



OKULEY'S PHARMACY

Medical Equipment • Specialty Medications

CONSULTANT PHARMACIST AGREEMENT

for

New Patients Starting General Wellness Program

Okuley's offers an ongoing wellness consultation service for women and men who are interested in improving their general health.

A consulting fee of \$100.00 for a one-hour session will be charged to you the day of your initial consultation. This fee covers services you receive with our clinical pharmacists including: initial work-up and consultation with you and your physician. This is a special program to promote balance and well-being. You will be asked to make follow-up visits 1, 3, 6, and 12 months after starting therapy. Each follow-up visit carries a fee of \$50.00 and lasts up to 30 minutes. Follow-up visits are needed to adjust therapies and ensure you are experiencing optimum health.

We will provide you with an official medical receipt for insurance purposes. Please be advised that your insurance may or may not pay some or all of your prescription and/or consultation fees.

Okuley's Pharmacy New Patient Information

Date: _____

Patient Information

Name: _____

Address: _____

Phone number: _____

Date of Birth: _____

Doctor's Information

Name: _____ Phone Number: _____

Medication Information

Allergies:

Allergic to What	Reaction

Current Medications:

Medication	Strength	Medication	Strength

Herbal/Over-the-Counter/Nutritional Products:

Product	Taken How Often	Product	Taken How Often

Diseases/Conditions

Disease/Condition	Year Diagnosed	Disease/Condition	Year Diagnosed

**Please provide your prescription insurance card before we fill your prescription*

Do You Have Tired Adrenals?

If you answer yes to 3 or more of these questions, you may have some degree of adrenal burnout:

1. Do you often feel tired for “no reason”?
2. Do you have trouble waking up in the morning?
3. Do you need coffee or caffeinated colas to keep you going?
4. Do you feel run down and/or stressed?
5. Do you crave salty or sweet snacks?
6. Are you struggling to keep up with life’s daily demands?
7. Are you able to bounce back from stress or illness?
8. Are you not having fun anymore?
9. Is your sex drive decreased?
10. Do you have difficulty falling/staying asleep or do you have trouble shutting your mind off at night?
11. Do you have vivid nightmares or dreams?
12. Do you have low blood pressure (lower than 110 for the top number and lower than 70 for the bottom number)?
13. Do you feel as if you could take a nap every day after lunch?
14. Do you eat at least one processed or sweetened food with each meal or do you frequently skip meals?
15. Are your pupils normally dilated during the day?
16. Do you seem to get sick or suffer from allergies more frequently than before?
17. Do you feel pressured or rushed often during the day?
18. Do you experience lightheadedness, mood swings or headaches if you go more than 4 to 6 hours between meals?

Thyroid Symptom Assessment

Please check all symptoms that apply:

- | | |
|--|---|
| <input type="checkbox"/> Fatigue (especially in evening) | <input type="checkbox"/> Heat Intolerance |
| <input type="checkbox"/> Dry, Coarse, or Itchy Skin | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Scalp Hair Loss | <input type="checkbox"/> Moist Skin |
| <input type="checkbox"/> Dry, Coarse, or Thinning Hair | <input type="checkbox"/> Increased Sweating |
| <input type="checkbox"/> Memory Lapses | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Thinning Eyebrows | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Brittle Hair |
| <input type="checkbox"/> Poor Concentration | <input type="checkbox"/> Thinning of Skin |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Trouble Sleeping |
| <input type="checkbox"/> Cold Feeling in Extremities | |
| <input type="checkbox"/> General Aches and Pains | |
| <input type="checkbox"/> Brittle Nails | |
| <input type="checkbox"/> Heart Palpitations | |
| <input type="checkbox"/> Low Stamina | |
| <input type="checkbox"/> Cold Intolerance | |
| <input type="checkbox"/> Swollen or Puffy Eyes | |
| <input type="checkbox"/> High Cholesterol | |
| <input type="checkbox"/> Upper Eyelid Drop | |
| <input type="checkbox"/> Low Libido | |
| <input type="checkbox"/> Depression | |
| <input type="checkbox"/> Low Heart Rate/Blood Pressure | |
| <input type="checkbox"/> Constipation | |
| <input type="checkbox"/> Low Body Temperature | |
| <input type="checkbox"/> Weight Gain | |
| <input type="checkbox"/> Increased Swelling | |
| <input type="checkbox"/> Infertility | |



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Retail Prescriptions

Physician Medical Release Authorization

"I hereby authorize my Physician to furnish and agent of Okuley's Pharmacy and Home Medical any and all records pertaining to my medical history, services rendered and/or treatments. I understand that employees of Okuley's Pharmacy and Home Medical will protect my privacy and this information will be released to other health care professionals only when it is necessary in order to provide health care services to me. I further understand that an Okuley's Pharmacy and Home Medical employee will not release this information unless authorized by me in writing. This authority shall continue until revoked by me in writing."

Physician Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Patient Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Signature: _____

Patient Name:	SS#:
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PHOTO CONSENT

**I freely give my consent to have my picture taken
and be used by Okuley's Pharmacy and Home Medical
for my patient file.**

Printed Name: _____

Signature: _____

Date: _____

Witness: _____

HEALTH APPRAISAL QUESTIONNAIRE

Name _____ Date _____

DIRECTIONS

This questionnaire asks you to assess how you have been feeling **during the last four months**. This information will help you keep track of how your physical, mental and emotional states respond to changes you make in your eating habits, priorities, supplement program, social and family life, level of physical activity and time spent on personal growth. All information is held in strict confidence. Take all the time you need to complete this questionnaire.

