

Date \_\_\_\_\_

**PATIENT INFORMATION**

Name \_\_\_\_\_

(last) (First) (middle)  
By what name do you like to be called? Mr. Mrs. Ms. \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Birthplace \_\_\_\_\_ Male or Female (circle one)

Street Address \_\_\_\_\_  
(street name and number) (city) (state) (zip)

E-mail Address \_\_\_\_\_

Social Security Number \_\_\_\_\_

Person Responsible for Payment \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature \_\_\_\_\_

**Note:** We do not submit insurance. Out-of-pocket costs include clinic consultations, infusion clinic services and testing.

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's Address \_\_\_\_\_

In Emergency Notify \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Education: Years in High School \_\_\_\_\_ Years in College \_\_\_\_\_ Years Post Grad \_\_\_\_\_

Single: Yes \_\_\_\_\_ No \_\_\_\_\_ Married: Yes \_\_\_\_\_ No \_\_\_\_\_ How many times? \_\_\_\_\_

Widow (er): Yes \_\_\_\_\_ No \_\_\_\_\_ Divorced: Yes \_\_\_\_\_ No \_\_\_\_\_ How many times? \_\_\_\_\_

Weight: Now \_\_\_\_\_ One year ago \_\_\_\_\_ Maximum \_\_\_\_\_ When \_\_\_\_\_

Height: \_\_\_\_\_ feet \_\_\_\_\_ inches

Primary Care Doctor \_\_\_\_\_ Date of last physical exam \_\_\_\_/\_\_\_\_/\_\_\_\_

Phone \_\_\_\_\_

Address \_\_\_\_\_

Email \_\_\_\_\_

Pharmacy Name and Phone Number \_\_\_\_\_

Reason for visit:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Referred by:  Physician referral (*name*) \_\_\_\_\_  
 Friend or family  
 Other (please list below)

Please check the color that best describes your hair.  
 Brown  Black  Blonde  Red  White  Grey  Bald

Please check the color that best describes your eyes.  
 Blue  Brown  Green  Gray  Hazel

Please check which best describes your handedness.  
 Right-handed  Left-handed  Ambidextrous

Please check the body type that best describes yours.  
 Ectomorph (slim, rangy body type)  Endomorph (rounder, plumper body type)  Mesomorph (thicker, muscular body type)

**Please indicate any personal history below:**

**CONSTITUTIONAL SYMPTOMS:**

Good general health lately ..... Yes No  
Recent weight change..... Yes No  
Decreased appetite..... Yes No  
Fever/night sweats..... Yes No  
Fatigue/weakness..... Yes No  
Headaches..... Yes No

**EYES**

Eye disease or injury..... Yes No  
Wear glasses/contact lenses..... Yes No  
Blurred or double vision..... Yes No  
Glaucoma/cataracts ..... Yes No

**EARS/NOSE/THROAT**

Hearing loss or ringing..... Yes No  
Earaches or drainage..... Yes No  
Chronic sinus problems..... Yes No  
Nose bleeds..... Yes No  
Mouth sores..... Yes No  
Sore throat or voice change..... Yes No  
Swollen glands in neck..... Yes No

**CARDIOVASCULAR**

Heart trouble..... Yes No  
Chest pain or angina pectoris..... Yes No  
Palpitation..... Yes No  
Shortness of breath with walking or lying flat... Yes No  
Swelling of feet, ankles, or hands..... Yes No

**RESPIRATORY**

Chronic or frequent coughs..... Yes No  
Spitting up blood..... Yes No  
Shortness of breath..... Yes No  
Asthma or wheezing..... Yes No

**GASTROINTESTINAL**

Loss of appetite..... Yes No  
Change in bowel movements..... Yes No  
Nausea or vomiting..... Yes No  
Frequent diarrhea..... Yes No  
Painful bowel movements or constipation..... Yes No  
Rectal bleeding or blood in stool..... Yes No  
Abdominal pain..... Yes No  
Ulcer (stomach or duodenal)..... Yes No

**GENITOURINARY**

Frequent urination..... Yes No  
Burning or painful urination..... Yes No  
Awaken at night to urinate..... Yes No  
Blood in urine..... Yes No  
Change in force of stream when urinating..... Yes No  
Incontinence or dribbling..... Yes No  
Sores or discharge..... Yes No  
Kidney stones..... Yes No  
Sexual difficulty..... Yes No  
Male testicular pain/lumps..... Yes No  
Female – pain with periods..... Yes No  
Female – irregular periods..... Yes No  
Female – vaginal discharge..... Yes No  
Female – # of pregnancies..... Yes No  
Female – # of miscarriages..... Yes No  
Female – date of last pap smear..... Yes No

