Male Intake Questionnaire

General Information

Name ______________________________ Age __________ Today's Date ______________

Date of Birth ______________ Email ______________________________

Address ______________ City ______________________________

State ______________ Zip ______________________________

Phone (Home) ______________ (Cell) ______________ (Work) ______________

Genetic Background: African American Hispanic Mediterranean Asian
Native American Caucasian Northern European
Other ______________________________

When, where and from whom did you last receive medical or health care?

____

Emergency Contact: ______________ Relationship ______________ Phone (Home) ______________
(Cell) ______________ (Work) ______________

How did you hear about our practice?

Clinic website IFM website ☐Referral from doctor ☐Referral from friend/family member ☐ Social media
Other ______________________________

Current Health Concerns

Please rank current and ongoing health concerns in order of priority

Describe Problem	Severity	Prior Treatment/Approach	Success
Example: Post Nasal Drip	Mild ☐Moderate ☐Severe	Elimination Diet	Good ☐Excellent ☐Fair
	☐Mild ☐Moderate ☐Severe		☐Good ☐Excellent ☐Fair
	☐Mild ☐Moderate ☐Severe		☐Good ☐Excellent ☐Fair
	☐Mild ☐Moderate ☐Severe		☐Good ☐Excellent ☐Fair
	☐Mild ☐Moderate ☐Severe		☐Good ☐Excellent ☐Fair
	☐Mild ☐Moderate ☐Severe		☐Good ☐Excellent ☐Fair
	☐Mild ☐Moderate ☐Severe		☐Good ☐Excellent ☐Fair
	☐Mild ☐Moderate ☐Severe		☐Good ☐Excellent ☐Fair
	☐Mild ☐Moderate ☐Severe		☐Good ☐Excellent ☐Fair
	☐Mild ☐Moderate ☐Severe		☐Good ☐Excellent ☐Fair
	☐Mild ☐Moderate ☐Severe		☐Good ☐Excellent ☐Fair

Allergies

1. Name of Medication/Supplement/Food: _____
   Reaction: _____
2. Name of Medication/Supplement/Food: _____
   Reaction: _____
3. Name of Medication/Supplement/Food: _____
   Reaction: _____
4. Name of Medication/Supplement/Food: _____
   Reaction: _____
5. Name of Medication/Supplement/Food: _____
   Reaction: _____

Lifestyle Review

Sleep

How many hours of sleep do you get each night on average? _____

Do you have problems falling asleep? Yes No Staying asleep? Yes No

Do you have problems with insomnia? Yes No Do you snore? Yes No

Do you feel rested upon awakening? Yes No

Do you use sleeping aids? Yes No

If yes, explain: _____

Exercise

Current Exercise Program:

Activity	Type	# of Times Per Week	Time/Duration (Minutes)
Cardio/Aerobic			
Strength/Resistance			
Flexibility/Stretching			
Balance			
Sports/Leisure (e.g., golf)			
Other:			

Do you feel motivated to exercise? Yes A little No

Are there any problems that limit exercise? Yes No

If yes, explain: _____

Do you feel unusually fatigued or sore after exercise? Yes No

If yes, explain: _____

Nutrition

Do you currently follow any of the following special diets or nutritional programs? (Check all that apply)

Vegetarian Vegan Allergy Elimination Low Fat Low Carb High Protein
Blood Type Low sodium No Dairy No Wheat Gluten Free
Other: _____

Do you have sensitivities to certain foods? Yes No
If yes, list food and symptoms: _____

Do you have an aversion to certain foods? Yes No
If yes, explain: _____

Do you adversely react to: (Check all that apply)

Monosodium glutamate (MSG) Artificial sweeteners Garlic/onion Cheese Citrus foods
Chocolate Alcohol Red wine Sulfite–containing foods (wine, dried fruit, salad bars)
Preservatives Food colorings Other food substances: _____

Are there any foods that you crave or binge on? Yes No
If yes, what foods? _____

Do you eat 3 meals a day? Yes No If no, how many _____

Does skipping a meal greatly affect you? Yes No

How many meals do you eat out per week? 0-1 1-3 3-5 More than 5 meals per week

Check the factors that apply to your current lifestyle and eating habits:

Fast eater
Eat too much
Late-night eating
Dislike healthy foods
Time constraints
Travel frequently
Eat more than 50% of meals away from home
Healthy foods not readily available
Poor snack choices
Significant other or family members don't like healthy foods
Significant other or family members have special dietary needs
Love to eat
Eat because I have to
Have negative relationship to food
Struggle with eating issues
Emotional eater (eat when sad, lonely, bored, etc.)
Eat too much under stress
Eat too little under stress
Don't care to cook
Confused about nutrition advice

