Darien Center for
FUNCTIONAL MEDICINE

Outline Procedures for New Patients

Step One	Your consultation with Dr. Zembroski to discuss your health problems. Fill out this questionnaire at home to bring to your next appointment.
Step Two	Diagnostic chiropractic, orthopedic, neurological, or nutritional examinations to determine what type of care is appropriate for your condition. If your case requires immediate attention, treatment will be administered, if possible.
Step Three	You will be scheduled for your "report of findings" to hear your examination results. You will be informed of specific recommendations regarding your condition.
Step Four	A specific treatment plan will be recommended and discussed.

Confidential Patient Information

Name		Date
Street Address	City/State	Zip Code
Home Phone ( )	Work Phone ( )	Cell Phone/Pager ( )
Email Address	Date of Birth	Current Age
Social Security #	Method of Payment	

Insurance Information:

Name or Insurance Company	Billing Address	Policy # and Subscriber

Referred by:

Name:	Event (i.e., lecture, etc.):	Other (please specify):

Your Doctors:

Primary Care Physician:	OB/GYN:	Other (please specify):

Work Status: ☐ Employed ☐ Retired ☐ Disabled ☐ Full-time Student ☐ Part-time Student

Employer	Occupation and Job Responsibilities	
Employer Address	City/State	Zip Code

Marital Status: ☐ Single ☐ Married/Spouse's Name_____ ☐ Partnered ☐ Divorced ☐ Widowed

Why Functional Medicine? Some patients want symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem, as well as the symptoms, corrected and relieved to avoid future relapses (Corrective Care). Still others want whatever is malfunctioning brought to the highest state of health possible in order to optimize their physical and emotional wellbeing (Comprehensive Care). Functional Medicine offers some of the latest advanced research for optimizing your health.

The Darien Center for Functional Medicine stresses that it is always YOUR CHOICE to choose which care you desire. We will honor and support your choice, and Dr. Z will weigh your needs and desires when recommending your treatment program. Please check the type of care you wish to receive.

☐ Relief Care ☐ Corrective Care ☐ Comprehensive Care ☐ Would like to discuss options

IMPORTANT INFORMATION:

Dr. Zembroski does not treat any disease. As a physician with a specialty in functional medicine, he uses specialized testing to fully understand your chronic health issue. His treatment recommendations are intended to provide nutritional and dietary support only. If you are undergoing other medical treatment for any condition, Dr. Z's recommendations are intended to complement such other treatment, not to replace it. Likewise, as a board-certified chiropractic neurologist, his evaluation and treatments are intended to resolve neurological dysfunction, musculo-skeletal problems, and pain.

PAYMENT POLICIES:

I understand that Darien Center for Functional Medicine (DCFM) does not participate in any health-insurance plans. DCFM will file claims for most services with my insurance company, and those claims will be processed on an out-of-network basis. Therefore, I agree to the following:

1. If my health insurance covers services rendered by this office, I agree that I am responsible to pay the co-insurance for each visit, as well as any portion of my annual out-of-network deductible which applies to my treatment here; or
2. If my health insurance denies coverage for any service rendered by this office, I agree to pay for that service. I also agree to pay co-insurance and deductible, as described above; or
3. If I have no out-of-network insurance, a financial arrangement will be created to enable me to cover the cost of my treatment here.

In accordance with your office policy, I agree to pay for services when rendered, and to keep my account up to date.

I acknowledge and understand the foregoing.

Patient's Signature_____ Date:_____

FEMALES ONLY

I,_____, To the best of my knowledge confirm that I am not pregnant and waive all responsibility for the doctor.

Signature: **Date**:

CONSENT OF TREATMENT OF A MINOR

I hereby authorize Dr. Robert Zembroski DC DACNB MS, and whomever he may so designate as his assistant, to administer care as he deems necessary to my son/daughter, _____, dated at Darien, Connecticut, this _____ day of _____, 20____.

Signature: **Witnessed**:

IN CASE OF EMERGENCY

Name of relative or close friend not living in your home:

Home Phone Work Phone Cell Phone

Please list your major complaints in order of severity:

1.	2.
3.	4.
5 .	6.

Complaint #1

When did you first notice this condition?

Did it begin ☐ Immediately or ☐ Gradually? Briefly describe.

What is the exact location of your symptoms?

Do your symptoms spread? ☐ No ☐ Yes Where?

How often do you experience these symptoms? ☐ Constantly ☐ Frequently (75% of day) ☐ Often (50%)
☐ Seldom (25%) ☐ Rarely (less than 25%)

Is this condition progressively ☐ Worsening ☐ Improving or ☐ Unchanged?