**MUSCULOSKELETAL**

Joint pain..... Yes No  
Joint stiffness or swelling..... Yes No  
Weakness of muscles of joints..... Yes No  
Muscle pain or cramps..... Yes No  
Back pain..... Yes No  
Difficulty in walking..... Yes No

**INTEGUMENTARY (skin, breast)**

Rash or itching..... Yes No  
Change in skin color..... Yes No  
Change in hair or nails..... Yes No  
Varicose veins..... Yes No  
Breast pain..... Yes No  
Breast lump..... Yes No  
Breast discharge..... Yes No

**NEUROLOGICAL**

Frequent or recurring headaches..... Yes No  
Light headed or dizzy..... Yes No  
Convulsions or seizures..... Yes No  
Shakes..... Yes No  
Paralysis..... Yes No  
Stroke..... Yes No  
Head injury..... Yes No

**PSYCHIATRIC**

Memory loss or confusion..... Yes No  
Nervousness..... Yes No  
Depression..... Yes No  
Difficulty sleeping..... Yes No

**ALLERGIC/IMMUNOLOGIC (continued)**

Other drugs/medications:

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Known food allergies:

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Environmental allergies:

Excessive exposure at home or work to:

Fumes?..... Yes No  
Dust?..... Yes No  
Solvents?..... Yes No  
Air Borne Particles?.. Yes No

Others: \_\_\_\_\_

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**SOCIAL HISTORY:**

Use of alcohol: Please circle answer: Never – On Occasion – Moderately - Daily

Use of tobacco: Please circle answer: Never – Previously But Quit – Currently Smoking - # of packs a day \_\_\_\_\_

Drugs: Please circle answer: Never – On Occasion – Moderately - Daily – Type \_\_\_\_\_/frequency \_\_\_\_\_

**Please rank your most troubling symptoms by level of concern to you.**

<b>PROBLEM</b>	<b>ONSET</b>	<b>FREQUENCY</b>	<b>SEVERITY</b>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____
9. _____	_____	_____	_____
10. _____	_____	_____	_____
11. _____	_____	_____	_____
12. _____	_____	_____	_____

What diagnosis or explanations have been given in the past?

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When was the last time you were in really good health? \_\_\_\_\_

Do you see yourself in good health again in the future? Yes or No

Please circle one of the following:

Taking everything into consideration, are you: much worse / worse / the same / better / much better than 6 months ago?

How much have you spent personally on medical treatment in the past 5 years? \_\_\_\_\_

How much has your insurance company spent on your medical treatment in the past 5 years? \_\_\_\_\_

What has happened to you as a consequence of your illness?

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What has happened to your family as a consequence of your illness?

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What is the relationship between what is happening in your life now and what was happening about a year ago?

