Portage Pharmacy
As Specialized as Your Needs
7966 Lovers Lane ▪ At Centre Avenue
Portage, Michigan 49002

phone: (269) 327-0033
toll free: (877) 774-8757
fax: (269) 327-2709
email: info@portagepharmacy.com
web: www.portagepharmacy.com

Consultation Services

Hormone Replacement Therapy

Our Consultation Services

Portage Pharmacy's Consulting Services are available to men and women of any age. Consultations are by appointment only, either in person or on the telephone. Following the initial consultation, we custom tailor a regimen for the patient. Portage Pharmacy has been working in tandem with medical providers for over 35 years helping patients receive customized therapy for their specific health needs. If necessary, we send a recommendation to the patient's medical provider for approval. We ask that patients verify approval of their prescription prior to coming in to pick it up or expecting it to be shipped. Upon approval by the medical provider, the prescription will be available for pick up or delivery within 24 business hours.

Bio-Individualized Therapies

Applying integrative, science-based therapies to help promote wellness focusing on the biochemically unique aspects of each patient, and then individually tailoring interventions to restore balance. This involves emphasis on the cause of the symptom rather than the symptom itself.

Diet, Nutraceuticals and Vitamin Supplementation

A healthy diet is essential for optimal health. Unfortunately, the fast-paced lifestyle of many Americans very often leads to a diet lacking the essential foods that should be present in a healthy diet. Supplementation and nutraceuticals can be used to gain these vital nutrients leading to a healthier life. Supplement requirements for each patient are unique based on diet, health condition, and lifestyle. We carry a variety of pharmaceutical grade products to ensure optimal absorption and effect.

Life Style Modifications

Adequate exercise and stress management are important to implement as they play an important role in our health. Excessive use of alcohol/recreational drugs, prescription medications and certain disease states may affect our well-being.

Appointments

To Make An Appointment: Please call Cindy Whisler at **269-492-7157** or email us at **consulting@portagepharmacy.com**. We ask that patients leave a detailed message including their name, telephone number and/or email address where they can be reached. The patient will then be contacted to schedule an appointment. **We require that a detailed questionnaire be completed and returned at least 48 hours prior to the scheduled appointment.** The health questionnaire is available online at **www.portagepharmacy.com** or may be mailed out upon request. Paper work must be completed and returned prior to the scheduled appointment to avoid cancellation or rescheduling (fax or return completed form to Portage Pharmacy). We ask that we be informed if there are limitations involved with scheduling. Arriving more than 10 minutes late for the consultation may result in cancellation of the appointment and rescheduling may be necessary. Please give 24 hours cancellation notice. Failure to do so may be subject to a cancellation fee.

***Purvi Peake,** Pharm. D, FAARFM*
Pharmacist / Health Specialist

Dr. Peake is a consultant pharmacist and graduate of Ferris State University, School of Pharmacy. She has extensive training in traditional pharmacy topics and is uniquely qualified to work with providers to customize therapies specific to patients needs. She has received advanced training in several aspects of women's health including proper consideration and use of compounded hormones. In addition, she has completed a Fellowship in Anti-Aging, Functional and Regenerative Medicine with the American Academy of Anti Aging Medicine.

"We are proud to have a qualified individual like Purvi on staff. Her genuine personality and vast knowledge of the female reproductive cycle from adolescence all the way to geriatrics makes her one of the best resources in the business! "

- Larry Curtis, RPh,Owner

Consultation Fees and Services

Initial Consultation..$395
(1) - 60 minute initial appointment
(1) - Adrenal fatigue appointment (if needed), and
(3) - 15 to 20 minute follow up appointments within 1 calendar year

Repurchase of additional year...$295
(4) - 15 to 20 minute follow up appointments within 1 calendar year

Saliva Testing
Prices vary based on individual testing needs. Will be required within first 6 months of consultation.

Prescriptions & Nutritional Supplements
Prices vary based on individual needs

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CONSENT & RELEASE AGREEMENT

Name:		DOB:	Date:
Address:			
City:	State:	Zip:	
Phone: ☐ home:	☐ cell:	☐ work:	

Consent

Portage Pharmacy ("Pharmacy") offers consultations with respect to hormonal evaluation, weight management, and nutritional consulting and provides certain related tests ("Services"). A Pharmacy representative has explained to me the nature of the Services I have asked to receive, which are specified in the questionnaire, the goals I hope to achieve with the help of the Pharmacy's Services, and some of the possible risks.

