



Rocky Mountain Center for  
Advanced Medicine

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_' \_\_\_\_"

Frame Size: Sm \_\_\_\_ Med \_\_\_\_ Large \_\_\_\_

**Please check the answer that applies to each question. Leave blank any questions you wish to discuss only with the doctor. Do you have a history of?**

	N/A	Myself	Parents	Siblings
1. Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Liver Disease (hepatitis, cirrhosis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Psychiatric illness (depression, panic attacks, Schizophrenia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Autoimmune disease (lupus, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Endocrine gland abnormalities (thyroid, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Neurological disease (stroke, seizures, Parkinson's disease)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Lung disease (asthma, emphysema)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Kidney disease (stones, infections)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Stomach disease (ulcers, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Bowel disease (malabsorption, lactose intolerance, diverticulitis, crohn's disease)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Alcoholism, prescription or recreation drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Weight control problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Carpel tunnel syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>





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Name: \_\_\_\_\_ Dose (mg): \_\_\_\_\_ Times/day: \_\_\_\_\_  
Name: \_\_\_\_\_ Dose (mg): \_\_\_\_\_ Times/day: \_\_\_\_\_

**25. Are you currently receiving: \_\_\_\_\_ Radiation therapy \_\_\_\_\_ Chemotherapy**

**These questions refer to your current status:**

26. Marital status: \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Partner

27. Number of children: \_\_\_\_\_ Number living in your household: \_\_\_\_\_

28. Occupation: \_\_\_\_\_

29. Alcohol consumption: (drinks per day/week) \_\_\_\_\_

30. What do you drink? \_\_\_ Beer \_\_\_ Liquor \_\_\_ Wine

31. Smokers: Currently smoke: \_\_\_\_\_ at \_\_\_\_\_ per day  
(What)

Previously smoked: \_\_\_\_\_ at \_\_\_\_\_ per day  
(What)

For: \_\_\_\_\_ (years) How many a day: \_\_\_\_\_

32. Current recreational drug use: \_\_\_\_\_  
(What)

For: \_\_\_\_\_ (years) How often: \_\_\_\_\_

33. Coffee/Caffeine: cups/day: \_\_\_\_\_

34. Diet soda or other drinks with aspartame: cans-cups/day: \_\_\_\_\_

35. Water, 8 oz cups/day: \_\_\_\_\_

**Are you currently experiencing the following symptoms to a degree you consider substantial or unusual?**

	Yes	No
36. Headaches	<input type="radio"/>	<input type="radio"/>
37. Visual problems	<input type="radio"/>	<input type="radio"/>
38. Hearing loss	<input type="radio"/>	<input type="radio"/>
39. Ringing in ears	<input type="radio"/>	<input type="radio"/>
40. Sore throat	<input type="radio"/>	<input type="radio"/>
41. Allergy symptoms (nasal congestion, watery eyes, post nasal drip)	<input type="radio"/>	<input type="radio"/>
42. Loss of smell or taste	<input type="radio"/>	<input type="radio"/>
43. Lumps in neck, armpits, groin or breast	<input type="radio"/>	<input type="radio"/>
44. Chest pain	<input type="radio"/>	<input type="radio"/>
45. Shortness of breath	<input type="radio"/>	<input type="radio"/>
46. Shortness of breath with exertion	<input type="radio"/>	<input type="radio"/>
47. Palpitations	<input type="radio"/>	<input type="radio"/>
48. Abdominal pain	<input type="radio"/>	<input type="radio"/>
49. Diarrhea	<input type="radio"/>	<input type="radio"/>



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|--|-----------------------|-----------------------|
| 50. Constipation (hard or effortful bowel movements) | <input type="radio"/> | <input type="radio"/> |
| 51. Blood in stool or black stool                    | <input type="radio"/> | <input type="radio"/> |
| 52. Difficulty urinating                             | <input type="radio"/> | <input type="radio"/> |
| 53. Leaking urine                                    | <input type="radio"/> | <input type="radio"/> |
| 54. Genital discharge or sores                       | <input type="radio"/> | <input type="radio"/> |
| 55. Urinating at night                               | <input type="radio"/> | <input type="radio"/> |
| Specify times per night: _____                       |                       |                       |
| 56. Muscle, bone or joint pain                       | <input type="radio"/> | <input type="radio"/> |
| Specify: _____                                       |                       |                       |
- 
- 