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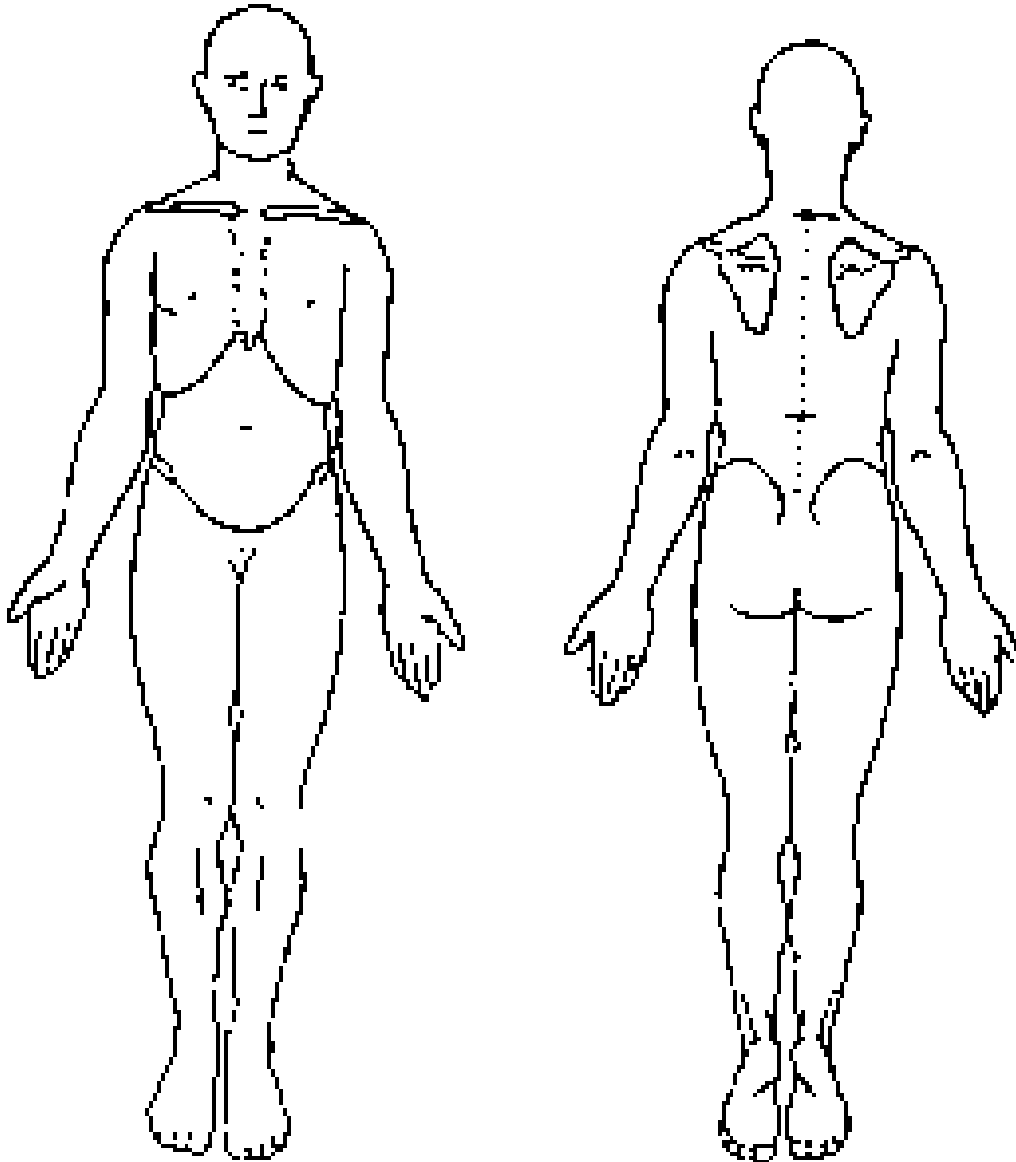
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How will you know you are better as the result of learning new strategies at The Program in Integrative Medicine?

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<p><b>OPERATIONS:</b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; text-align: center;"><u>When</u></td> <td style="width: 50%; text-align: center;"><u>When</u></td> </tr> <tr> <td>Tonsillectomy _____</td> <td>Appendectomy _____</td> </tr> <tr> <td>Hysterectomy _____</td> <td>Hernia _____</td> </tr> <tr> <td>Gall Bladder _____</td> <td>P.E. Tubes in ears _____</td> </tr> <tr> <td>1<sup>st</sup> Dental Filling _____</td> <td>1<sup>st</sup> Root Canal _____</td> </tr> <tr> <td>Other Surgeries _____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> </table>	<u>When</u>	<u>When</u>	Tonsillectomy _____	Appendectomy _____	Hysterectomy _____	Hernia _____	Gall Bladder _____	P.E. Tubes in ears _____	1 <sup>st</sup> Dental Filling _____	1 <sup>st</sup> Root Canal _____	Other Surgeries _____	_____	_____	_____	<p><b>DIAGNOSTIC STUDIES:</b></p> <p>When have you had a(n):</p> <p>Chest X-ray _____</p> <p>Mammogram _____</p> <p>EKG _____</p> <p>Sigmoidoscopy _____</p> <p>Colonoscopy _____</p> <p>Upper GI Series _____</p> <p>Barium Enema _____</p> <p><b>MRI Scan of:</b></p> <p>Brain _____</p> <p>Abdomen _____</p> <p>Spine _____</p> <p>Liver Scan _____</p> <p>Bone Scan _____</p> <p>Neck X-ray _____</p>
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<u>When</u>	<u>When</u>														
Head Injury _____	Broken _____														
Neck Injury _____	Broken _____														
Back Injury _____	_____														
Other: _____	_____														
_____	_____														



**Please mark the location(s) of your pain with an “x” on the diagram above. If whole areas are painful, please shade in the painful area.**

**How often do you have your pain?**

- Constantly (100% of the time)**
- Nearly constantly (60% to 95% of the time)**
- Intermittently (30% to 60% of the time)**
- Occasionally (less than 30% of the time)**



**FAMILY HISTORY**

Please complete the following information as it relates to your family's health history.