I understand that making recommendations regarding health matters is not an exact science and that the Pharmacy makes no guarantee that I will be able to achieve the goals I seek or avoid any particular risks. I understand that the Pharmacy is not engaged in the practice of medicine and it is my responsibility to seek the advice of my physician before acting on recommendations provided by the Pharmacy. I understand that the personal and medical history I provide to the Pharmacy and the Pharmacy's evaluation of my health status is done to help me achieve my individualized goals and is not intended to identify specific health problems I may have and is not a substitute for a physician's examination. I understand it is my responsibility to provide complete and accurate information to the Pharmacy and to inform the Pharmacy about physical or mental conditions that may affect the Services and that my failure to do so could adversely affect my health, the Pharmacy's recommendations and my ability to achieve my individualized goals.

The data and/or results derived from the Services are to be considered preliminary only. Test results are in no way conclusive and do not constitute a diagnosis of any medical condition. The responsibility to obtain professional medical assistance and to initiate any follow-up medical care to confirm results of screenings or tests is mine alone, and not that of the Pharmacy or its affiliates. No other person will have access to my personal medical profile and/or test results without my express verbal or written permission. Aggregate data may be used for statistical and research purposes. I voluntarily consent to receive the Services under the terms described in this Agreement.

Release

I voluntarily assume all risks of physical or other problems that may result from the Pharmacy's Services and I release the Pharmacy, its affiliates and their employees and owners (the "Pharmacy Group") from all claims, damages, liabilities and expenses (including attorney's fees and costs) of any kind, including injury or death, arising from or related to the Services provided by the Pharmacy (the "Claims"), known or unknown, that I, or anyone claiming on my behalf, might now or later have as a result of the negligence of any member of the Pharmacy Group and I agree not to sue or otherwise assert any Claims against any member of the Pharmacy Group.

I am at least 18 years of age, or if I am under age 18, I understand that I may not receive Services from the Pharmacy unless my parent or guardian signs this Agreement. **I HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS AND ALL MY QUESTIONS WERE ANSWERED TO MY SATISFACTION BEFORE SIGNING THIS AGREEMENT.**

Date Signed: ________________________ Signature: ___________________________________

Type or Print Name: ___________________________________

PARENT OR GUARDIAN SIGN BELOW, IF APPLICABLE

I am the parent or legal guardian of ______________________________ (the "Minor"). I have read the foregoing Agreement and I agree that the Minor and I, as his or her parent or guardian, will be bound by the Agreement.

Date Signed: ________________________ Signature: ___________________________________

Type or Print Name: ___________________________________

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PERSONAL HISTORY QUESTIONNAIRE

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the Consultant during your consultations. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify health and nutritional issues and will assist us in helping you to achieve your individual goals.

First Name: ________________________ Middle Name: __________________ Last Name: ____________________________

Address: ___________________________ City: ___________________________ State: _____________ ZIP: ______________

Home Phone: (_____) __________-___________ Work Phone: (_____) __________-___________

Birth Date: ______________ / ______________ / ______________ Age: __________________

Month Day Year

Place of Birth: ____

Occupation: ____ Referred by: ____________________________________

Name(s) of Medical Provider(s): ____

Height: ___________________________ Weight: ___________________________ Sex: ______________________________

Today's Date: ____

---

1. Please check appropriate box(es):

☐ African American ☐ Hispanic ☐ Mediterranean ☐ Asian

☐ Native American ☐ Caucasian ☐ Northern European ☐ Other

2. Please rank current and ongoing problems by priority and fill in the other boxes as completely as possible:

DESCRIBE PROBLEM	MILD/ MODERATE/ SEVERE	TREATMENT	SUCCESS
Example: Post Nasal Drip	Moderate	Elimination Diet	Moderate
1.			
2.			
3.			
4.			
5.			
6.			
7.			

3. With whom do you live (Include children, parents, relatives, and/or friends and the ages of each individual):

____

____

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4. Do you have any pets or farm animals: ☐ Yes ☐ No
   If yes, where do they live: Indoors __________ Outdoors __________ Both Indoors/Outdoors ____________________________

5. Have you lived or traveled outside of the United States: ☐ Yes ☐ No
   If yes, when and where: ____
   ____

6. Have you or your family recently experienced any major life changes: ☐ Yes ☐ No
   If yes, please comment: ____
   ____

7. Have you experienced any major losses in life: ☐ Yes ☐ No
   If yes, please comment: ____
   ____

8. How important is religion (or spirituality) for you and/or your family's life:
   a. ☐ Not Important
   b. ☐ Somewhat Important
   c. ☐ Extremely Important

9. How much time have you lost from work or school in the past year:
   a. ☐ 0-2 days
   b. ☐ 3 –14 days
   c. ☐ > 15 days