Diet

Please record what you eat in a typical day:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Fluids _____

How many servings do you eat in a typical week of these foods:

Fruits (not juice) _____ Vegetables (not including white potatoes) _____

Legumes (beans, peas, etc) _____ Red meat _____ Fish _____

Dairy/Alternatives _____ Nuts & Seeds _____ Fats & Oils _____

Cans of soda (regular or diet) _____ Sweets (candy, cookies, cake, ice cream, etc.) _____

Do you drink caffeinated beverages? Yes No If yes, check amounts:

Coffee (cups per day) 1 2-4 More than 4 Tea (cups per day) 1 2-4 More than 4

Caffeinated sodas—regular or diet (cans per day) 1 2-4 More than 4

Do you have adverse reactions to caffeine? Yes No

If yes, explain: _____

When you drink caffeine do you feel: Irritable or wired Aches or pains

Smoking

Do you smoke currently? Yes No Packs per day: _____ Number of years_____

What type? Cigarettes Smokeless Pipe Cigar E-Cig

Have you attempted to quit? Yes No

If yes, using what methods: _____

If you smoked previously: Packs per day: _____ Number of years _____

Are you regularly exposed to second-hand smoke? Yes No

Alcohol

How many alcoholic beverages do you drink in a week? *(1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits)*

1-3 4-6 7-10 More than 10 None

Previous alcohol intake? Yes (Mild Moderate High) None

Have you ever had a problem with alcohol? Yes No

If yes, when? _____

Explain the problem: _____

Have you ever thought about getting help to control or stop your drinking? Yes No

Other Substances

Are you currently using any recreational drugs? Yes No

If yes, type:_____

Have you ever used IV or inhaled recreational drugs? Yes No

Stress

Do you feel you have an excessive amount of stress in your life? Yes No

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

How much stress do each of the following cause on a daily basis *(Rate on scale of 1-10, 10 being highest)*
Work _____ Family _____ Social _____ Finances _____ Health _____ Other _____

Do you use relaxation techniques? Yes No
If yes, how often? _____

Which techniques do you use? *(Check all that apply)*
Meditation Breathing Tai Chi Yoga Prayer Other: _____

Have you ever sought counseling? Yes No

Are you currently in therapy? Yes No
If yes, describe: _____

Have you ever been abused, a victim of crime, or experienced a significant trauma? Yes No

What are your hobbies or leisure activities? _____

Relationships

Marital status: Single Married Divorced Gay/Lesbian Long-Term Partner Widow/er

With whom do you live? (Include children, parents, relatives, friends, pets)

_____

Current occupation: _____

Previous occupations: _____

Do you have resources for emotional support? Yes No *(Check all that apply)*
Spouse/Partner Family Friends Religious/Spiritual Pets Other: _____

Do you have a religious or spiritual practice? Yes No
If yes, what kind? _____

How well have things been going for you?

*(Enter score on scale of 1–10, with 1 being **poorly**, 5 being **fine**, and 10 being **very well**; choose **N/A** if not applicable)*

How Well Have Things Been Going for You?		
Overall	N/A	Score_____
At school	N/A	Score_____
In your job	N/A	Score_____
In your social life	N/A	Score_____
With close friends	N/A	Score_____
With sex	N/A	Score_____
With your attitude	N/A	Score_____
With your boyfriend/girlfriend	N/A	Score_____
With your children	N/A	Score_____
With your parents	N/A	Score_____
With your spouse	N/A	Score_____

History

Patient's Birth/Childhood History:

You were born: Term Premature Don't know

Were there any pregnancy or birth complications? Yes No
If yes, explain: _____

You were: Breast-fed/How long? _____ Bottle-fed/Type of formula: _____ Don't know

Age of introduction of: Solid food: _____ Wheat _____ Dairy _____

As a child, were there any foods that were avoided because they gave you symptoms? Yes No
If yes, what foods and what symptoms? (Example: milk—gas and diarrhea)

Did you eat a lot of sugar or candy as a child? Yes No

Dental History:

Check if you have any of the following, and provide number if applicable:

Silver mercury fillings _____ Gold fillings _____ Root canals _____ Implants _____
Caps/Crowns _____ Tooth pain _____ Bleeding gums _____ Gingivitis _____
Problems with chewing _____ Other dental concerns (explain): _____