	If Living		If Deceased			If Living		If Deceased	
	Age	Health	Age at death	Cause		Age	Health	Age at death	Cause
<b>Father</b>					<b>Husband or Wife</b>				
<b>Mother</b>					<b>Son</b>				
<b>Brother</b>					<b>Daughter 1.</b>				
<b>Sister 1.</b>					<b>2.</b>				
<b>2.</b>					<b>3.</b>				
<b>3.</b>					<b>4.</b>				

Place an "X" in the appropriate column for any illnesses that your blood relatives have experienced. Take your time filling out this questionnaire and feel free to discuss these items with your family members.

ILLNESSES	Father	Mother	Brothers or Sisters	Grand-Parents	Children	ILLNESSES	Father	Mother	Brothers or Sisters	Grand-Parents	Children
Alcoholism						Undiagnosed Chronic Illness					
Allergies						Jaundice					
Anemia						Kidney or bladder problems					
Appendicitis						Meningitis					
Arthritis/Rheumatism						Menstrual Problems					
Asthma						Mental Illness					
Bleeding						Miscarriage or Spontaneous Abortion					
Blood pressure- High						Neuritis or Neuralgia					
Blood pressure- Low						Obesity					
Bronchitis- Chronic						Pleurisy					
Bursitis, Sciatica, Lumbago						Pneumonia					
Cancer						Polio					
Cholesterol- Too High						Prostate Problems					
Cirrhosis						Rheumatic Fever					
Colon problem						Skin Problems					
Physical Abnormalities/ Birth Defects						Stroke					
Convulsions						Stomach or Small Intestinal Disease					
Depression						Suicide- Attempt or Successful					
Diabetes						Surgeries					
Emphysema						Teeth/Gum problems					
Gall Bladder Disease						Transfusions					
Headache						Triglycerides- Too High					
Heart Problem						Tuberculosis					
Hepatitis						Ulcers					
Hernia						Vaginal Problems					
Hemorrhoids						Varicose Veins					
Hypoglycemia						Veneral Disease					

### CURRENT SYMPTOM PROFILE

Please circle the dot that best approximates how you've been feeling for the past month on each symptom listed below.  
 Use margins for comments.

	Health ←-----→	Disease
1. Energetic	• • • • • • •	Fatigued
2. Headache-free	• • • • • • •	Headaches
3. Migraine-free	• • • • • • •	Migraines
4. Anger-free	• • • • • • •	Angry often
5. No fluid retention	• • • • • • •	Fluid retention
6. Calm	• • • • • • •	Anxious
7. Confident	• • • • • • •	Panicky
8. Healthy hair	• • • • • • •	Hair loss
9. Depression-free	• • • • • • •	Depressed
10. Good memory	• • • • • • •	Poor memory
11. Good concentration	• • • • • • •	Can't concentrate
12. Sexual function OK	• • • • • • •	Sexual dysfunction
13. Healthy nails	• • • • • • •	Nail abnormalities
14. Strong motivation	• • • • • • •	Low motivation
15. BM 1 to 3 times/day	• • • • • • •	Constipation
16. Healthy bowels	• • • • • • •	Bowel spasms / diarrhea
17. Healthy weight	• • • • • • •	Overweight
18. Healthy skin	• • • • • • •	Dry skin
19. Good sleep	• • • • • • •	Insomnia
20. Daytime alertness	• • • • • • •	Daytime drowsiness
21. Healthy joints	• • • • • • •	Joint dysfunction
22. Allergy-free	• • • • • • •	Allergies
23. Breath freely	• • • • • • •	Wheezing