10. Previous jobs:
    ____
    ____

11. Past Illness, Injury and Surgical History:

ILLNESSES	WHEN	COMMENTS
a. Anemia		
b. Arthritis		
c. Asthma		
d. Bronchitis		
e. Cancer		
f. Chronic Fatigue Syndrome		
g. Crohn's Disease or Ulcerative Colitis		
h. Diabetes		
i. Emphysema		
j. Epilepsy, convulsions, or seizures		
k. Gallstones		
l. Gout		
m. Heart attack/Angina		
n. Heart failure		
o. Hepatitis		
p. High blood fats (cholesterol, triglycerides)		
q. High blood pressure (hypertension)		
r. Irritable bowel		

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s.	Kidney stones		
t.	Mononucleosis		
u.	Pneumonia		
v.	Rheumatic fever		
w.	Sinusitis		
x.	Sleep apnea		
y.	Stroke		
z.	Thyroid disease		
	Other (describe)		
	INJURIES	**WHEN**	**COMMENTS**
aa.	Back injury		
ab.	Broken (describe)		
ac.	Head injury		
ad.	Neck injury		
ae.	Other (describe)		
	DIAGNOSTIC STUDIES	**WHEN**	**COMMENTS**
af.	Barium Enema		
ag.	Bone Scan		
ah.	CAT Scan of Abdomen		
ai.	CAT Scan of Brain		
aj.	CAT Scan of Spine		
ak.	Chest X-ray		
al.	Colonoscopy		
am.	EKG		
an.	Liver scan		
ao.	Neck X-ray		
ap.	NMR/MRI		
aq.	Sigmoidoscopy		
ar.	Upper GI Series		
as.	Other (describe)		
	OPERATIONS	**WHEN**	**COMMENTS**
at.	Appendectomy		
au.	Dental Surgery		
av.	Gall Bladder		
aw.	Hernia		
ax.	Hysterectomy (Complete or Partial)		
ay.	Tonsillectomy		
az.	Other (describe)		
bb.	Other (describe)		

12. Hospitalizations

WHERE HOSPITALIZED	WHEN	REASON
1.		
2.		
3.		
4.		
5.		

13. How often have you have taken antibiotics:

	< 5 times	**> 5 times**
Infancy/ Childhood	☐	☐
Teen	☐	☐
Adulthood	☐	☐

14. How often have you taken oral steroids (e.g., Cortisone, Prednisone, etc.):

	< 5 times	**> 5 times**
Infancy/ Childhood	☐	☐
Teen	☐	☐
Adulthood	☐	☐

15. What medications are you taking now:

Medication Name	Date started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

16. Are you allergic to any medications: ☐ Yes ☐ No
If yes, please list: ____
____

17. List all vitamins, minerals, and other nutritional supplements that you are taking. Please indicate the dosage and how many times per day each supplement is taken:

Vitamin/Mineral/Supplement	Date started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

18. Childhood:

Question	Yes	No	Unsure	Comment
1. Were you a full term baby	☐	☐	☐	
a. Premature	☐	☐	☐	
b. Breast fed	☐	☐	☐	
c. Bottle fed	☐	☐	☐	
2. As a child did you eat a lot of sugar and/or candy	☐	☐	☐	

19. As a child, were there any foods that you had to avoid because they caused symptoms? ☐ Yes ☐ No
If yes, please name the food(s) and symptom(s) below:
____
____
____

20. How much of the following do you consume **each week**:

a. Candy	
b. Cheese	
c. Chocolate	
d. Cups of caffeinated coffee or tea	
e. Cups of decaffeinated coffee or tea	
f. Cups of hot chocolate	
g. Diet sodas	
h. Ice cream	
i. Salty foods	
j. Slices of white bread (rolls/bagels)	
k. Sodas with caffeine	
l. Sodas without caffeine	

21. Are you on a special diet? ☐ Yes ☐ No If yes, what kind:
☐ Ovo-Lacto ☐ Vegetarian ☐ Diabetic ☐ Vegan ☐ Dairy Restricted ☐ Blood Type Diet ☐ Other (describe):
____

22. Is there anything special about your diet that we should know: ☐ Yes ☐ No
If yes, please explain: ____

23. Place a check mark next to the food/drink that applies to your current diet (list continues on next page):

	Usual Breakfast	√		Usual Lunch	√		Usual Dinner	√
a.	None	☐	a.	None	☐	a.	None	☐
b.	Bacon/Sausage	☐	b.	Butter	☐	b.	Beans (legumes)	☐
c.	Bagel	☐	c.	Coffee	☐	c.	Brown rice	☐
d.	Butter	☐	d.	Eat in a cafeteria	☐	d.	Butter	☐
e.	Cereal	☐	e.	Eat in restaurant	☐	e.	Carrots	☐
f.	Coffee	☐	f.	Fish sandwich	☐	f.	Coffee	☐
g.	Donut	☐	g.	Juice	☐	g.	Fish	☐
h.	Eggs	☐	h.	Leftovers	☐	h.	Green vegetables	☐
i.	Fruit	☐	i.	Lettuce	☐	i.	Juice	☐
j.	Juice	☐	j.	Margarine	☐	j.	Margarine	☐
k.	Margarine	☐	k.	Mayo	☐	k.	Milk	☐