Have you had any mercury fillings removed? Yes No If yes, when: _____

How many fillings did you have as a kid? _____

Do you brush regularly? Yes No Do you floss regularly? Yes No

Environmental/Detoxification History

Do any of these significantly affect you?
Cigarette smoke Perfume/colognes Auto exhaust fumes Other: _____

In your work or home environment are you regularly exposed to: *(Check all that apply)*
Mold Water leaks Renovations Chemicals Electromagnetic radiation
Damp environments Carpets or rugs Old paint Stagnant or stuffy air Smokers
Pesticides Herbicides Harsh chemicals (solvents, glues, gas, acids, etc) Cleaning chemicals
Heavy metals (lead, mercury, etc.) Paints Airplane travel Other _____

Have you had a significant exposure to any harmful chemicals? Yes No
If yes: Chemical name, length of exposure, date: _____

Do you have any pets or farm animals? Yes No

If yes, do they live: Inside Outside Both inside and outside

Men's History

(Check box if applicable)

Testicular mass | Testicular pain | Prostate enlargement | Prostate infection

Change in sex drive | Impotence | Premature ejaculation | Difficulty obtaining an erection

Difficulty maintaining an erection | Loss of control of urine | Urinary urgency/hesitancy/change in stream

Vasectomy | Nocturia (urination at night) # of times per night _____

Sexually transmitted diseases (describe) _____

Screening/Procedures: (If applicable, provide date)

Last PSA test: _____ PSA Level: 0-2 2-4 4-10 More than 10

Other tests/procedures (list type and dates):

Medical History: Illnesses/Conditions

Check YES = a condition you currently have, ***Check PAST*** = a condition you've had in the past.

Gastrointestinal		
Irritable bowel syndrome	☐ Yes	☐ Past
GERD (reflux)	☐ Yes	☐ Past
Crohn's disease/ulcerative colitis	☐ Yes	☐ Past
Peptic ulcer disease	☐ Yes	☐ Past
Celiac disease	☐ Yes	☐ Past
Gallstones	☐ Yes	☐ Past
Other:	☐ Yes	☐ Past
Respiratory		
Bronchitis	☐ Yes	☐ Past
Asthma	☐ Yes	☐ Past
Emphysema	☐ Yes	☐ Past
Pneumonia	☐ Yes	☐ Past
Sinusitis	☐ Yes	☐ Past
Sleep apnea	☐ Yes	☐ Past
Other:	☐ Yes	☐ Past
Urinary/Genital		
Kidney stones	☐ Yes	☐ Past
Gout	☐ Yes	☐ Past
Interstitial cystitis	☐ Yes	☐ Past
Frequent yeast infections	☐ Yes	☐ Past
Frequent urinary tract infections	☐ Yes	☐ Past
Sexual dysfunction	☐ Yes	☐ Past
Sexually transmitted diseases	☐ Yes	☐ Past
Other:	☐ Yes	☐ Past
Endocrine/Metabolic		
Diabetes	☐ Yes	☐ Past
Hypothyroidism (low thyroid)	☐ Yes	☐ Past
Hyperthyroidism (overactive thyroid)	☐ Yes	☐ Past
Infertility	☐ Yes	☐ Past
Metabolic syndrome/insulin resistance	☐ Yes	☐ Past
Eating disorder	☐ Yes	☐ Past
Hypoglycemia	☐ Yes	☐ Past
Other:	☐ Yes	☐ Past
Inflammatory/Immune		
Rheumatoid arthritis	☐ Yes	☐ Past
Chronic fatigue syndrome	☐ Yes	☐ Past
Food allergies	☐ Yes	☐ Past
Environmental allergies	☐ Yes	☐ Past
Multiple chemical sensitivities	☐ Yes	☐ Past
Autoimmune disease	☐ Yes	☐ Past
Immune deficiency	☐ Yes	☐ Past
Mononucleosis	☐ Yes	☐ Past
Hepatitis	☐ Yes	☐ Past
Other:	☐ Yes	☐ Past