**Health ←-----→ Disease**

24. Adequate breath	•	•	•	•	•	•	•	Short of breath
25. Good muscle tone	•	•	•	•	•	•	•	Muscle spasms
26. Itch-free	•	•	•	•	•	•	•	Itchiness
27. Normal cholesterol	•	•	•	•	•	•	•	High cholesterol
28. Strong stomach	•	•	•	•	•	•	•	Gastric pains
29. Nicotine-free	•	•	•	•	•	•	•	Nicotine user
30. Caffeine-free	•	•	•	•	•	•	•	Caffeine user
31. Healthy throat	•	•	•	•	•	•	•	Sore throat
32. Normal sweat	•	•	•	•	•	•	•	Too much or too little sweat
33. Normal body odor	•	•	•	•	•	•	•	Offensive body odor
34. Tolerate cold well	•	•	•	•	•	•	•	Cold intolerant
35. Blood pressure OK	•	•	•	•	•	•	•	Blood pressure high
36. Resistant to colds	•	•	•	•	•	•	•	Over 4 colds a year
37. Normal urination	•	•	•	•	•	•	•	Urination difficulty
38. Normal balance	•	•	•	•	•	•	•	Dizzy, imbalanced
39. No ringing in ears	•	•	•	•	•	•	•	Ringing in ears
40. Heal quickly	•	•	•	•	•	•	•	Heal slowly
41. Rarely bruise	•	•	•	•	•	•	•	Bruise easily
42. Stable body heat	•	•	•	•	•	•	•	Hot flashes/flushing
43. Warm hands/feet	•	•	•	•	•	•	•	Cold hands/feet
44. Skin is clear	•	•	•	•	•	•	•	Rashes, acne
45. Swallow easily	•	•	•	•	•	•	•	Difficulty swallowing
46. Good skin color	•	•	•	•	•	•	•	Pale, poor color
47. Alert after eating	•	•	•	•	•	•	•	Drowsy after eating
48. Clear vision	•	•	•	•	•	•	•	Poor vision
49. See well at night	•	•	•	•	•	•	•	Poor night vision

**Health ←-----→ Disease**

50. No hives	•	•	•	•	•	•	•	Hives
51. Fresh breath	•	•	•	•	•	•	•	Bad breath
52. Regular heartbeat	•	•	•	•	•	•	•	Irregularities
53. Dream recall	•	•	•	•	•	•	•	No dream recall
54. Healthy mouth	•	•	•	•	•	•	•	Mouth/lip sores
55. Digest well	•	•	•	•	•	•	•	Indigestion, bloating
56. Normal sensations	•	•	•	•	•	•	•	Numbness or burning
57. Sinuses clear	•	•	•	•	•	•	•	Sinus congestion
58. Healthy tongue	•	•	•	•	•	•	•	Sore tongue
59. Hands are steady	•	•	•	•	•	•	•	Shakiness, tremor
60. Feel strong	•	•	•	•	•	•	•	Weakness
61. Normal nails	•	•	•	•	•	•	•	White spots on nails
62. Healthy jaws	•	•	•	•	•	•	•	Jaw pain
63. Healthy back	•	•	•	•	•	•	•	Back pain
64. Normal thirst	•	•	•	•	•	•	•	Excessive thirst
65. Healthy gums	•	•	•	•	•	•	•	Bleeding, sore gums
66. Normal teeth	•	•	•	•	•	•	•	Loose teeth
67. Eyes comfortable	•	•	•	•	•	•	•	Eyes dry, irritated
68. Normal taste/smell	•	•	•	•	•	•	•	Diminished taste/smell
69. Legs relaxed	•	•	•	•	•	•	•	Restless legs
70. Bright lights OK	•	•	•	•	•	•	•	Bright lights bother
71. Normal voice	•	•	•	•	•	•	•	Hoarseness
72. Restful sleep	•	•	•	•	•	•	•	Wake up tired
73. Ache free muscles	•	•	•	•	•	•	•	Muscles ache
74. No craving for sugar	•	•	•	•	•	•	•	Often crave sugar
75. No craving for salt	•	•	•	•	•	•	•	Often crave salt
76. Normal appetite for bread	•	•	•	•	•	•	•	Often crave bread
77. No craving for chocolate	•	•	•	•	•	•	•	Often crave chocolate