**MALES ONLY**

- |   |                       |                       |
|---|-----------------------|-----------------------|
| 57. Ejaculation cause pain                    | <input type="radio"/> | <input type="radio"/> |
| 58. Difficulty maintaining/attaining erection | <input type="radio"/> | <input type="radio"/> |
| 59. Premature ejaculation                     | <input type="radio"/> | <input type="radio"/> |
| 60. Infertile                                 | <input type="radio"/> | <input type="radio"/> |
| 61. Low sperm count                           | <input type="radio"/> | <input type="radio"/> |
| 62. Date of last prostate exam: _____         |                       |                       |
| 63. Sexual drive: under active                | <input type="radio"/> | <input type="radio"/> |
| 64. Sexual drive: overactive                  | <input type="radio"/> | <input type="radio"/> |

**FEMALES ONLY**

- |   |                       |                       |
|---|-----------------------|-----------------------|
| 65. Sex drive: overactive   | <input type="radio"/> | <input type="radio"/> |
| 66. Sex drive: under active   | <input type="radio"/> | <input type="radio"/> |
| 67. Missed periods  | <input type="radio"/> | <input type="radio"/> |
| 68. Pelvic soreness   | <input type="radio"/> | <input type="radio"/> |
| 69. Menstrual pain  | <input type="radio"/> | <input type="radio"/> |
| 70. Heavy menstrual bleeding  | <input type="radio"/> | <input type="radio"/> |
| 71. Hot flashes   | <input type="radio"/> | <input type="radio"/> |
| 72. Infertile   | <input type="radio"/> | <input type="radio"/> |
| 73. Form of birth control: ___ None ___ Pill ___ IUD ___ Sponge<br>___ Diaphragm ___ Foam ___ Condom ___ Other: _____ |                       |                       |
| 74. Date of last: Menstrual period _____ Mammogram: _____<br>Breast Exam: _____ Pap smear: _____                      |                       |                       |



**MALES AND FEMALES**

75. Date of last: Colonoscopy (sigmoidoscopy): \_\_\_\_\_ Rectal exam: \_\_\_\_\_  
Stress EKG (treadmill stress test): \_\_\_\_\_ Chest x-ray: \_\_\_\_\_  
76. Were any of the above tests abnormal? Please describe: \_\_\_\_\_

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**YOU'RE GOALS**

77. What are your most important expectations as a patient? \_\_\_\_\_

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**CURRENT EXERCISE SUMMARY**

78. How often do you engage in aerobic exercise (walking, jogging, biking, and swimming)? \_\_\_\_\_ (times/week)

79. Please describe your routine: \_\_\_\_\_

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80. How often do you engage in flexibility and/or stretching exercises (yoga, tai chi, stretch & toning classes, brief stretching after aerobics or weights) \_\_\_\_\_ (times/week)

81. Please describe your routine: \_\_\_\_\_

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82. How often do you participate in resistance/strength training exercises (free weights, weight machines, body pump classes, water aerobics) \_\_\_\_\_ (times/week)

83. Please describe your routine: \_\_\_\_\_

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**FITNESS ACTIVITY ASSESSMENT**

- |  | <b>Yes</b>               | <b>No</b>                |
|--|--------------------------|--------------------------|
| 84. Are you currently involved in an exercise program?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 85. Have/are you a member of a health club?<br>How Long? _____ (years)   | <input type="checkbox"/> | <input type="checkbox"/> |
| 86. Have you ever worked with a personal trainer?<br>If yes, for how long? _____                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 87. Are you still with a personal trainer?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 88. Do you have any exercise equipment at home?<br>(bike, treadmill, free weights etc)<br>If yes, what type? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

\_\_\_\_\_

89. Are you presently receiving physical therapy?  
If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

90. If exercise is not part of your weekly routine, please explain why:  
\_\_\_\_\_ Lack of time \_\_\_\_\_ No motivation \_\_\_\_\_ Physical limitations  
\_\_\_\_\_ Unsure of what to do \_\_\_\_\_ don't enjoy it \_\_\_\_\_ other: \_\_\_\_\_

**SUPPLEMENTATION**

91. Are you taking vitamins, minerals or herbs on a regular basis? \_\_\_ yes \_\_\_ no  
If yes, please list what you are taking or copy labels and send with questionnaire.