Musculoskeletal		
Fibromyalgia	☐ Yes	☐ Past
Osteoarthritis	☐ Yes	☐ Past
Chronic pain	☐ Yes	☐ Past
Other:	☐ Yes	☐ Past
Skin		
Eczema	☐ Yes	☐ Past
Psoriasis	☐ Yes	☐ Past
Acne	☐ Yes	☐ Past
Skin cancer	☐ Yes	☐ Past
Other:	☐ Yes	☐ Past
Cardiovascular		
Angina	☐ Yes	☐ Past
Heart attack	☐ Yes	☐ Past
Heart failure	☐ Yes	☐ Past
Hypertension (high blood pressure)	☐ Yes	☐ Past
Stroke	☐ Yes	☐ Past
High blood fats (cholesterol, triglycerides)	☐ Yes	☐ Past
Rheumatic fever	☐ Yes	☐ Past
Arrythmia (irregular heart rate)	☐ Yes	☐ Past
Murmur	☐ Yes	☐ Past
Mitral valve prolapse	☐ Yes	☐ Past
Other:	☐ Yes	☐ Past
Neurologic/Emotional		
Epilepsy/Seizures	☐ Yes	☐ Past
ADD/ADHD	☐ Yes	☐ Past
Headaches	☐ Yes	☐ Past
Migraines	☐ Yes	☐ Past
Depression	☐ Yes	☐ Past
Anxiety	☐ Yes	☐ Past
Autism	☐ Yes	☐ Past
Multiple sclerosis	☐ Yes	☐ Past
Parkinson's disease	☐ Yes	☐ Past
Dementia	☐ Yes	☐ Past
Other:	☐ Yes	☐ Past
Cancer		
Lung	☐ Yes	☐ Past
Breast	☐ Yes	☐ Past
Colon	☐ Yes	☐ Past
Prostate	☐ Yes	☐ Past
Skin	☐ Yes	☐ Past
Other:	☐ Yes	☐ Past

Medical History *(continued)*

Diagnostic Studies		
Bone Density	Date:	Comments:
CT scan	Date:	Comments:
Colonoscopy	Date:	Comments:
Cardiac stress test	Date:	Comments:
EKG	Date:	Comments:
MRI	Date:	Comments:
Upper endoscopy	Date:	Comments:
Upper GI series	Date:	Comments:
Chest X-ray	Date:	Comments:
Other X-rays	Date:	Comments:
Barium enema	Date:	Comments:
Other:	Date:	Comments:
Injuries		
Broken bone(s)	Date:	Comments:
Back injury	Date:	Comments:
Neck injury	Date:	Comments:
Head injury	Date:	Comments:
Other:	Date:	Comments:
Surgeries		
Appendectomy	Date:	Comments:
Dental	Date:	Comments:
Gallbladder	Date:	Comments:
Hernia	Date:	Comments:
Tonsillectomy	Date:	Comments:
Joint Replacement	Date:	Comments:
Heart surgery	Date:	Comments:
Other:	Date:	Comments:
Hospitalizations		
	Date:	Reason:
	Date:	Reason:
	Date:	Reason:
	Date:	Reason:
	Date:	Reason:

Name: _____ Date:_____

SYMPTOM QUESTIONNAIRE

Ear, Nose, and Throat

Sneezing and/or nasal itchiness?	❑ Yes	❑ No
Water nasal drainage?	❑ Yes	❑ No
Nasal congestion, blockage, and stuffiness?	❑ Yes	❑ No
Post nasal drip?	❑ Yes	❑ No
Thick, cloudy, mucus discharge?	❑ Yes	❑ No
Frequent "sinus" problems and/or infections?	❑ Yes	❑ No
Frequent colds?	❑ Yes	❑ No
Loss of smell?	❑ Yes	❑ No
Recurrent sore throats?	❑ Yes	❑ No
Itching of mouth, throat and/or palate?	❑ Yes	❑ No
Swelling of tongue, lips and/or palate?	❑ Yes	❑ No
Recurrent hoarseness and/or laryngitis?	❑ Yes	❑ No
Recurrent ear infections?	❑ Yes	❑ No
Popping or fullness in the ears?	❑ Yes	❑ No
Hearing loss?	❑ Yes	❑ No
Itching ears?	❑ Yes	❑ No

Eyes

Eye itchiness, watering, redness?	❑ Yes	❑ No
Swelling or puffiness around the eyes?	❑ Yes	❑ No

Chest

Chronic dry cough?	❑ Yes	❑ No
Chest tightness, congestion, and/or shortness of breath?	❑ Yes	❑ No
Asthma (wheezing)?	❑ Yes	❑ No
Asthma present only with exercise?	❑ Yes	❑ No
Frequent pneumonia and/or bronchitis?	❑ Yes	❑ No