For each question, circle the number that best describes your symptoms:

0 = No or Rarely—You have never experienced the symptom or the symptom is familiar to you but you perceive it as insignificant (monthly or less)

1 = Occasionally—Symptom comes and goes and is linked in your mind to stress, diet, fatigue or some identifiable trigger

4 = Often—Symptom occurs 2-3 times per week and/or with a frequency that bothers you enough that you would like to do something about it

8 = Frequently—Symptom occurs 4 or more times per week and/or you are aware of the symptom every day, or it occurs with regularity on a monthly or cyclical basis

Some questions require a YES or NO response: 0 = NO 8 = YES

PART I		No/Rarely Occasionally Often Frequently
SECTION A		
1. Indigestion, food repeats on you after you eat	0	1 4 8
2. Excessive burping, belching and/or bloating following meals	0	1 4 8
3. Stomach spasms and cramping during or after eating	0	1 4 8
4. A sensation that food just sits in your stomach creating uncomfortable fullness, pressure and bloating during or after a meal	0	1 4 8
5. Bad taste in your mouth	0	1 4 8
6. Small amounts of food fill you up immediately	0	1 4 8
7. Skip meals or eat erratically because you have no appetite	0	1 4 8
Total points		
SECTION B		
1. Strong emotions, or the thought or smell of food aggravates your stomach or makes it hurt	0	1 4 8
2. Feel hungry an hour or two after eating a good-sized meal	0	1 4 8
3. Stomach pain, burning and/or aching over a period of 1-4 hours after eating	0	1 4 8
4. Stomach pain, burning and/or aching relieved by eating food; drinking carbonated beverages, cream or milk; or taking antacids	0	1 4 8
5. Burning sensation in the lower part of your chest, especially when lying down or bending forward	0	1 4 8
6. Digestive problems that subside with rest and relaxation	(0)No	(8)Yes
7. Eating spicy and fatty (fried) foods, chocolate, coffee, alcohol, citrus or hot peppers causes your stomach to burn or ache	0	1 4 8
8. Feel a sense of nausea when you eat	0	1 4 8
9. Difficulty or pain when swallowing food or beverage	0	1 4 8
Total points		
SECTION C		
1. When massaging under your rib cage <i>on your left side</i> , there is pain, tenderness or soreness	0	1 4 8
2. Indigestion, fullness or tension in your abdomen is delayed, occurring 2-4 hours after eating a meal	0	1 4 8
3. Lower abdominal discomfort is relieved with the passage of gas or with a bowel movement	0	1 4 8
4. Specific foods/beverages aggravate indigestion	0	1 4 8
5. The consistency or form of your stool changes (e.g., from narrow to loose) within the course of a day	0	1 4 8
SECTION C (cont.)		
6. Stool odor is embarrassing	0	1 4 8
7. Undigested food in your stool	0	1 4 8
8. Three or more large bowel movements daily	0	1 4 8
9. Diarrhea (frequent loose, watery stool)	0	1 4 8
10. Bowel movement shortly after eating (within 1 hour)	0	1 4 8
Total points		
SECTION D		
1. Discomfort, pain or cramps in your colon (lower abdominal area)	0	1 4 8
2. Emotional stress and/or eating raw fruits and vegetables causes abdominal bloating, pain, cramps or gas	0	1 4 8
3. Generally constipated (or straining during bowel movements)	0	1 4 8
4. Stool is small, hard and dry	0	1 4 8
5. Pass mucus in your stool	0	1 4 8
6. Alternate between constipation and diarrhea	0	1 4 8
7. Rectal pain, itching or cramping	0	1 4 8
8. No urge to have a bowel movement	(0)No	(8)Yes
9. An almost continual need to have a bowel movement	(0)No	(8)Yes
Total points		
PART II		
1. When massaging under your rib cage <i>on your right side</i> , there is pain, tenderness or soreness	0	1 4 8
2. Abdominal pain worsens with deep breathing	0	1 4 8
3. Pain at night that may move to your back or right shoulder	0	1 4 8
4. Bitter fluid repeats after eating	0	1 4 8
5. Feel abdominal discomfort or nausea when eating rich, fatty or fried foods	0	1 4 8
6. Throbbing temples and/or dull pain in forehead associated with overeating	0	1 4 8
7. Unexplained itchy skin that's worse at night	0	1 4 8
8. Stool color alternates from clay colored to normal brown	0	1 4 8
9. General feeling of poor health	0	1 4 8

PART II

	No/Rarely	Occasionally	Often	Frequently
10. Aching muscles not due to exercise	0	1	4	8
11. Retain fluid and feel swollen around the abdominal area	0	1	4	8
12. Reddened skin, especially palms	0	1	4	8
13. Very strong body odor,	0	1	4	8
14. Are you embarrassed by your breath?	0	1	4	8
15. Bruise easily	(0)No	(8)Yes		
16. Yellowish cast to eyes	(0)No	(8)Yes		