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l.	Milk	☐	l.	Meat sandwich	☐	l.	Pasta	☐
m.	Oat bran	☐	m.	Milk	☐	m.	Potato	☐
n.	Sugar		n.	Salad	☐	n.	Poultry	☐
o.	Sweet roll	☐	o.	Salad dressing	☐	o.	Red meat	☐
p.	Sweetener	☐	p.	Soda	☐	p.	Rice	☐
q.	Tea	☐	q.	Soup	☐	q.	Salad	☐
r.	Toast	☐	r.	Sugar	☐	r.	Salad dressing	☐
s.	Water	☐	s.	Sweetener	☐	s.	Soda	☐
t.	Wheat bran	☐	t.	Tea	☐	t.	Sugar	☐
u.	Yogurt	☐	u.	Tomato	☐	u.	Sweetener	☐
v.	Other: (List below)	☐	v.	Water	☐	v.	Tea	☐
		☐	w.	Yogurt	☐	w.	Water	☐
		☐	x.	Other: (List below)	☐	x.	Yellow vegetables	☐
		☐			☐	y.	Other: (List below)	☐
		☐			☐			☐
		☐			☐			☐

24. Do you have symptoms immediately after eating (belching, bloating, sneezing, hives, etc.): ☐ Yes ☐ No
    If yes, please name the food(s) and symptom(s):
    ____
    ____

25. Do you feel you have delayed symptoms after eating certain foods (symptoms may not be evident for 24 hours or more and may include fatigue, muscle aches, sinus congestion, etc.): ☐ Yes ☐ No

26. Do you feel **worse** when you eat:
    ☐ High Fat Foods ☐ Refined Sugar ☐ High Protein Foods ☐ Fried Foods
    ☐ High Carbohydrate Foods ☐ Alcohol ☐ Breads/Pastas/Potatoes
    ☐ Other ____

27. Do you feel **better** when you eat:
    ☐ High Fat Foods ☐ Refined Sugar ☐ High Protein Foods ☐ Fried Foods
    ☐ High Carbohydrate Foods ☐ Alcoholic ☐ Breads/Pastas/Potatoes
    ☐ Other ____

28. Does skipping a meal greatly affect your symptoms: ☐ Yes ☐ No

29. Have you ever had a food that you craved or really "binged" on over a period of time (food craving may be an indicator that you may be allergic to that food): ☐ Yes ☐ No
    If yes, please list:
    ____
    ____

30. Do you have an aversion to certain foods: ☐ Yes ☐ No
    If yes, please list:
    ____
    ____

31. Please fill in the chart below with information about your bowel movements:

a. Frequency	√	**c. Color**	√
2-3x/day	☐	Medium brown consistently	☐
1x/day	☐	Very dark or black	☐
4-6x/week	☐	Greenish color	☐
2-3x/week	☐	Blood is visible	☐
1 or fewer/week	☐	Varies a lot	☐
		Dark brown consistently	☐
b. Consistency	☐	Yellow, light brown	☐
Soft and well formed	☐	Greasy, shiny appearance	☐
Often float	☐		
Difficult to pass	☐		
Diarrhea	☐		
Thin, long or narrow	☐		
Small and hard	☐		
Loose but not watery	☐		
Alternating between hard and loose/watery	☐		

32. Intestinal gas: ☐ Daily ☐ Present with pain ☐ Occasionally ☐ Foul smelling ☐ Excessive ☐ Little odor

33. a. Have you ever used alcohol: ☐ Yes ☐ No
    b. If yes, how often do you now drink alcohol (see below) or ☐ No longer drinking alcohol
    ☐ Average 1-3 drinks per week
    ☐ Average 4-6 drinks per week
    ☐ Average 7-10 drinks per week
    ☐ Average >10 drinks per week
    c. Have you ever had a problem with alcohol: ☐ Yes ☐ No
    If yes, please indicate time period (month/year): From ____________________________ to______________________________

34. Have you ever used recreational drugs: ☐ Yes ☐ No

35. Have you ever used tobacco: ☐ Yes ☐ No
    If yes, number of years as a nicotine user: _______________ Amount per day: __________________ Year quit: ______________
    If yes, what type of nicotine have you used? ☐ Cigarette ☐ Smokeless ☐ Cigar ☐ Pipe ☐ Patch/Gum

36. Are you exposed to second hand smoke regularly: ☐ Yes ☐ No

37. Do you have mercury amalgam fillings: ☐ Yes ☐ No

38. Do you have any artificial joints or implants: ☐ Yes ☐ No

39. Do you feel worse at certain times of the year: ☐ Yes ☐ No
    If yes, when: ☐ Spring ☐ Fall ☐ Summer ☐ Winter

40. Have you, to your knowledge, been exposed to toxic metals: ☐ Yes ☐ No
    If yes, which one(s): ☐ Lead ☐ Cadmium ☐ Arsenic ☐ Mercury ☐ Aluminum ☐ Other: _________________________

41. Do odors affect you: ☐ Yes ☐ No If yes, please list: ____

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42. How well have things been going for you?