**Health ←-----→ Disease**

- |  |   |   |   |   |   |   |   |   |
|--|---|---|---|---|---|---|---|---|
| 30. Laugh several times a day              | • | • | • | • | • | • | • | Seldom laugh                                |
| 31. Compliment others regularly            | • | • | • | • | • | • | • | Almost never compliment others              |
| 32. Listen to body signals                 | • | • | • | • | • | • | • | Try to ignore body signals                  |
| 33. Stop eating when comfortably satisfied | • | • | • | • | • | • | • | Consistently overeat                        |
| 34. Read health-related articles daily     | • | • | • | • | • | • | • | Seldom read health related literature       |
| 35. Ask doctor questions when curious      | • | • | • | • | • | • | • | Afraid to ask doctor questions when curious |
| 36. Take time to evaluate and plan ahead   | • | • | • | • | • | • | • | Rushed and seldom take time to plan ahead   |

List important health behaviors you have done recently, which were omitted above:

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### Diagnosis Profile

1. If you have ever been diagnosed with any of the items listed below, please indicate the approximate date the diagnosis was made.
2. If you are currently still having problems resulting from the disease diagnosed, please indicate how severe those difficulties are by circling the dot which best represents that severity.

Understanding the seven dot scale:

No problem	(•)	•	•	•	•	•	•
Moderate problem	•	•	(•)	•	•	•	•
Moderately severe problem	•	•	•	•	(•)	•	•
Severe Problem	•	•	•	•	•	•	(•)

#### Year of Onset

#### Current Severity

None Severe

_____ Achlorhydria	•	•	•	•	•	•	•
_____ Acne	•	•	•	•	•	•	•
_____ Alcoholism	•	•	•	•	•	•	•
_____ Alcoholism in Remission	•	•	•	•	•	•	•
_____ Allergy, Unknown Origin	•	•	•	•	•	•	•
_____ Alzheimers	•	•	•	•	•	•	•
_____ Amebiasis	•	•	•	•	•	•	•
_____ Anemia, Iron Deficiency	•	•	•	•	•	•	•
_____ Anemia, General	•	•	•	•	•	•	•
_____ Angina	•	•	•	•	•	•	•
_____ Anxiety Disorder	•	•	•	•	•	•	•
_____ Arrhythmia	•	•	•	•	•	•	•
_____ Arteriosclerosis	•	•	•	•	•	•	•
_____ Arthritis	•	•	•	•	•	•	•
_____ Arthritis, Allergic	•	•	•	•	•	•	•
_____ Arthritis, Psoriatic	•	•	•	•	•	•	•
_____ Arthritis, Rheumatoid	•	•	•	•	•	•	•
_____ Asthma	•	•	•	•	•	•	•
_____ Back Pain	•	•	•	•	•	•	•
_____ Blood Pressure-High	•	•	•	•	•	•	•



**Year of Onset**

**Current Severity**

None

Severe

_____ Headache, Tension	•	•	•	•	•	•	•
_____ Heart Disease	•	•	•	•	•	•	•
_____ Heavy Metal Poisoning	•	•	•	•	•	•	•
_____ Hepatitis	•	•	•	•	•	•	•
_____ Hypercholesterolemia	•	•	•	•	•	•	•
_____ Hyperthyroid	•	•	•	•	•	•	•
_____ Hypochlorhydria	•	•	•	•	•	•	•
_____ Hypoglycemia	•	•	•	•	•	•	•
_____ Intestinal Candidiasis	•	•	•	•	•	•	•
_____ Intestinal Malabsorption	•	•	•	•	•	•	•
_____ Intestinal Parasites	•	•	•	•	•	•	•
_____ Irritable Bowel Syndrome	•	•	•	•	•	•	•
_____ Lead Poisoning	•	•	•	•	•	•	•
_____ Lumbar Sprain	•	•	•	•	•	•	•
_____ Lupus	•	•	•	•	•	•	•
_____ Manic Depressive	•	•	•	•	•	•	•
_____ Mitral Valve Prolapse	•	•	•	•	•	•	•
_____ Multiple Sclerosis	•	•	•	•	•	•	•
_____ Myositis	•	•	•	•	•	•	•
_____ Nearsightedness	•	•	•	•	•	•	•
_____ Nervousness	•	•	•	•	•	•	•
_____ Obesity	•	•	•	•	•	•	•
_____ Osteoarthritis	•	•	•	•	•	•	•
_____ Panic Attacks	•	•	•	•	•	•	•
_____ Parasitic Disease NEC	•	•	•	•	•	•	•
_____ Phlebitis	•	•	•	•	•	•	•
_____ Pneumonia	•	•	•	•	•	•	•
_____ Premenstrual Syndrome	•	•	•	•	•	•	•



**BODY-MIND PROFILE**

**SDS**

Below are 20 statements. Please rate each one using the following scale

- 1 = Never or little of the time**
- 2 = Some of the time**
- 3 = Good part of the time**
- 4 = Most or all of the time**

Please record your rating in the space to the left of each item.