Total points**PART III****SECTION A**

1. Feel cold or chilled—hands, feet or all over—for no apparent reason	0	1	4	8
2. Your upper eyelids look swollen	0	1	4	8
3. Muscles are weak, cramp and/or tremble	0	1	4	8
4. Are you forgetful?	0	1	4	8
5. Do you feel like your heart beats slowly?	0	1	4	8
6. Reaction time seems slowed down	0	1	4	8
7. In general, are you disinterested in sex because your desire is low?	0	1	4	8
8. Feel slow-moving, sluggish	0	1	4	8
9. Constipation	0	1	4	8
10. Dryness, discoloration of skin and/or hair	(0)No	(8)Yes		
11. Have you noticed recently that your voice is deepening?	(0)No	(8)Yes		
12. Thick, brittle nails	(0)No	(8)Yes		
13. Weight gain for no apparent reason	(0)No	(8)Yes		
14. Outer third of your eyebrow is thinning or disappearing	(0)No	(8)Yes		
15. Swelling of the neck	(0)No	(8)Yes		

Total points**SECTION B**

1. Lingering mild fatigue after exertion or stress	0	1	4	8
2. Do you find that you get tired and exhaust easily?	0	1	4	8
3. Craving for salty foods	0	1	4	8
4. Sensitive to minor changes in weather and surroundings	0	1	4	8
5. Dizzy when rising or standing up from a kneeling position	0	1	4	8
6. Dark bluish or black circles under your eyes	0	1	4	8
7. Have bouts of nausea with or without vomiting	0	1	4	8
8. Catch colds or infections easily	(0)No	(8)Yes		
9. Wounds heal slowly	(0)No	(8)Yes		
10. Your body or parts of your body feel tender, sore, sensitive to the touch, hot and/or painful	0	1	4	8
11. Feel puffy and swollen all over your body	0	1	4	8
12. Skin is gradually tanning without exposure to sun or the ingestion of high levels of carotene-rich foods (e.g., daily carrot juice intake) or supplements	(0)No	(8)Yes		

Total points**PART IV**

	No/Rarely	Occasionally	Often	Frequently
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SECTION A

When you miss meals or go without food for extended periods of time, do you experience any of the following symptoms?

1. A sense of weakness	0	1	4	8
2. A sudden sense of anxiety when you get hungry	0	1	4	8
3. Tingling sensation in your hands	0	1	4	8
4. A sensation of your heart beating too quickly or forcefully	0	1	4	8
5. Shaky, jittery, hands trembling	0	1	4	8
6. Sudden profuse sweating and/or your skin feels clammy	0	1	4	8
7. Nightmares possibly associated with going to bed on an empty stomach	0	1	4	8
8. Wake up at night feeling restless	0	1	4	8
9. Agitation, easily upset, nervous	0	1	4	8
10. Poor memory, forgetful	0	1	4	8
11. Confused or disoriented	0	1	4	8
12. Dizzy, faint	0	1	4	8
13. Cold or numb	0	1	4	8
14. Mild headaches or head pounding	0	1	4	8
15. Blurred vision or double vision	0	1	4	8
16. Feel clumsy and uncoordinated	0	1	4	8

Total points**SECTION B**

1. Frequent urination during the day and night	0	1	4	8
2. Unusual thirst—feeling like you can't drink enough water	0	1	4	8
3. Unusual hunger—eating all the time	0	1	4	8
4. Vision blurs	0	1	4	8
5. Feel itchy all over	0	1	4	8
6. Tingling or numbness in your feet	0	1	4	8
7. Sense of drowsiness, lethargy during the day not associated with missing meals or not sleeping	0	1	4	8
8. Eating starchy foods, even if they are healthy and unprocessed (like rice, corn, beans, whole wheat or oats), causes you to gain weight or prevents you from losing weight	(0)No	(8)Yes		
9. Sores heal slowly	(0)No	(8)Yes		
10. Loss of hair on your legs	(0)No	(8)Yes		

Total points**PART V****SECTION A**

1. Feel jittery	0	1	4	8
2. First effort of the day causes pain, pressure, tightness or heaviness around the chest	0	1	4	8
3. Exhaustion with minor exertion	0	1	4	8
4. Heavy sweating (no exertion, no hot flashes)	0	1	4	8
5. Difficulty catching breath, especially during exercise	0	1	4	8
6. Heart pounding, sensation of heart beating too quickly, too slowly or irregularly	0	1	4	8
7. Swelling in feet, ankles and/or legs comes and goes for no apparent reason	0	1	4	8

Total points

PART V (cont.)**SECTION B**

	No/Rarely	Occasionally	Often	Frequently
1. Muscle pain at rest	0	1	4	8
2. Cramp-like pains in your ankles, calves or legs	0	1	4	8
3. Numbness, tingling and prickling sensation in hands and feet	0	1	4	8
4. Cold feet and/or toes appear blue	0	1	4	8
5. Brief moments of hearing loss	0	1	4	8
6. Nausea comes and goes quickly (unrelated to eating)	0	1	4	8
7. Feel worse standing: legs get heavy and fatigued	0	1	4	8
8. Leg discomfort or fatigue relieved by elevating legs	0	1	4	8
9. Fingers and toes get numb in cold weather even when protected	0	1	4	8
10. Notice changes in your ability to feel pain or differentiate between sensations of hot or cold	(0)No	(8)Yes		
11. Body hair (on arms, hands, fingers, legs and toes) is thinning or has disappeared	(0)No	(8)Yes		
12. Do you notice a decline in your ability to make decisions, concentrate, focus attention or follow directions?	(0)No	(8)Yes		