	Very Well	Fair	Poor	Very Poor	N/A
a. At school					
b. In your job					
c. In your social life					
d. With close friends					
e. With sex					
f. With your attitude					
g. With your boyfriend/girlfriend					
h. With your children					
i. With your parents					
j. With your spouse					

43. Have you ever had psychotherapy or counseling: ☐ Yes ☐ No
Currently ☐ Previously ☐ If previously: From ________________to________________________________
What kind: ____
Comments: ____

44. Are you currently, or have you ever been married: ☐ Yes ☐ No
If yes, when were you married: ____
Please list your spouse's occupation: ____
Have you ever been separated: ☐ Yes ☐ No ☐ Never
Have you ever been divorced: ☐ Yes ☐ No ☐ Never
Were you ever remarried: ☐ Yes ☐ No ☐ Never If yes, please list your spouse's occupation: ____________
Comments: ____

45. Hobbies and leisure activities: ____
____

46. Do you exercise regularly: ☐ Yes ☐ No
If yes, how many times a week and length of each session:

1.☐ 1x	1.☐ ≤15 min
2.☐ 2x	2.☐ 16-30 min
3.☐ 3x	3.☐ 31-45 min
4.☐ 4x or more	4.☐ > 45 min

47. Type of exercise:

☐ Jogging/Walking	☐ Tennis
☐ Basketball	☐ Water Sports
☐ Home Aerobics	☐ Other ______________________________

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48. FAMILY HISTORY

(*Note: Except for* ***spouse****, Family refers to* ***blood*** *or* ***natural*** *relatives.)* **PRINT NAMES BELOW**	Good Health	Poor Health	Deceased	Write in age and cause of death. Include accidents and suicides.	Alcoholism	Allergies or Asthma	Alzheimer's or Dementia	Anemia	Blood Clotting Problems	Diabetes	Cancer or Tumor	Epilepsy	Genetic Disease	Heart Heart Trouble	High Blood Pressure	Kidney or Bladder	Nervous Breakdown	Rheumatism or Arthritis	Stomach or ulcer
Father	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother:	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brothers/Sisters:	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Spouse:	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Child:	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Child:	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Child:	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Child:	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal relatives (in each box, write in how many affected with condition):	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal relatives (in each box, write in how many affected with condition):	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

49. Any other family history we should know about: ☐ Yes ☐ No
    If yes, please comment: ____________________

50. What is the attitude of those close to you about your symptoms:
    ☐ Supportive, explain: ____________________
    ☐ Non-supportive, explain: ____________________

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FOR WOMEN ONLY (questions 51 - 61):

51. Have you ever been pregnant (if no skip to question 53): ☐ Yes ☐ No

    Number of term births: __________ Birth weight of largest baby: __________ Birth weight of smallest baby: ____________

    Were any of your children born premature: ☐ Yes ☐ No If yes, please comment: ________________________________

    Did you develop any complications with any of your pregnancies: ☐ Yes ☐ No
    If yes, please list: ____

52. Have you ever had any interrupted pregnancies: ☐ Yes ☐ No
    If yes, please list: Number of miscarriages: __________ Abortions: __________ Other: _________________________________

53. Age of first cycle: _______________ Date of last Pap Smear: _______________ Date of last Mammogram: ______________

    Pap Smear: ☐ Normal ☐ Abnormal If abnormal, please comment: ____

    Mammogram: ☐ Normal ☐ Abnormal If abnormal, please comment: ____

54. Have you ever used birth control pills: ☐ Yes ☐ No If yes, when: ____

55. Are you taking birth control pills now: ☐ Yes ☐ No

56. Did taking birth control pills agree with you: ☐ Yes ☐ No

57. Do you currently use contraception: ☐ Yes ☐ No If yes, please comment: _______________________________________

58. Are you in menopause: ☐ Yes ☐ No If yes, date of last cycle: ____

59. Please list all hormones you are currently taking or have taken in the past: ____
    ____

60. How long have you been on hormone therapy (if applicable): ____

61. In the second half of your cycle, do you have symptoms of breast tenderness, water retention, irritability, etc. (PMS):
    ☐ Yes ☐ No ☐ Not applicable If yes, please comment: ____

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62. Please check if these symptoms occur presently or have occurred in the past 6 months:

GENERAL:	Mild	Moderate	Severe
Cold intolerance	☐	☐	☐
Daytime sleepiness	☐	☐	☐
Difficulty falling asleep	☐	☐	☐
Early waking	☐	☐	☐
Fatigue	☐	☐	☐
Fever	☐	☐	☐
Flushing	☐	☐	☐
Heat intolerance	☐	☐	☐
Night waking	☐	☐	☐
Nightmares	☐	☐	☐
No dream recall	☐	☐	☐

MUSCULOSKELETAL:	Mild	Moderate	Severe
Back muscle spasm	☐	☐	☐
Calf cramps	☐	☐	☐
Chest tightness	☐	☐	☐
Foot cramps	☐	☐	☐
Joint deformity	☐	☐	☐
Joint pain	☐	☐	☐
Joint redness	☐	☐	☐
Joint stiffness	☐	☐	☐
Muscle pain	☐	☐	☐
Muscle spasms	☐	☐	☐
Muscle stiffness	☐	☐	☐
Muscle twitches: Around eyes	☐	☐	☐
Arms or legs	☐	☐	☐
Muscle weakness	☐	☐	☐
Neck muscle spasm	☐	☐	☐
Tendonitis	☐	☐	☐
Tension headache	☐	☐	☐
TMJ problems	☐	☐	☐

MOOD/NERVES:	Mild	Moderate	Severe
Agoraphobia	☐	☐	☐
Anxiety	☐	☐	☐
Auditory hallucinations	☐	☐	☐
Black-out	☐	☐	☐
Depression	☐	☐	☐
Difficulty: Concentrating	☐	☐	☐
With balance	☐	☐	☐
With thinking	☐	☐	☐
With judgment	☐	☐	☐
With speech	☐	☐	☐
With memory	☐	☐	☐
Dizziness (spinning)	☐	☐	☐
Fainting	☐	☐	☐
Fearfulness	☐	☐	☐
Irritability	☐	☐	☐
Light-headedness	☐	☐	☐
Numbness	☐	☐	☐
Other phobias	☐	☐	☐
Panic attacks	☐	☐	☐
Paranoia	☐	☐	☐
Seizures	☐	☐	☐
Suicidal thoughts	☐	☐	☐
Tingling	☐	☐	☐
Tremor/trembling	☐	☐	☐
Visual hallucinations	☐	☐	☐

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HEAD, EYES & EARS:	Mild	Moderate	Severe
Conjunctivitis	☐	☐	☐
Distorted sense of smell	☐	☐	☐
Distorted taste	☐	☐	☐
Ear fullness	☐	☐	☐
Ear pain	☐	☐	☐
Ear ringing/buzzing	☐	☐	☐
Eye crusting	☐	☐	☐
Eye pain	☐	☐	☐
Headache	☐	☐	☐
Hearing loss	☐	☐	☐
Hearing problems	☐	☐	☐
Lid margin redness	☐	☐	☐
Migraine	☐	☐	☐
Sensitivity to loud noises	☐	☐	☐
Vision problems	☐	☐	☐

EATING:	Mild	Moderate	Severe
Binge eating	☐	☐	☐
Bulimia	☐	☐	☐
Can't gain weight	☐	☐	☐
Can't lose weight	☐	☐	☐
Carbohydrate craving	☐	☐	☐
Carbohydrate intolerance	☐	☐	☐
Poor appetite	☐	☐	☐
Salt craving	☐	☐	☐

DIGESTION:	Mild	Moderate	Severe
Anal spasms	☐	☐	☐
Bleeding gums	☐	☐	☐
Bloating of: Lower abdomen	☐	☐	☐
Whole abdomen	☐	☐	☐
Blood in stools	☐	☐	☐
Burping	☐	☐	☐
Canker sores	☐	☐	☐
Cold sores	☐	☐	☐
Constipation	☐	☐	☐
Cracking at corner of lips	☐	☐	☐
Dentures w/poor chewing	☐	☐	☐
Diarrhea	☐	☐	☐
Difficulty swallowing	☐	☐	☐
Dry mouth	☐	☐	☐
Farting	☐	☐	☐
Fissures	☐	☐	☐
Foods "repeat" (reflux)	☐	☐	☐
Heartburn	☐	☐	☐
Hemorrhoids	☐	☐	☐
Intolerance to: Lactose	☐	☐	☐
All milk products	☐	☐	☐
Intolerance to: Gluten (wheat)	☐	☐	☐
Corn	☐	☐	☐
Eggs	☐	☐	☐
Fatty foods	☐	☐	☐
Yeast	☐	☐	☐
Liver disease/jaundice	☐	☐	☐
Lower abdominal pain	☐	☐	☐
Mucus in stools	☐	☐	☐
Nausea	☐	☐	☐
Periodontal disease	☐	☐	☐
Sore tongue	☐	☐	☐
Strong stool odor	☐	☐	☐
Undigested food in stools	☐	☐	☐
Upper abdominal pain	☐	☐	☐
Vomiting	☐	☐	☐