What is the intensity of your symptoms? ☐ Severe ☐ Moderate ☐ Mild

Rate your symptoms on a scale of 1-10, considering 1 to be minimal, and 10 to be severe/excruciating pain.
1 ☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10 ☐

Is your pain ☐ Deep or ☐ Superficial?

Please indicate the character of your pain: ☐ Dull ☐ Sharp ☐ Burning ☐ Aching ☐ Knife-like ☐ Throbbing

Are you experiencing any of the following associated symptoms? ☐ Pins/Needles ☐ Tingling ☐ Numbness ☐ Twitching
If Yes, Please describe:

Please indicate what activities provoke (P) or Aggravate (A) your condition:
☐ Sitting ___min. ☐ Standing ☐ Walking ☐ Lying ☐ Pushing ☐ Pulling ☐ Lifting ____ lbs. ☐ Gripping ☐ Hot/Cold
☐ Coughing/Sneezing ☐ Bowel Movements ☐ Mental Activities ☐ Bright Lights ☐ Other _____
☐ Other_____ ☐ Other_____ ☐ Other_____

Please indicate what helps to alleviate the pain.
☐Lying ☐ Sitting ☐ Walking ☐ Standing ☐ Rest ☐ Heat/Cold ☐ Medications _____
☐ _____ ☐ _____ ☐_____

Please list what doctors you have seen for this condition. Please include doctor's name and location, diagnoses, treatment received, and any changes in your condition.

Please include any other relevant history in regards to this complaint.

Complaint #2

When did you first notice this condition?

Did it begin ☐ Immediately or ☐ Gradually? Briefly describe.

What is the exact location of your symptoms?

Do your symptoms spread? ☐ No ☐ Yes Where?

How often do you experience these symptoms? ☐ Constantly ☐ Frequently (75% of day) ☐ Often (50%) ☐ Seldom (25%) ☐ Rarely (less than 25%)

Is this condition progressively ☐ Worsening ☐ Improving or ☐ Unchanged?

What is the intensity of your symptoms? ☐ Severe ☐ Moderate ☐ Mild

Rate your symptoms on a scale of 1-10, considering 1 to be minimal and 10 to be severe/excruciating pain.
1 ☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10 ☐

Is your pain ☐ Deep or ☐ Superficial?

Please indicate the character of your pain: ☐ Dull ☐ Sharp ☐ Burning ☐ Aching ☐ Knife-like ☐ Throbbing

Are you experiencing any of the following associated symptoms? ☐ Pins/Needles ☐ Tingling ☐ Numbness ☐ Twitching
If Yes, Please describe:

Please indicate what activities provoke (P) or Aggravate (A) your condition:
☐ Sitting ___min. ☐ Standing ☐ Walking ☐ Lying ☐ Pushing ☐ Pulling ☐ Lifting ____ lbs. ☐ Gripping ☐ Hot/Cold
☐ Coughing/Sneezing ☐ Bowel Movements ☐ Mental Activities ☐ Bright Lights ☐ Other _____
☐ Other_____ ☐ Other_____ ☐ Other_____

Please indicate what helps to alleviate the pain.
☐Lying ☐ Sitting ☐ Walking ☐ Standing ☐ Rest ☐ Heat/Cold ☐ Medications _____
☐ _____ ☐ _____ ☐_____

Please list what doctors you have seen for this condition. Please include doctor's name and location, diagnoses, treatment received, and any changes in your condition.

Please include any other relevant history regarding this complaint.

Complaint #3

When did you first notice this condition?

Did it begin ☐ Immediately or ☐ Gradually? Briefly describe.

What is the exact location of your symptoms?

Do your symptoms spread? ☐ No ☐ Yes Where?

How often do you experience these symptoms? ☐ Constantly ☐ Frequently (75% of day) ☐ Often (50%) ☐ Seldom (25%) ☐ Rarely (less than 25%)

Is this condition progressively ☐ Worsening ☐ Improving or ☐ Unchanged?

What is the intensity of your symptoms? ☐ Severe ☐ Moderate ☐ Mild

Rate your symptoms on a scale of 1-10, considering 1 to be minimal and 10 to be severe/excruciating pain.
1 ☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10 ☐

Is your pain ☐ Deep or ☐ Superficial?