Total points**PART VI****SECTION A**

1. Family, friends, work, hobbies or activities you hold dear are no longer of interest	0	1	4	8
2. Do you cry?	0	1	4	8
3. Does life look entirely hopeless?	0	1	4	8
4. Would you describe yourself as feeling miserable and sad, unhappy or blue?	0	1	4	8
5. Do you find it hard to make the best of difficult situations?	0	1	4	8
6. Sleep problems—too much or too little sleep	0	1	4	8
7. Changes in your appetite and weight	(0)No	(8)Yes		
8. Lately you've noticed an inability to think clearly or concentrate	(0)No	(8)Yes		
9. Difficulty making decisions and/or clarifying and achieving your goals	(0)No	(8)Yes		

Total points**SECTION B**

1. Does worrying get you down?	0	1	4	8
2. Does every little thing get on your nerves and wear you out?	0	1	4	8
3. Would you consider yourself a nervous person?	0	1	4	8
4. Do you feel easily agitated?	0	1	4	8
5. Do you shake and tremble?	0	1	4	8
6. Are you keyed up and jittery?	0	1	4	8
7. Do you tremble or feel weak when someone shouts at you?	0	1	4	8
8. Do you become scared at sudden movements or noises at night?	0	1	4	8
9. Do you find yourself sighing a lot?	0	1	4	8
10. Are you awakened out of your sleep by frightening dreams?	0	1	4	8
11. Do frightening thoughts keep coming back in your mind?	0	1	4	8

No/Rarely
Occasionally
Often
Frequently

SECTION B (cont.)

12. Do you become suddenly scared for no reason?	0	1	4	8
13. Do you break out in a cold sweat?	0	1	4	8
14. "Butterflies in your stomach," nausea and/or diarrhea	0	1	4	8

Total points**SECTION C**

1. Do you feel pent up and ready to explode?	0	1	4	8
2. Are you prone to noisy and emotional outbursts?	0	1	4	8
3. Do you do things on impulse?	0	1	4	8
4. Are you easily upset or irritated?	0	1	4	8
5. Do you go to pieces if you don't control yourself?	0	1	4	8
6. Do little annoyances get on your nerves and make you angry?	0	1	4	8
7. Does it make you angry to have anyone tell you what to do?	0	1	4	8
8. Do you flare up in anger if you can't have what you want right away?	0	1	4	8

Total points**PART VII**

1. Eyes water or tear	0	1	4	8
2. Mucus discharge from the eyes	0	1	4	8
3. Ears ache, itch, feel congested or sore	0	1	4	8
4. Discharge from ears	0	1	4	8
5. Is your nose continually congested?	0	1	4	8
6. Are you prone to loud snoring?	(0)No	(8)Yes		
7. Does your nose run?	0	1	4	8
8. Nosebleeds	(0)No	(8)Yes		
9. Hoarse voice	0	1	4	8
10. Do you have to clear your throat?	0	1	4	8
11. Do you feel a choking lump in your throat?	0	1	4	8
12. Do you suffer from severe colds?	(0)No	(8)Yes		
13. Do frequent colds keep you miserable all winter?	(0)No	(8)Yes		
14. Flu symptoms last longer than 5 days	(0)No	(8)Yes		
15. Do infections settle in your lungs?	(0)No	(8)Yes		
16. Chest discomfort or pain	0	1	4	8
17. Do you experience sudden breathing difficulties?	0	1	4	8
18. Do you struggle with shortness of breath?	0	1	4	8
19. Difficulty exhaling (breathing out)	0	1	4	8
20. Breathlessness followed by coughing during exertion, no matter how slight	0	1	4	8
21. Inability to breathe comfortably while lying down	0	1	4	8
22. Do you cough up lots of phlegm?	0	1	4	8
23. Can you hear noisy rattling sounds when breathing in and out?	0	1	4	8
24. Are you troubled with coughing?	0	1	4	8
25. Do you wheeze?	0	1	4	8
26. Do you have severe soaking sweats at night?	0	1	4	8
27. Do your lips and/or nails have a bluish hue?	0	1	4	8
28. Are you sleepy during the day?	0	1	4	8

PART VII (cont.)

	No/Rarely	Occasionally	Often	Frequently
29. Do you have difficulty concentrating?	0	1	4	8
30. Eyes, ears, nose, throat and lung symptoms seem associated with specific foods like dairy or wheat products	(0)No		(8)Yes	
31. Eyes, ears, nose, throat and lung symptoms are associated with seasonal changes	(0)No		(8)Yes	
Total points				

PART VIII

1. Involuntary loss of urine when you cough, lift something or strain during an activity	0	1	4	8
2. Mild lower back ache or pain	0	1	4	8
3. Abdominal achiness or pain	0	1	4	8
4. Pain or burning when urinating	0	1	4	8
5. Rarely feel the urge to urinate	0	1	4	8
6. Feel the need to urinate less than every two hours during the day or night	0	1	4	8
7. Strong smelling urine	0	1	4	8
8. Back or leg pains are associated with dripping after urination	0	1	4	8
9. Sore or painful genitals	0	1	4	8
10. Urine is a rose color	0	1	4	8
11. Sudden urge to void causes involuntary loss of urine	0	1	4	8
12. Generalized sense of water retention throughout your body	0	1	4	8
Total points				