- \_\_\_\_\_ 1. I feel down-hearted, blue, and sad.
- \_\_\_\_\_ 2. Morning is when I feel the best.
- \_\_\_\_\_ 3. I have crying spells or feel like it.
- \_\_\_\_\_ 4. I have trouble sleeping through the night.
- \_\_\_\_\_ 5. I eat as much as I used to.
- \_\_\_\_\_ 6. I enjoy looking at, talking to, and being with attractive women/men.
- \_\_\_\_\_ 7. I notice that I am losing weight.
- \_\_\_\_\_ 8. I have trouble with constipation.
- \_\_\_\_\_ 9. My heart beats faster than usual.
- \_\_\_\_\_ 10. I get tired for no reason.
- \_\_\_\_\_ 11. My mind is as clear as it used to be.
- \_\_\_\_\_ 12. I find it easy to do the things I used to do.
- \_\_\_\_\_ 13. I am restless and cannot keep still.
- \_\_\_\_\_ 14. I feel hopeful about the future.
- \_\_\_\_\_ 15. I am more irritable than usual.
- \_\_\_\_\_ 16. I find it easy to make decisions.
- \_\_\_\_\_ 17. I feel that I am useful and needed.
- \_\_\_\_\_ 18. My life is pretty full.
- \_\_\_\_\_ 19. I feel that others would be better off if I were dead.
- \_\_\_\_\_ 20. I still enjoy the things I used to enjoy.

### SAS

Below are 20 statements. Please rate each one using the following scale:

- |  |                                    |
|--|------------------------------------|
| <b>1 = Never or little of the time</b> | <b>3 = Good part of the time</b>   |
| <b>2 = Some of the time</b>            | <b>4 = Most or all of the time</b> |

Please record your rating in the space to the left of each item.

- \_\_\_\_\_ 1. I feel more nervous and anxious than usual.
- \_\_\_\_\_ 2. I feel afraid for no reason at all.
- \_\_\_\_\_ 3. I get upset easily or feel panicky.
- \_\_\_\_\_ 4. I feel like I am falling apart and going to pieces.
- \_\_\_\_\_ 5. I feel that everything is all right and nothing bad will happen.
- \_\_\_\_\_ 6. My arms and legs shake and tremble.
- \_\_\_\_\_ 7. I am bothered by headaches, neck, and back pains.
- \_\_\_\_\_ 8. I feel weak and get tired easily.
- \_\_\_\_\_ 9. I feel calm and can sit still easily.
- \_\_\_\_\_ 10. I can feel my heart beating fast.
- \_\_\_\_\_ 11. I am bothered by dizzy spells.
- \_\_\_\_\_ 12. I have fainting spells or feel like it.
- \_\_\_\_\_ 13. I can breath in and out easily.
- \_\_\_\_\_ 14. I get feelings of numbness and tingling in my fingers and/or toes.
- \_\_\_\_\_ 15. I am bothered by stomach aches or indigestion.
- \_\_\_\_\_ 16. I have to empty my bladder often.
- \_\_\_\_\_ 17. My hands are usually dry and warm.
- \_\_\_\_\_ 18. My face gets hot and blushes.
- \_\_\_\_\_ 19. I fall asleep easily and get a good night's rest.
- \_\_\_\_\_ 20. I have nightmares.

### SWLS

Below are five statements with which you may agree or disagree. Using the scale below, indicate your level of agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding.

- |                                       |                           |
|---------------------------------------|---------------------------|
| <b>1 = Strongly disagree</b>          | <b>5 = Slightly agree</b> |
| <b>2 = Disagree</b>                   | <b>6 = Agree</b>          |
| <b>3 = Slightly disagree</b>          | <b>7 = Strongly agree</b> |
| <b>4 = Neither agree nor disagree</b> |                           |

- \_\_\_\_\_ 1. In most ways my life is close to my ideal.
- \_\_\_\_\_ 2. The conditions of my life are excellent.
- \_\_\_\_\_ 3. I am satisfied with my life.
- \_\_\_\_\_ 4. So far I have gotten the important things I want in life.
- \_\_\_\_\_ 5. If I could live my life over, I would change almost nothing.