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SKIN PROBLEMS:	Mild	Moderate	Severe
Acne	☐	☐	☐
Bumps on back of upper arms	☐	☐	☐
Cellulite	☐	☐	☐
Dark circles under eyes	☐	☐	☐
Ears get red	☐	☐	☐
Easy bruising	☐	☐	☐
Eczema	☐	☐	☐
Herpes – genital	☐	☐	☐
Hives	☐	☐	☐
Jock itch	☐	☐	☐
Lackluster skin	☐	☐	☐
Moles with color/size change	☐	☐	☐
Oily skin	☐	☐	☐
Pale skin	☐	☐	☐
Patchy dullness	☐	☐	☐
Psoriasis	☐	☐	☐
Rash	☐	☐	☐
Red face	☐	☐	☐
Sensitive to bites	☐	☐	☐
Sensitive to poison ivy	☐	☐	☐
Shingles	☐	☐	☐
Skin cancer	☐	☐	☐
Skin darkening	☐	☐	☐
Strong body odor	☐	☐	☐
Thick calluses	☐	☐	☐

SKIN, ITCHING:	Mild	Moderate	Severe
Anus	☐	☐	☐
Ear canals	☐	☐	☐
Eyes	☐	☐	☐
Feet or legs	☐	☐	☐
Hands or arms	☐	☐	☐
Nipples	☐	☐	☐
Nose	☐	☐	☐
Penis	☐	☐	☐
Roof of mouth	☐	☐	☐
Scalp	☐	☐	☐
Throat	☐	☐	☐

DRYNESS OF:	Mild	Moderate	Severe
Eyes	☐	☐	☐
Feet	☐	☐	☐
Any cracking	☐	☐	☐
Any peeling	☐	☐	☐
Hair	☐	☐	☐
And unmanageable	☐	☐	☐
Hands	☐	☐	☐
Any cracking	☐	☐	☐
Any peeling	☐	☐	☐
Mouth/throat	☐	☐	☐
Scalp	☐	☐	☐
Any dandruff	☐	☐	☐
Skin in general	☐	☐	☐

LYMPH NODES:	Mild	Moderate	Severe
Enlarged (neck)	☐	☐	☐
Tender (neck)	☐	☐	☐
Other enlarged/tender lymph nodes	☐	☐	☐

NAILS:	Mild	Moderate	Severe
Bitten	☐	☐	☐
Brittle	☐	☐	☐
Curve up	☐	☐	☐
Frayed	☐	☐	☐
Fungus - fingers	☐	☐	☐
Fungus - toes	☐	☐	☐
Pitting	☐	☐	☐
Ragged cuticles	☐	☐	☐
Ridges	☐	☐	☐
Soft	☐	☐	☐
Thickening of: Finger nails	☐	☐	☐
Toenails	☐	☐	☐
White spots/lines	☐	☐	☐

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RESPIRATORY:	Mild	Moderate	Severe
Bad breath	☐	☐	☐
Bad odor in nose	☐	☐	☐
Cough - dry	☐	☐	☐
Cough - productive	☐	☐	☐
Hay fever : Spring	☐	☐	☐
Summer	☐	☐	☐
Fall	☐	☐	☐
Change of season	☐	☐	☐
Hoarseness	☐	☐	☐
Nasal stuffiness	☐	☐	☐
Nose bleeds	☐	☐	☐
Post nasal drip	☐	☐	☐
Sinus fullness	☐	☐	☐
Sinus infection	☐	☐	☐
Snoring	☐	☐	☐
Sore throat	☐	☐	☐
Wheezing	☐	☐	☐
Winter stuffiness	☐	☐	☐

CARDIOVASCULAR:	Mild	Moderate	Severe
Angina/chest pain	☐	☐	☐
Breathlessness	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
High blood pressure	☐	☐	☐
Irregular pulse	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Palpitations	☐	☐	☐
Phlebitis	☐	☐	☐
Swollen ankles/feet	☐	☐	☐
Varicose veins	☐	☐	☐

MALE REPRODUCTIVE:	Mild	Moderate	Severe
Discharge from penis	☐	☐	☐
Ejaculation problem	☐	☐	☐
Genital pain	☐	☐	☐
Impotence	☐	☐	☐
Infection	☐	☐	☐
Lumps in testicles	☐	☐	☐
Poor libido (sex drive)	☐	☐	☐

URINARY:	Mild	Moderate	Severe
Bed wetting	☐	☐	☐
Hesitancy	☐	☐	☐
Infection	☐	☐	☐
Kidney disease	☐	☐	☐
Kidney stone	☐	☐	☐
Leaking/incontinence	☐	☐	☐
Pain/burning	☐	☐	☐
Prostate enlargement	☐	☐	☐
Prostate infection	☐	☐	☐
Urgency	☐	☐	☐