PART IX**SECTION A**

1. Bones throughout your entire body ache, feel tender or sore	0	1	4	8
2. Localized bone pain	0	1	4	8
3. Hands, feet or throat get tight, spasm or feel numb	0	1	4	8
4. Difficulty sitting straight	0	1	4	8
5. Upper back pain	0	1	4	8
6. Lower back pain	0	1	4	8
7. Pain when sitting down or walking	0	1	4	8
8. Find yourself limping or favoring one leg	0	1	4	8
9. Shins hurt during or after exercise	0	1	4	8
Total points				

SECTION B

1. Are you stiff in the morning when you wake up?	0	1	4	8
2. Difficulty bending down and picking up clothing or anything from the floor	0	1	4	8
3. Joint swelling, pain or stiffness involving one or more areas (fingers, hands, wrists, elbows, shoulders, toes, arches, feet, ankles, knees or ankles)	0	1	4	8
4. Joints hurt when moving or when carrying weight	0	1	4	8
5. A routine exercise program, like daily walking, causes your knees to swell or hurt	0	1	4	8
6. Difficulty opening jars that were previously easy to open	0	1	4	8
7. Discomfort, numbness, prickling or tingling sensation, or pain in neck, shoulder or arm	0	1	4	8

SECTION B (cont.)

8. Intermittent pain or ache on one side of head spreading to cheek, temple, lower jaw, ear, neck and shoulder	0	1	4	8
9. Difficulty chewing food or opening mouth	0	1	4	8
10. Difficulty standing up from a sitting position	0	1	4	8
11. Shooting, aching, tingling pain down the back of leg	0	1	4	8
12. Is it difficult to reach up and get a 5-pound object like a bag of flour from just above your head?	(0)No		(8)Yes	
13. Injure, strain or sprain easily	(0)No		(8)Yes	
Total points				

SECTION C

1. Muscles stiff, sore, tense and/or achy	0	1	4	8
2. Burning, throbbing, shooting or stabbing muscle pain	0	1	4	8
3. Muscle cramps or spasms (involuntary or after exertion/exercise)	0	1	4	8
4. Is muscle pain or stiffness greater in the morning than other times of the day?	0	1	4	8
5. Specific points on body feel sore when pressed	0	1	4	8
6. Feel unrefreshed upon awakening	0	1	4	8
7. Headaches	0	1	4	8
8. Pain at the sides of your head or in your face especially when awakening	0	1	4	8
9. Your jaw clicks or pops	0	1	4	8
10. Muscle twitch or tremor—eyelids, thumb, calf muscle	0	1	4	8
11. Irresistible urge to move legs	0	1	4	8
12. Legs move during sleep	0	1	4	8
13. Unpleasant crawling sensation inside calves when lying down	0	1	4	8
14. Hand and wrist numbness or pain (e.g., interferes with writing or with buttoning or unbuttoning your clothes)	0	1	4	8
15. Feeling of "pins and needles" in your thumb and first three fingers	0	1	4	8
16. Pain in forearm and sometimes in shoulder	0	1	4	8
Total points				

PART X**SECTION A**

1. Head feels heavy	0	1	4	8
2. Dizziness	0	1	4	8
3. Difficulty bending over, standing up from sitting, rolling over in bed and/or turning your head from side to side	0	1	4	8
4. Your hands tremble, ever so slightly, for no apparent reason	0	1	4	8
5. You feel like you're wearing heavy weights on your feet when walking	0	1	4	8
6. Bump into things, trip, stumble and feel clumsy	0	1	4	8
7. Difficulty breathing	0	1	4	8
8. Difficulty swallowing	0	1	4	8
9. People tell you to speak up because they have trouble hearing you	0	1	4	8
10. Speaking and forming words does not feel automatic	0	1	4	8
11. Need 10-12 hours of sleep to feel rested	0	1	4	8

PART X (cont.)

No/Rarely
Occasionally
Often
Frequently

SECTION A (cont.)

- | | | | | |
|--|-------|---|--------|---|
| 12. Lack strength (your grip is weak, holding your head or picking your arms up takes effort) | 0 | 1 | 4 | 8 |
| 13. Hands get tired when you write and your handwriting is less legible and smaller than it used to be | (0)No | | (8)Yes | |
| 14. Muscles in arms and legs seem softer and smaller | (0)No | | (8)Yes | |
| 15. Is your eyesight, sense of smell and taste or ability to hear not as sharp as it used to be? | (0)No | | (8)Yes | |
| 16. Do you find yourself moving slower than you used to? | (0)No | | (8)Yes | |

Total points**SECTION B**

- | | | | | |
|--|---|---|---|---|
| 1. Difficulty absorbing new information | 0 | 1 | 4 | 8 |
| 2. Tend to forget things | 0 | 1 | 4 | 8 |
| 3. Trouble thinking or concentrating | 0 | 1 | 4 | 8 |
| 4. Easily distracted | 0 | 1 | 4 | 8 |
| 5. Do you have a tendency to become frustrated quickly? | 0 | 1 | 4 | 8 |
| 6. Inability to sit still for any length of time, even at mealtime | 0 | 1 | 4 | 8 |
| 7. Finishing tasks is easier said than done | 0 | 1 | 4 | 8 |
| 8. Do you have more trouble solving problems or managing your time than usual? | 0 | 1 | 4 | 8 |
| 9. Low tolerance for stress and otherwise ordinary problems | 0 | 1 | 4 | 8 |