Please indicate the character of your pain: ☐ Dull ☐ Sharp ☐ Burning ☐ Aching ☐ Knife-like ☐ Throbbing

Are you experiencing any of the following associated symptoms? ☐ Pins/Needles ☐ Tingling ☐ Numbness ☐ Twitching
If Yes, Please describe:

Please indicate what activities provoke (P) or Aggravate (A) your condition:
☐ Sitting ___min. ☐ Standing ☐ Walking ☐ Lying ☐ Pushing ☐ Pulling ☐ Lifting ____ lbs. ☐ Gripping ☐ Hot/Cold
☐ Coughing/Sneezing ☐ Bowel Movements ☐ Mental Activities ☐ Bright Lights ☐ Other _____
☐ Other_____ ☐ Other_____ ☐ Other_____

Please indicate what helps to alleviate the pain.
☐Lying ☐ Sitting ☐ Walking ☐ Standing ☐ Rest ☐ Heat/Cold ☐ Medications _____
☐ _____ ☐ _____ ☐_____

Please list what doctors you have seen for this condition. Please include doctor's name and location, diagnoses, treatment received, and any changes in your condition.

Please include any other relevant history regarding this complaint.

Past Medical History

Please include any of your previous conditions.
If possible include: Dates, Diagnosis, Treatment received and any Residual Symptoms you still have.

Utero, Birth and Infancy

Was your mother healthy when you were in utero? ☐ No ☐ Yes Explain:
Did she smoke or consume alcohol? ☐ No ☐ Yes Explain:
Where were you born?
Were you delivered ☐ vaginally or through ☐ cesarean section?
Were there any complications during your birth process? ☐ No ☐ Yes Explain:
Were you vaccinated? ☐ No ☐ Yes
Did you have normal neurological, structural, emotional, and social development? ☐ No ☐ Yes Explain:

Did you have any of the following?

Injuries, Accidents, Falls or Traumas ☐ No ☐ Yes Explain:
Illnesses/Hospitalizations ☐ No ☐ Yes Explain:
Surgeries ☐ No ☐ Yes Explain:

Childhood (ages 2 – 12)

Did you have normal neurological, structural, emotional, social, and academic development? ☐ Yes ☐ No Explain:

Please rate the following abilities and traits:

Academics	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Athletics	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Emotions	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Dietary Habits	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Overall Health	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor

Did you have any of the following?

Injuries, Accidents, Falls or Traumas ☐ No ☐ Yes Explain:
Illnesses/Hospitalizations ☐ No ☐ Yes Explain:
Surgeries ☐ No ☐ Yes Explain:

Teens (ages 13-19)

Did you have normal neurological, structural, emotional, social, and academic development? ☐ Yes ☐ No Explain:

Please rate the following abilities and traits:

Academics	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Athletics	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Emotions	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Dietary Habits	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Overall Health	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor

Did you have any of the following?

Injuries, Accidents, Falls or Traumas ☐ No ☐ Yes Explain:
Illnesses/Hospitalizations ☐ No ☐ Yes Explain:
Surgeries ☐ No ☐ Yes Explain:

Females Only: What age did you start your menses? _____ ☐ Regular ☐ Irregular

Twenties

Academics	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Athletics	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Emotions	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Dietary Habits	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Overall Health	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor

Did you have any of the following?

Motor Vehicle Accidents ☐ No ☐ Yes Explain:
Work Injuries ☐ No ☐ Yes Explain:
Illnesses/Hospitalizations ☐ No ☐ Yes Explain:
Injuries, Accidents, Falls, or Traumas ☐ No ☐ Yes Explain:
Surgeries ☐ No ☐ Yes Explain:

Thirties

Mental Abilities	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Exercise Level	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Emotions	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Dietary Habits	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Overall Health	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor

Did you have any of the following?

Motor Vehicle Accidents ☐ No ☐ Yes Explain:
Work Injuries ☐ No ☐ Yes Explain:
Illnesses/Hospitalizations ☐ No ☐ Yes Explain:
Injuries, Accidents, Falls, or Traumas ☐ No ☐ Yes Explain:
Surgeries ☐ No ☐ Yes Explain:

Forties

Mental Abilities	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Exercise Level	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Emotions	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Dietary Habits	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Overall Health	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor

Did you have any of the following?

Motor Vehicle Accidents ☐ No ☐ Yes Explain:
Work Injuries ☐ No ☐ Yes Explain:
Illnesses/Hospitalizations ☐ No ☐ Yes Explain:
Injuries, Accidents, Falls, or Traumas ☐ No ☐ Yes Explain:
Surgeries ☐ No ☐ Yes Explain:
Females Only (40's): Menopausal Symptoms ☐ None ☐ Yes Explain:

Fifties

Mental Abilities	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Exercise Level	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Emotions	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Dietary Habits	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Overall Health	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor

Did you have any of the following?