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



**SYMPTOMS**

**Check the box that best describes the following symptoms you might have:**

	Mild/ Never	Rare	Moderate/ Occasional	Severe/ Often
92. Water retention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
93. Inflamed or bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
94. Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
95. Indigestion after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
96. Flatulence (gas)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
97. Allergy or food sensitivities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please list: _____				
_____				
_____				
98. Lactose intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
99. Dependency on antacids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
100. Toe and fingernail fungus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
101. Boils or stys	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
102. Vaginal yeast infection (women)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
103. Jock itch (men)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
104. Difficulty in gaining weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
105. Bad breath (no relief by brushing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
106. Body odor (no relief by washing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
107. Memory problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
108. Energy loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
109. Decreased self-image	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
110. Back/spine problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please Describe: _____				
_____				
_____				
111. Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
112. Poor concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
113. Rapid mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
114. Impatient, moody, nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
115. Lack of mental alertness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
116. Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
117. Dry/Flaky hair and/or dry Brittle skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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118. Acne
119. Hair thinning or falling out
120. Premenstrual tension (females)
121. Any other health issue that is causing you problems or you would like to discuss?
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### LIFESTYLE CHANGES SCALE

Review the events below. Beside each one, indicate the number of times each event occurred during the past year only.

#### Life Event

1. Death of a spouse: \_\_\_\_\_
2. Divorce: \_\_\_\_\_
3. Marital separation: \_\_\_\_\_
4. Jail term: \_\_\_\_\_
5. Death of a close family member: \_\_\_\_\_
6. Personal injury or illness: \_\_\_\_\_
7. Marriage: \_\_\_\_\_
8. Fired at work: \_\_\_\_\_
9. Marital reconciliation: \_\_\_\_\_
10. Retirement: \_\_\_\_\_
11. Change in health of family member: \_\_\_\_\_
12. Pregnancy: \_\_\_\_\_
13. Sex difficulties: \_\_\_\_\_
14. Gain of new family member: \_\_\_\_\_
15. Business readjustment: \_\_\_\_\_
16. Change in financial state: \_\_\_\_\_
17. Death of a close friend: \_\_\_\_\_
18. Change to different line of work: \_\_\_\_\_
19. Change in number of arguments with spouse: \_\_\_\_\_
20. Mortgage over \$100,000: \_\_\_\_\_
21. Foreclosure of mortgage or loan: \_\_\_\_\_
22. Change in responsibilities at work: \_\_\_\_\_
23. Son or daughter leaving home: \_\_\_\_\_
24. Trouble with in-laws: \_\_\_\_\_
25. Outstanding personal achievement: \_\_\_\_\_
26. Spouse begin or stop work: \_\_\_\_\_



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- 27. Begin or end school: \_\_\_\_\_
- 28. Change in living conditions: \_\_\_\_\_
- 29. Revision of personal habits: \_\_\_\_\_
- 30. Trouble with boss: \_\_\_\_\_
- 31. Change in work hours or conditions: \_\_\_\_\_
- 32. Change in residence: \_\_\_\_\_
- 33. Change in schools: \_\_\_\_\_
- 34. Change in recreation: \_\_\_\_\_
- 35. Change in religious activities: \_\_\_\_\_
- 36. Change in social activities: \_\_\_\_\_
- 37. Change in sleeping habits: \_\_\_\_\_
- 38. Change in number of family get-togethers: \_\_\_\_\_
- 39. Change in eating habits: \_\_\_\_\_
- 40. Vacation: \_\_\_\_\_
- 41. Religious holidays: \_\_\_\_\_
- 42. Minor violations of the law: \_\_\_\_\_

**PHYSICIAN INFORMATION:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

**Please allow us to copy your insurance card(s).**