Total points**PART XI****Men Only**

- | | | | | |
|--|---|---|---|---|
| 1. Sensation of not emptying your bladder completely | 0 | 1 | 4 | 8 |
| 2. Need to urinate less than 2 hours after you have finished urinating | 0 | 1 | 4 | 8 |
| 3. Find yourself needing to stop and start again several times while urinating | 0 | 1 | 4 | 8 |
| 4. Find it difficult to postpone urination | 0 | 1 | 4 | 8 |
| 5. Have a weak urinary stream | 0 | 1 | 4 | 8 |
| 6. Need to push or strain to begin urinating | 0 | 1 | 4 | 8 |
| 7. Dripping after urination | 0 | 1 | 4 | 8 |
| 8. Urge to urinate several times a night | 0 | 1 | 4 | 8 |

Total points**PART XII****Women Only**

(Menopausal women should skip to Sections E and F)

SECTION A**Do you persistently experience any of these symptoms within three days to two weeks prior to menstruation?****[A]**

- | | | |
|--|-------|--------|
| 1. Anxious, irritable or restless | (0)No | (8)Yes |
| 2. Numbness, tingling in hands and feet | (0)No | (8)Yes |
| 3. Easy to anger, resentful | (0)No | (8)Yes |
| 4. Aggressive or hostile toward family/friends | (0)No | (8)Yes |

No/Rarely
Occasionally
Often
Frequently

SECTION A (cont.)**[B]**

- | | | |
|---|-------|--------|
| 5. Abdominal bloating, feeling swollen (e.g., feet) | (0)No | (8)Yes |
| 6. Temporary weight gain | (0)No | (8)Yes |
| 7. Breast tenderness, swelling | (0)No | (8)Yes |
| 8. Appearance of breast lumps | (0)No | (8)Yes |
| 9. Discharge from nipples | (0)No | (8)Yes |
| 10. Nausea and/or vomiting | (0)No | (8)Yes |
| 11. Diarrhea or constipation | (0)No | (8)Yes |
| 12. Aches and pains (back, joints, etc.) | (0)No | (8)Yes |

[C]

- | | | |
|---|-------|--------|
| 13. Craving for sweets | (0)No | (8)Yes |
| 14. Increased appetite or binge eating | (0)No | (8)Yes |
| 15. Headaches | (0)No | (8)Yes |
| 16. Being easily overwhelmed, shaky or clumsy | (0)No | (8)Yes |
| 17. Heart pounding | (0)No | (8)Yes |
| 18. Dizziness or fainting | (0)No | (8)Yes |

[D]

- | | | |
|--|-------|--------|
| 19. Confused and forgetful to the point that work suffers | (0)No | (8)Yes |
| 20. Overwhelmed with feelings of sadness and worthlessness | (0)No | (8)Yes |
| 21. Difficulty sleeping or falling asleep | (0)No | (8)Yes |
| 22. Engaging in self-destructive behavior | (0)No | (8)Yes |

Total points**SECTION B****Do you experience any of these symptoms during your period?**

- | | | |
|--|-------|--------|
| 1. Cramping in lower abdomen or pelvic area | (0)No | (8)Yes |
| 2. Lower abdominal pain is sharp and/or dull or intermittent | (0)No | (8)Yes |
| 3. Bloating and sense of abdominal fullness | (0)No | (8)Yes |
| 4. Diarrhea or constipation | (0)No | (8)Yes |
| 5. Nausea and/or vomiting | (0)No | (8)Yes |
| 6. Low back and/or legs ache | (0)No | (8)Yes |
| 7. Headaches | (0)No | (8)Yes |
| 8. Unusual fatigue (take naps) resulting in missed work | (0)No | (8)Yes |
| 9. Painful and/or swollen breasts | (0)No | (8)Yes |
| 10. Scanty blood flow | (0)No | (8)Yes |

Total points**SECTION C**

- | | | | | |
|--|-------|--------|---|---|
| 1. Painful or difficult sexual intercourse | 0 | 1 | 4 | 8 |
| 2. Low abdominal, back and vaginal pain throughout the month | 0 | 1 | 4 | 8 |
| 3. Pelvic pressure or pain while sitting down or standing up, relieved by lying down | 0 | 1 | 4 | 8 |
| 4. Vaginal bleeding other than during your period | 0 | 1 | 4 | 8 |
| 5. Painful bowel movements | 0 | 1 | 4 | 8 |
| 6. Difficult (straining) urination | 0 | 1 | 4 | 8 |
| 7. Abnormal vaginal discharge | 0 | 1 | 4 | 8 |
| 8. Offensive vaginal discharge | 0 | 1 | 4 | 8 |
| 9. Vaginal itching or burning with or without intercourse | 0 | 1 | 4 | 8 |
| 10. Pain during periods is getting progressively worse | (0)No | (8)Yes | | |
| 11. Profuse or prolonged menstrual bleeding | (0)No | (8)Yes | | |
| 12. Unable to get pregnant | (0)No | (8)Yes | | |