### SRMI

Below is a list of words which people use to describe how they feel at different times. Please select and write down the word that best describes how you feel at this moment in the blank just below. So that you will become familiar with the general range of feeling that the list represents, please read carefully the entire list before making your selection. Again, write down only one word—the one that best describes how you feel at this moment.

1. \_\_\_\_\_ (Current Moment Feeling)

- |                |                       |
|----------------|-----------------------|
| 1. Numb        | 12. Grateful          |
| 2. Encouraged  | 13. Helpless/Hopeless |
| 3. Angry       | 14. Calm              |
| 4. Satisfied   | 15. Lonely            |
| 5. Awe         | 16. Comfortable       |
| 6. Sad         | 17. Anxious           |
| 7. Happy       | 18. Hurt              |
| 8. Guilty      | 19. Panic             |
| 9. Rejected    | 20. Joy               |
| 10. Ecstasy    | 21. Depressed         |
| 11. Frustrated |                       |

Use the same list of words above which people use to describe how they feel at different times. This time please select and write down the five words which best describe the predominant feelings you have had during the past two weeks. Please write them in the five blanks provided below. List the most frequent feeling first, the second most frequent feeling second, and so on.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

(Dominant Feelings Past Two Weeks)

4. \_\_\_\_\_

5. \_\_\_\_\_

Please list below the five words which best describe the feelings which have normally been predominant for most of your life.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

(Dominant Feelings Most of Life)

4. \_\_\_\_\_

5. \_\_\_\_\_

## FSS-2

Most all people have some things they fear to various degrees. Some people have lots of fears; others have very few. Below are 51 different stimuli which can cause fear in people. Please rate how much fear you feel using the following rating scale and record your answer in the space provided.

- 1 = None**
- 2 = Very little fear**
- 3 = A little fear**
- 4 = Some fear**
- 5 = Much fear**
- 6 = Very much fear**
- 7 = Terror**

- |  |   |
|--|---|
| _____ 1. Sharp objects                       | _____ 27. Being with drunks                       |
| _____ 2. Being a passenger in a car          | _____ 28. Illness or injury to loved ones         |
| _____ 3. Dead bodies                         | _____ 29. Being self-conscious                    |
| _____ 4. Suffocating                         | _____ 30. Driving a car                           |
| _____ 5. Failing a test                      | _____ 31. Meeting authority                       |
| _____ 6. Looking foolish                     | _____ 32. Mental Illness                          |
| _____ 7. Being a passenger in an airplane    | _____ 33. Closed spaces                           |
| _____ 8. Worms                               | _____ 34. Boating                                 |
| _____ 9. Arguing with parents                | _____ 35. Spiders                                 |
| _____ 10. Rats and mice                      | _____ 36. Thunderstorms                           |
| _____ 11. Life after death                   | _____ 37. Not being a success                     |
| _____ 12. Hypodermic needles                 | _____ 38. God                                     |
| _____ 13. Being criticized                   | _____ 39. Snakes                                  |
| _____ 14. Meeting someone for the first time | _____ 40. Cemeteries                              |
| _____ 15. Roller coasters                    | _____ 41. Speaking before a group                 |
| _____ 16. Being alone                        | _____ 42. Seeing a flight                         |
| _____ 17. Making mistakes                    | _____ 43. Death of a loved one                    |
| _____ 18. Being misunderstood                | _____ 44. Dark places                             |
| _____ 19. Death                              | _____ 45. Strange dogs                            |
| _____ 20. Being in a fight                   | _____ 46. Deep water                              |
| _____ 21. Crowded places                     | _____ 47. Being with a member of the opposite sex |
| _____ 22. Blood                              | _____ 48. Stinging insects                        |
| _____ 23. Heights                            | _____ 49. Untimely or early death                 |
| _____ 24. Being a leader                     | _____ 50. Losing a job                            |
| _____ 25. Swimming alone                     | _____ 51. Auto accidents                          |
| _____ 26. Illness                            |   |

**I, Dr. \_\_\_\_\_ have reviewed this questionnaire on \_\_\_\_/\_\_\_\_/\_\_\_\_.**