Skin/Joints

Eczema? ❑ Yes ❑ No

Hives/urticaria? ❑ Yes ❑ No

Allergic skin reactions (swelling)? ❑ Yes ❑ No

Itchiness? ❑ Yes ❑ No

Muscle or joint pain and/or vomiting? ❑ Yes ❑ No

Gastro-Intestinal

Indigestion, belching, gas, heartburn? ❑ Yes ❑ No

Bloating? ❑ Yes ❑ No

Diarrhea? ❑ Yes ❑ No

Constipation? ❑ Yes ❑ No

Nausea and/or vomiting? ❑ Yes ❑ No

General

Dizziness, unsteadiness, or light-headedness? ❑ Yes ❑ No

Chronic headaches/migraines? ❑ Yes ❑ No

Depression, anxiety or tension? ❑ Yes ❑ No

Chronic fatigue or tiredness? ❑ Yes ❑ No

Difficulty concentrating? ❑ Yes ❑ No

Hyperactivity? ❑ Yes ❑ No

Signature

Date

Medications/Supplements

Current medications (include prescription and over-the-counter)

Medication	Dosage	Start Date (mo/yr)	Reason for Use

Nutritional supplements (vitamins/minerals/herbs etc.)

Name and Brand	Dosage	Start Date (mo/yr)	Reason for Use

Have medications or supplements ever caused unusual side effects or problems? Yes No

If yes, describe: _____

Have you used any of these regularly or for a long time:

NSAIDs (Advil, Aleve, etc.), Motrin, Aspirin? Yes No Tylenol (acetaminophen)? Yes No

Acid-blocking drugs (Zantac, Prilosec, Nexium, etc.)? Yes No

How many times have you taken antibiotics?

Infancy/childhood ☐ Less than 5 ☐ 5 or more Reason for use _____

Teen ☐ Less than 5 ☐ 5 or more Reason for use _____

Adulthood ☐ Less than 5 ☐ 5 or more Reason for use _____

Have you ever taken long term antibiotics? Yes No

If yes, explain: _____

How often have you taken oral steroids (e.g., cortisone, prednisone, etc.)?

Infancy/childhood ☐ Less than 5 ☐ 5 or more Reason for use _____

Teen ☐ Less than 5 ☐ 5 or more Reason for use _____

Adulthood ☐ Less than 5 ☐ 5 or more Reason for use _____

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 feel needs to happen for you to get better?

Tiffani Huckels, Pharm.D/Herbalist, Lifestyle Coach

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Phone (719)930-1829

CLIENT AGREEMENT

Tiffani Huckels, The Herb Doctor, TheeHerbDoc.com, and any and all associates are interested in health, not disease. We are not able and do not diagnose, treat, prescribe for, palliate, or prevent human disease, ailment, pain, injury, deformity, physical condition, or mental condition. Our concern is what constitutes health, what supports health, and what undermines health. The nutritional consultant evaluates signs of nutritional deficiency and suggests or recommends foods, food supplements, and foods for special dietary uses which includes both vitamins and minerals singularly or together to correct such nutritional deficiencies. We encourage self-help to prevent problems and educate clients on nutrition but do not practice medicine, diagnose, prevent, or treat any disease.

1. I understand that Tiffani Huckels is not able to diagnose, treat, prescribe, palliate, or prevent human disease, ailment, pain, injury, deformity, physical condition, or mental condition. I understand that her services are that of a nutritional consultant who strives for optimal health by teaching nutrition as the normal need of good health.
2. I understand that all recommended diets are only to achieve optimum good health and not to treat or cure any disease.
3. I understand that if I have any medical problem, health condition, or disease I am now being advised to seek qualified medical opinions.
4. I understand that the services provided by the holistic health practitioner are limited to education pertaining to my overall general health and physical fitness. I understand that these services may include examination of hair samples, lab work, questionnaires, Zyto scan, food intolerances, but that these examinations are not used to diagnose, treat any health condition, disease, or food allergy.
5. I understand that exercises for muscle tone or body energy are exercises intended to produce wellness and enhance physical fitness. These demonstrations and/or exercises which I can do are not treatment of a health condition or disease.
6. I understand that nutritional recommendations are intended for the maintenance of the best possible state of nutritional health and do not involve diagnosing, treating, or

prescribing of foods, supplements, or remedies for the treatment of any disease or health condition. Rather, these educational recommendations are a holistic approach to optimal physical, psychological, and social well-being.

7. I understand that according to some scientific opinions nutrition is considered to be an inexact science with many variables and that the results obtained from improved nutrition are not always consistent or predictable.
8. I fully understand that the services provided by my holistic health practitioner are not regulated or licensed by any federal, state, or local agency.

I acknowledge receipt of an exact copy of this agreement. I also acknowledge that I have read the above agreement and understand it completely. I therefore retain Tiffani Huckels or associate as a holistic health practitioner to educate me in the improvement of my overall general health.

Signature: _____ Date: _____

Phone: _____

Holistic Health Practitioner: _____