Total points

PART XII (cont.)
SECTION D

	No/Rarely	Occasionally	Often	Frequently
1. Absence of periods for six months or longer	(0)No	(8)Yes		
2. Periods occur irregularly (e.g., 3 to 6 times a year)	(0)No	(8)Yes		
3. Profuse heavy bleeding during periods	0	1	4	8
4. Menstrual blood contains clots and tissue	0	1	4	8
5. Bleeding between periods can occur anytime	0	1	4	8
6. Periods occur greater than every 35 days	(0)No	(8)Yes		
7. Intense upper stomach pain, lasting several hours at the time you ovulate (approximately day 14 of your cycle)	0	1	4	8
8. Bleeding occurs at ovulation (approximately day 14 of your cycle)	0	1	4	8
9. Monthly abdominal pain without bleeding	0	1	4	8
10. Abundant cervical mucus	0	1	4	8
11. Acne and/or oily skin	0	1	4	8
12. Overwhelming urges for sexual intercourse	0	1	4	8
13. Aggressive feelings	0	1	4	8
14. Increased growth of dark facial and/or body hair	(0)No	(8)Yes		
15. Poor sense of smell	(0)No	(8)Yes		
16. Voice is becoming deeper	(0)No	(8)Yes		
17. Breasts seem to be getting smaller	(0)No	(8)Yes		
18. Receding hairline	(0)No	(8)Yes		

Total points
SECTION E

1. Vaginal discharge	0	1	4	8
2. Vaginal secretions are watery and thin	0	1	4	8
3. Vaginal dryness	0	1	4	8
4. Sexual intercourse is uncomfortable	0	1	4	8

SECTION E (cont.)

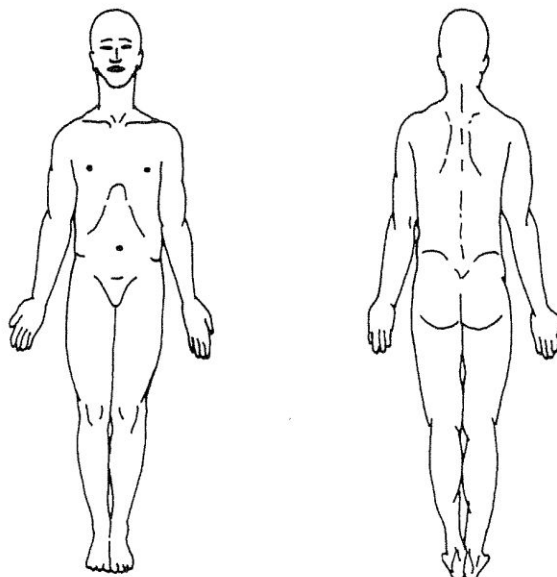
5. Interest in having sex is low	0	1	4	8
6. Engorged breasts	0	1	4	8
7. Breast tenderness, soreness	0	1	4	8
8. Difficulty with orgasm	0	1	4	8
9. Vaginal bleeding after sexual intercourse	0	1	4	8
10. Do you skip periods?	(0)No	(8)Yes		
11. The length (number of days) of your period varies month to month, with the number of days of bleeding getting fewer	(0)No	(8)Yes		

Total points
SECTION F

1. Sense of well-being fluctuates throughout the day for no apparent reason	0	1	4	8
2. Sudden hot flashes	0	1	4	8
3. Spontaneous sweating	0	1	4	8
4. Chills	0	1	4	8
5. Cold hands and feet	0	1	4	8
6. Heart beats rapidly or feels like it is fluttering	0	1	4	8
7. Numbness, tingling or prickling sensations	0	1	4	8
8. Dizziness	0	1	4	8
9. Mental foggiess, forgetful or distracted	0	1	4	8
10. Inability to concentrate	0	1	4	8
11. Depression, anxiety, nervousness and/or irritability	0	1	4	8
12. Difficulty sleeping	0	1	4	8
13. Conscious of new feelings of anger and frustration	0	1	4	8
14. Skin, hair, vagina and/or eyes feel dry	0	1	4	8
15. Stopped menstruating around six months ago, yet still experience some vaginal bleeding	(0)No	(8)Yes		

Total points

Please mark an "X" to indicate areas where you feel pain, swelling or discomfort, or areas of your skin that have changed color or texture (e.g., moles, rashes, etc.). Describe what you feel or observe in your own words. Write anywhere in this area.



General Medical History Form

Please return your form to the Pharmacy when you have finished.
The Pharmacist will meet with you to review your information. Thank you.

PATIENT INFORMATION:

TODAY'S DATE: _____

Name: _____

Birth Date: _____

Address: _____

Age: _____

City: _____

Phone: _____

Occupation: _____

Wk Phone: _____

Living Situation: Spouse Alone Partner Friend(s) Parent Children Other

Status: Married Divorced Widowed

Blood Type: O A B AB

MEDICAL STATUS

How do you rate your general health? Excellent; Good; Fair Poor.

Height: _____ft.____in.; Weight: _____lbs

Blood pressure: _____ Pulse: _____

Lifestyle Information:		
	Do you use: Yes or No	If yes, how often and how much?
Tobacco (smoke, chew, dip)		
Alcohol (beer, wine, hard liquor)		
Caffeine (cola drinks, tea, coffee)		

IMPAIRMENTS: Check if you have any of the following:

_____ Physical impairment _____ Visual impairment _____ Hearing impairment

EXERCISE: Do you exercise regularly? YES NO

If YES, describe what you do and how often:

STRESS MANAGEMENT: Do you practice any stress management techniques?