Motor Vehicle Accidents ☐ No ☐ Yes Explain:
Work Injuries ☐ No ☐ Yes Explain:
Illnesses/Hospitalizations ☐ No ☐ Yes Explain:
Injuries, Accidents, Falls, or Traumas ☐ No ☐ Yes Explain:
Surgeries ☐ No ☐ Yes Explain:
Females Only (50's): Menopausal Symptoms ☐ None ☐ Yes Explain:

Sixties

Mental Abilities	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Exercise Level	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Emotions	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Dietary Habits	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Overall Health	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor

Did you have any of the following?

Motor Vehicle Accidents ☐ No ☐ Yes Explain:
Work Injuries ☐ No ☐ Yes Explain:
Illnesses/Hospitalizations ☐ No ☐ Yes Explain:
Injuries, Accidents, Falls, or Traumas ☐ No ☐ Yes Explain:
Surgeries ☐ No ☐ Yes Explain:

Seventies

Mental Abilities	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Exercise Level	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Emotions	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Dietary Habits	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor
Overall Health	☐ Excellent	☐ Good	☐ Average	☐ Below Average	☐ Poor

Did you have any of the following?

Motor Vehicle Accidents ☐ No ☐ Yes Explain:
Work Injuries ☐ No ☐ Yes Explain:
Illnesses/Hospitalizations ☐ No ☐ Yes Explain:
Injuries, Accidents, Falls, or Traumas ☐ No ☐ Yes Explain:
Surgeries ☐ No ☐ Yes Explain:

Family History

Mother ☐ Alive & Well, age ____ ☐ Deceased age ____ From what? _____ Any Healthy Conditions?
Father ☐ Alive & Well, age ____ ☐ Deceased age ____ From what? _____ Any Healthy Conditions?
Brother ☐ Alive & Well, age ____ ☐ Deceased age ____ From what? _____ Any Healthy Conditions?
Brother ☐ Alive & Well, age ____ ☐ Deceased age ____ From what? _____ Any Healthy Conditions?
Sister ☐ Alive & Well, age ____ ☐ Deceased age ____ From what? _____ Any Healthy Conditions?
Sister ☐ Alive & Well, age ____ ☐ Deceased age ____ From what? _____ Any Healthy Conditions?
Children: Ages and health conditions?
Maternal Grandmother ☐ Alive & Well, age ____ ☐ Deceased age ____ From what? _____ Any Healthy Conditions?
Maternal Grandfather ☐ Alive & Well, age ____ ☐ Deceased age ____ From what? _____ Any Healthy Conditions?
Paternal Grandmother ☐ Alive & Well, age ____ ☐ Deceased age ____ From what? _____ Any Healthy Conditions
Paternal Grandfather ☐ Alive & Well, age ____ ☐ Deceased age ____ From what? _____ Any Healthy Conditions?

Have any of your family members ever suffered from any of the following conditions?

☐ Diabetes ☐ Heart Disease ☐ Stroke ☐ Neurological Disorders_____ ☐ Autoimmune Disorders_____ ☐ Cancer_____ ☐ _____ ☐ _____ ☐ _____
Medications: Please list your current medications, why you take them, and who prescribes them.
Vitamins and Minerals: Please list your current supplements, why you take them, and who prescribes them.

Habits

Cigarettes	☐ None ☐ Yes How much per week?
Cigars	☐ None ☐ Yes How many per week?
Alcohol	☐ None ☐ Yes How many drinks per week? What type of Alcohol?
Coffee	☐ None ☐ Yes How many cups per week?
Recreational Drugs	☐ None ☐ Yes Types? Frequency? Years of Usage?
Exercise	☐ None ☐ Yes Hours/Days per week? Types?
Water	☐ None ☐ Yes Glasses per day?
Soft Drinks	☐ None ☐ Yes Amount per week? Types?
Sleep	☐ None ☐ Yes Average per night? Do you have difficulty falling asleep or staying asleep? Hours desires per night?
Eating	Meals per day? What types of food do you eat? Do you consider your diet healthy? ☐ Yes ☐ No Explain:

DATE OF LAST:

Physical Examination	By Whom?	Results?
Blood Work	By Whom?	Results
Bone Density Study	By Whom?	Results?
Mammogram	By Whom?	Results?
Pelvic Exam	By Whom?	Results?
Self Breast Exam	Regularity	
Digital Prostate Exam	Results	
EKG	Results	
PSA Level	Results	
Chest X-rays	Results	
Echocardiogram	Results	
Spinal X-rays	By Whom?	Where are they located?
MRI/Cat Scan	Results	Where are they located?
Other Tests		

Check the first box of any of the following conditions you have HAD, and check the second box of anything you HAVE.

