectal Itching
- \_\_\_ Abnormal Muscle Aches from Exercise
- \_\_\_ Severe Reaction to Tobacco, Perfume, Chemical Odors
- \_\_\_ Hives, Psoriasis, Acne, Skin Rashes
- \_\_\_ Recurrent Heartburn/Digestive Upsets
- \_\_\_ Gas, Abdominal Bloating

- \_\_\_ Chronic Diarrhea
- \_\_\_ Bladder Infections
- \_\_\_ Feel Tired a Lot
- \_\_\_ Unexpected Weight Gain
- \_\_\_ Endometriosis/Ovary Problems
- \_\_\_ Crave Sugars, Breads, Alcohol

(27)\_\_\_\_\_

- \_\_\_ Fluid Retention
- \_\_\_ Low Hormone Levels
- \_\_\_ Weakness in General
- \_\_\_ Slow Recovery of Wounds/Illness
- \_\_\_ High Stress Lifestyle

- \_\_\_ Anemia
- \_\_\_ Nausea or Dizziness
- \_\_\_ Premature Aging
- \_\_\_ Low Resistance to Infection

(28)\_\_\_\_\_

**Move on to the next section, if this section does not apply to you.**

**DO THE FOLLOWING OCCUR WITHIN 14 DAYS BEFORE MENSTRUAL PERIOD?**

- \_\_\_ Headaches
- \_\_\_ Increased Appetite
- \_\_\_ Bloating
- \_\_\_ Fatigue
- \_\_\_ Swelling Hands and Feet
- \_\_\_ Nervous Tension, Irritability
- \_\_\_ Crave Sweets
- \_\_\_ Cramps

- \_\_\_ Weight Gain
- \_\_\_ Frequent Crying
- \_\_\_ Depression
- \_\_\_ Breast Tenderness
- \_\_\_ Backache
- \_\_\_ Confusion
- \_\_\_ Forgetfulness

(29)\_\_\_\_\_

- \_\_\_ Low energy
- \_\_\_ Stress
- \_\_\_ Chronic illness

- \_\_\_ Caffeine addiction
- \_\_\_ Poor immunity
- \_\_\_ Poor endurance

(30)\_\_\_\_\_

- \_\_\_ Atherosclerosis
- \_\_\_ Chronic Heart Failure
- \_\_\_ Poor mental alertness

- \_\_\_ Irregular heartbeat
- \_\_\_ High Blood Pressure
- \_\_\_ Memory loss

(31)\_\_\_\_\_

- \_\_\_ Joint pain and/or tenderness
- \_\_\_ Cartilage degeneration
- \_\_\_ Osteoarthritis

- \_\_\_ Swollen joints
- \_\_\_ Decreased mobility

(32)\_\_\_\_\_

\_\_\_ Yes[ ] No[ ] Are you exposed to chemicals or chemical fumes?

\_\_\_ Score 3 if Yes to above question

(33)\_\_\_\_\_

- \_\_\_ Motion sickness: sea, car, plane, etc.
- \_\_\_ Gas, indigestion
- \_\_\_ Diarrhea

- \_\_\_ Morning sickness
- \_\_\_ Abdominal cramps
- \_\_\_ Nausea

(34)\_\_\_\_\_

- \_\_\_ Chronic fatigue or sluggishness
- \_\_\_ Excessive crying
- \_\_\_ Lack of drive or motivation

- \_\_\_ Mood swings
- \_\_\_ Suicidal thoughts
- \_\_\_ Persistent sadness or empty feeling

(35)\_\_\_\_\_

- \_\_\_ Anxiety
- \_\_\_ Exhaustion
- \_\_\_ Muscle tension, Fibromyalgia
- \_\_\_ ADD, Learning disorder, Hyperactivity

- \_\_\_ Nervousness
- \_\_\_ Insomnia
- \_\_\_ Headache, Migraines
- \_\_\_ Nervous tension

(36)\_\_\_\_\_

- \_\_\_ Excessive Hair Loss
- \_\_\_ Dandruff
- \_\_\_ Hair Won't Grow

- \_\_\_ Thinning Hair
- \_\_\_ Hair Breaks Easily

(37)\_\_\_\_\_

- \_\_\_ Yes[ ] No[ ] Are you interested in preventing respiratory diseases
- \_\_\_ Yes[ ] No[ ] Do you have a mold or similar problem in your home
- \_\_\_ Yes[ ] No[ ] Do you or does anyone in your immediate household have allergies?
- \_\_\_ Yes[ ] No[ ] Are you interested in the quality of indoor air in your home

- \_\_\_ Yes[ ] No[ ] Are you interested in preventing heart disease
- \_\_\_ Yes[ ] No[ ] Are you interested in preventing cancer

\_\_\_ Score 1 for each Yes answer in Section 38.

(38)\_\_\_\_\_

**Please double check that you 1)followed the instructions carefully, 2)answered ALL the questions, and 3)put your name on the form.**