YES NO If YES, describe what you do and how often.

SLEEP: How long does it take you to fall asleep? Minutes: 5 10 15 30 60+

How many hours of sleep do you get per night? _____ hours

Do you sleep uninterrupted all night? YES NO

If NO, how many times do you awaken: _____ times. Do you awaken at a particular time(s)?

What awakens you? _____

Do you nap during the day? YES NO How often and how long do you nap?

DIET: Describe your typical daily food intake:

First Meal:

Second Meal:

Third Meal:

Any Snacks/Other:

DOCTOR INFORMATION: Are you currently under the care of a physician? YES NO

If YES, please list each doctor from whom you seek care, including address and phone number, if known:

Doctor Name: _____ Address: _____ Phone: _____

Doctor Name: _____ Address: _____ Phone: _____

Doctor Name: _____ Address: _____ Phone: _____

ALLERGIES: Please check all that apply:

____penicillin ____morphine ____dye allergies ____pet allergies
____codeine ____aspirin ____nitrate allergy ____seasonal(pollen)allergies
____sulfa drug ____food allergies ____no known allergies Other: _____

Please describe the allergic reaction you experienced and when it occurred:

MEDICAL CONDITIONS/DISEASES:

Please check all that apply to you.

<input type="checkbox"/> Heart disease (ex. Congestive Heart Failure)
<input type="checkbox"/> High cholesterol or lipids (ex. Hyperlipidemia)
<input type="checkbox"/> High blood pressure (ex. Hypertension)
<input type="checkbox"/> Cancer
<input type="checkbox"/> Ulcers (stomach, esophagus)
<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Hormonal related Issues
<input type="checkbox"/> Blood Clotting Problems

<input type="checkbox"/> Lung condition (ex. Asthma, Emphysema, COPD)
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Arthritis or joint problems
<input type="checkbox"/> Depression
<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Headaches/migraines
<input type="checkbox"/> Eye disease (glaucoma, etc.)
<input type="checkbox"/> Other. Please list: _____

OVER-THE-COUNTER (OTC) ISSUES:

Please check all products that you use occasionally or regularly.

<input type="checkbox"/> Pain Reliever
<input type="checkbox"/> Acetaminophen (ex. Tylenol®)
<input type="checkbox"/> Ibuprofen (ex. Motrin IB®)
<input type="checkbox"/> Naproxen (ex. Aleve®)
<input type="checkbox"/> Ketoprofen (ex. Orudis KT®)
<input type="checkbox"/> Cough Suppressant (ex. Robitussin DM®)
<input type="checkbox"/> Antihistamine product (ex. Chlor-Trimeton®)
<input type="checkbox"/> Decongestant product (ex. Sudafed®)
<input type="checkbox"/> Combination product (cough & cold reliever) (ex. Triaminic DM®)
<input type="checkbox"/> Sleep aids (ex. Excedrin PM®, Unisom®, Sominex®, Nytol®)

<input type="checkbox"/> Antidiarrheals (ex. Imodium®, Pepto Bismol®, Kaopectate®)
<input type="checkbox"/> Laxative/Stool Softeners (ex. Doxidan®, Correctol®, etc.)
<input type="checkbox"/> Diet aids/Weight loss products (ex. Dexatrim®)
<input type="checkbox"/> Antacids (ex. Maalox®, Mylanta®)
<input type="checkbox"/> Acid Blockers (ex. Tagament HB®, Pepcid AC®, Zantac 75®)
<input type="checkbox"/> Other (please list): _____

FAMILY HISTORY:

Relative:

Disease:

TOP THREE BIGGEST CONCERNS/SYMPTOMS:

1. _____ Since When: _____
2. _____ Since When: _____
3. _____ Since When: _____

Amino Acid Deficiency Symptoms

Instructions: Mark the box or boxes that identify your corresponding symptoms.

L-glutamine

- ☐ Cravings for sugar, starch, or alcohol
- ☐ Reduced mental stability

L-tyrosine, L-phenylalanine

- ☐ Depression
- ☐ Lack of energy
- ☐ Lack of drive
- ☐ Lack of focus, concentration

GABA

- ☐ Stiff and tense muscles
- ☐ Stressed
- ☐ Feeling “burned out”
- ☐ Unable to relax

DL-phenylalanine, D-phenylalanine

- ☐ Very sensitive to emotional or physical pain
- ☐ Cry easily
- ☐ Crave comfort, reward, or numbing treats
- ☐ “Love” certain foods or drugs

L-tryptophan, 5-HTP (serotonin), Melatonin (sleep)

- ☐ Depression, Negativity
- ☐ Worry, anxiety
- ☐ Low self-esteem
- ☐ Obsessive thoughts/behaviors
- ☐ The “winter blues”
- ☐ PMS
- ☐ Irritability, rage
- ☐ Heat intolerance
- ☐ Panic, phobias
- ☐ Afternoon or evening cravings
- ☐ Fibromyalgia, TMJ
- ☐ Sleep disturbances – hard time getting to sleep, or staying asleep
- ☐ Suicidal thoughts

Do you crave any of the following to compensate for the above symptoms? (Circle)

- ☐ Sweets, starches, alcohol, chocolate, caffeine, tobacco, marijuana, cocaine, heroin