

## Social and Occupational History

**Diet:** Food Cravings:  Sweets  Salt  Sour  Bitter  Spicy

Alcohol (type/drinks per week) \_\_\_\_\_

Sugar (type/amount per day) \_\_\_\_\_

Caffeine (type/drinks per day) \_\_\_\_\_

Tobacco (type/amount per day) \_\_\_\_\_

Typical Breakfast: \_\_\_\_\_

Mid morning snack: \_\_\_\_\_

Typical Lunch: \_\_\_\_\_

Afternoon snack: \_\_\_\_\_

Typical Dinner: \_\_\_\_\_

Typical Beverages: \_\_\_\_\_

Favorite Foods: \_\_\_\_\_

Food Allergies:  No  Yes (list please) \_\_\_\_\_

**FEMALE ONLY:** Total Length of cycle \_\_\_\_\_ Length of Menses \_\_\_\_\_ Menses:  Heavy  Moderate  Light  
PMS  Mood Swings  Cramping  Breast Tenderness  Pregnant  Post Menopausal

**Gastrointestinal:**  Excess Hunger  Poor appetite  Nausea  Hemorrhoids  Diarrhea  Constipation  Heartburn  Gas  
 Bloating  Strong Smell # of Bowel Movements/Day \_\_\_\_\_

**Sleep:** Hours per night \_\_\_\_\_ Quality:  Poor  Fair  Good  Trouble Falling Asleep  Staying Asleep  Insomnia  
At what time do you wake up \_\_\_\_\_ How many times do you wake up? \_\_\_\_\_  
Do you sleep on your:  Back  Side  Stomach  All Night Urination: How many times? \_\_\_\_\_

**Urination:**  Excess urination  Frequent urination  Painful urination

Job activities include: \_\_\_\_\_

Physical activity at work  Sedentary  Light manual labor  Moderate manual labor  Heavy manual labor

How long do you speak on the telephone each day \_\_\_\_\_  Traditional receiver  Headset

Do any of your work activities aggravate your present main complaints? Please Describe: \_\_\_\_\_

**Stress Level:**  Mild  Medium  Severe

Reason \_\_\_\_\_

How do you handle stress?  Exercise  Sleep  Eat  Other \_\_\_\_\_

**Energy Level:** 0 1 2 3 4 5 6 7 8 9 10 Time of Lows \_\_\_\_\_

**Exercise:** 1.Type \_\_\_\_\_ Frequency \_\_\_\_\_

2.Type \_\_\_\_\_ Frequency \_\_\_\_\_

3.Type \_\_\_\_\_ Frequency \_\_\_\_\_