☐ ☐ Mental Disorders	☐ ☐ Diabetes	☐ ☐ Pneumonia	☐ ☐ Infective Disease
☐ ☐ Epilepsy	☐ ☐ Anemia	☐ ☐ Tuberculosis	☐ ☐ Fungal Infection
☐ ☐ Tumors	☐ ☐ Glaucoma	☐ ☐ Hepatitis ____	☐ ☐ Herpes
☐ ☐ Alcoholism	☐ ☐ Heart Disease	☐ ☐ Thyroid Disease	☐ ☐ Arthritis
☐ ☐ Drug Addiction	☐ ☐ Rheumatic Fever	☐ ☐ Parasites	☐ ☐ Autoimmune Disease
☐ ☐ Cancer	☐ ☐ Scarlet Fever	☐ ☐ Venereal Infection	☐ ☐ Chicken Pox

NERVOUS SYSTEM	EENT	GI	MUSCULOSKELETAL
☐ ☐ Depression	☐ ☐ Vision Problems	☐ ☐ Poor/Excess Appetite	☐ ☐ Jaw Pain
☐ ☐ Memory Loss	☐ ☐ Flashing Lights	☐ ☐ Excessive Thirst	☐ ☐ Difficulty Chewing
☐ ☐ Confusion	☐ ☐ Black Spots	☐ ☐ Frequent Nausea	☐ ☐ Face Pain
☐ ☐ Dizziness	☐ ☐ Blurriness	☐ ☐ Hemorrhoids	☐ ☐ Neck Pain
☐ ☐ Fainting	☐ ☐ Hearing Loss	☐ ☐ Black/Bloody Stools	☐ ☐ Arm/Elbow Pain
☐ ☐ Convulsions	☐ ☐ Ringing in Ears	☐ ☐ Digestive Problems	☐ ☐ Wrist/Hand Pain
☐ ☐ Weakness	☐ ☐ Swallowing Difficulty	☐ ☐ Abdominal Cramping	☐ ☐ Mid-Back Pain
☐ ☐ Poor Balance		☐ ☐ Gas/Bloating after meals	☐ ☐ Lower-Back Pain
☐ ☐ Twitches/Tremor	GU	☐ ☐ Heartburn	☐ ☐ Thigh/Knee Pain
☐ ☐ Cold/Tingle Extremities	☐ ☐ Bladder Trouble	☐ ☐ Weight Problems	☐ ☐ Ankle/Foot Pain
☐ ☐ Sleeping Difficulties	☐ ☐ Painful Urination	☐ ☐ Gall Bladder Problems	☐ ☐ Difficulty Walking
☐ ☐ Headaches	☐ ☐ Incontinence	☐ ☐ Liver Problems	☐ ☐ Leg/Arm Fatigue
C-V	☐ ☐ Discolored Urine		
☐ ☐ Chest Pain		GENERAL	☐ ☐ Cold Hands & Feet
☐ ☐ Irregular Heartbeat	REPRODUCTIVE	☐ ☐ Low Energy/Stamina	☐ ☐ Weight Issues
☐ ☐ High Blood Pressure	☐ ☐ Erectile Difficulties	☐ ☐ Inability to lose weight	☐ ☐ Hair Loss
☐ ☐ Shortness of Breath	☐ ☐ Sexual Dysfunction	☐ ☐ Dry Skin/Hair	☐ ☐ Swelling/Puffiness
☐ ☐ Lung/Congestion	☐ ☐ Menstrual Irregularity	☐ ☐ Thinning hair/Eyebrows	☐ ☐ Hives/Acne/Pimples
☐ ☐ Varicose Veins	☐ ☐ Menstrual Cramping	☐ ☐ General Aches/Pains	☐ ☐ Low Body Temperature
☐ ☐ Ankle Swelling	☐ ☐ Poor Sex Drive	☐ ☐ High Cholesterol	☐ ☐ Allergies

How often do you have a bowel movement?	Are your movements consistent? ☐ Yes ☐ No
Do your stools ☐ Float or ☐ Sink?	Do you experience any urgency, dribbling, or incontinence?
How many times a day do you urinate?	Is this consistent? ☐ Yes ☐ No