**General Health**:............................\_\_excellent \_\_ good \_\_fair \_\_poor

Magic Wand: Imagine you had a magic wand and could change three things about yourself and your life. What would they be?

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

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

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

**Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_**employed \_\_unemployed \_\_retired \_\_\_\_\_\_\_\_\_\_\_\_
Do you feel stressed at work? yes no

if yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Exercise**: Do you exercise?...... \_\_No \_\_1 - 3 times per week? \_\_more than 3 times per week?
What kind of exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Spiritual Life:**

Is there a particular spiritual practice or belief system that is meaningful to you?.................... yes no

Name or Description (optional): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Daily Nutrition**

1. On average, how many times do you eat fast food in a week?

Never 1 2 3 4 5 6+

1. How often do you drink or eat any dairy product in a week i.e milk, cheese, yogurt?

Never 1 2 3 4 5 6+

1. How often do you eat meat in a **week** i.e. beef, pork, chicken, fish ?

Never 1 2 3 4 5 6+

1. How often do you eat grain in a **week** i.e. bread, rice, pasta, crackers, cereal?

Never 1 2 3 4 5 6+

1. Do you eat organic ? Yes or No

How many times in a **week**? 1 2 3 4 5 6+

1. Do you drink caffeinated beverage? Yes or No

How many cups per **day** of: Coffee \_\_\_\_\_\_ Tea \_\_\_\_\_\_ Soda \_\_\_\_\_\_

1. How many sports drinks, flavored water, juice per **day** ?

Never 1 2 3 4 5 6+

1. How many servings of fruits and vegetables do you eat in a **day**?

Never 1 2 3 4 5 6+

1. How many times do you treat yourself in a **week** with candy or sweets?

Never 1 2 3 4 5 6+

**Stress**:
Do you feel stress is a problem in your life..............................................................................yes no

Are you currently providing care for a disabled or elderly family member?............................. yes no

 Do you have concerns about your children or your relationship with them?.......................... yes no

Are you afraid of your own temper or that of anyone else in your family?............................. yes no

Do you have problems with getting angry frequently or at little things?................................ yes no

 Do you sometimes feel out of control?................................................................................. yes no

Do you sometimes feel you are no good or you can’t do anything right?..................................yes no

 Have you ever thought about or tried to commit suicide.........................................................yes no

Does someone you live with have serious health or emotional problem ................................ yes no

Have you or anyone on your block been shot or mugged in the last year?................................yes no

Is there any history of violence in your family?........................................................................yes no

Has anyone close to you ever physically hit you or hurt you?..................................................yes no

Do you feel unsafe in your current relationship?......................................................................yes no

Is there a partner from a previous relationship who is making you feel unsafe now?..................yes no

**Social Support**:
How do you deal with conflict in your family? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who provides you with emotional support (family, close friend, religious advisor, other)?

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

**Other provider involved in your care:** Do you see other health care providers other than your primary doctor (such as a therapist, other physicians chiropractors, accupuncturists, naturopaths, herbalists, etc.) on a regular basis? yes no

Who do you see? Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Profession \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like your integrative provider here to consult with/coordinate your care with your other provider(s)?

yes no