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FEMALE REPRODUCTIVE:	Mild	Moderate	Severe
Breast tenderness	☐	☐	☐
Breast cysts (lumps)	☐	☐	☐
Carbohydrate craving	☐	☐	☐
Chocolate craving	☐	☐	☐
Constipation/Diarrhea	☐	☐	☐
Cramps	☐	☐	☐
Decreased sleep	☐	☐	☐
Endometriosis	☐	☐	☐
Fatigue	☐	☐	☐
Fibroids	☐	☐	☐
Heavy periods	☐	☐	☐
Infertility	☐	☐	☐
Irregular periods	☐	☐	☐
No/Light periods	☐	☐	☐
Ovarian cyst(s)	☐	☐	☐
Poor libido (sex drive)	☐	☐	☐
Spotting	☐	☐	☐
Vaginal discharge/odor	☐	☐	☐
Vaginal itch	☐	☐	☐
Vaginal pain	☐	☐	☐

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Adrenal Fatigue

What is Adrenal Fatigue?

Adrenal Fatigue is known as a syndrome that results when the adrenal glands function at a suboptimal level. It can affect people of all ages, occupations, races, and social and economic groups. It may also contribute to various aspects of aging.

Adrenal Fatigue, though common, is routinely overlooked and if recognized, is seldom addressed.

If you experience any of the following symptoms, you may be suffering from adrenal fatigue.

- Do you tire easily?
- Do you feel fatigued rather than energetic?
- Are people telling you "you don't look so good lately?"
- Do you feel like you are working harder but accomplishing less?
- Do you often experience unexplained sadness?
- Are you forgetting appointments, deadlines, or personal possessions more frequently?
- Have you become more irritable?
- Are you more short-tempered?
- Are you more disappointed with people around you?
- Do you see family members and close friends less frequently?
- Are you too busy to do even routine things like make phone calls, read, etc?
- Do you feel disoriented when the activity of the day comes to a halt?
- Are you unable to laugh at a joke about yourself?

Please complete the following comprehensive questionnaire to allow us to do a preliminary assessment on the potential state of your adrenal system. Further evaluation may be recommended on an individual basis if needed.

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Adrenal Fatigue Questionnaire

Name:
Date of Birth:
Date:
How were you referred to Portage Pharmacy's Consulting Services?

Instructions: Please enter the appropriate numeric response to each statement in the columns below. When done correctly, you will have 2 answers for each question. The response in the past column should be based on a time period in which you last remembering feeling well. Think back to the last time you felt well and respond accordingly. The response in the now column should be based on how you feel now on a day to day basis. If a statement does not apply to you, enter 0 or leave blank.

0 = Never/Rarely
1 = Occasionally/Slightly
2 = Moderate in Intensity or Frequency
3 = Intense/Severe or Frequent

I have not felt well since (date) _______________ when (describe event, if any) ______________________________________.

Predisposing Factors

	Past	Now	
1	_____	_____	I have experienced long periods of stress that have affected my well-being.
2	_____	_____	I have had one or more severely stressful events that have affected my well-being.
3	_____	_____	I have driven myself to exhaustion.
4	_____	_____	I overwork with little play or relaxation for extended periods.
5	_____	_____	I have had extended, severe or recurring respiratory infections.
6	_____	_____	I have taken long term or intense steroid therapy (corticosteroids).
7	_____	_____	I tend to gain weight, especially around the middle (spare tire).
8	_____	_____	I have a history of alcoholism and/or drug abuse.
9	_____	_____	I have environmental sensitivities.
10	_____	_____	I have diabetes.
11	_____	_____	I suffer from posttraumatic distress syndrome.
12	_____	_____	I suffer from anorexia. *
13	_____	_____	I have one or more other chronic illnesses or diseases.
	_____	_____	Total

Key Signs & Symptoms

	Past	Now	
1	_____	_____	My ability to handle stress and pressure has decreased.
2	_____	_____	I am less productive at work.
3	_____	_____	I seem to have decreased in cognitive ability. I do not think as clearly as I used to.
4	_____	_____	My thinking is confused when hurried or under pressure.
5	_____	_____	I tend to avoid emotional situations.
6	_____	_____	I tend to shake or am nervous when under pressure.
7	_____	_____	I suffer from nervous stomach or indigestion when tense.
8	_____	_____	I have many unexplained fears/anxieties.
9	_____	_____	My sex drive is noticeably less than it used to be.
10	_____	_____	I get lightheaded or dizzy when rising rapidly from a sitting or lying position.
11	_____	_____	I have feelings of blacking out.
12	_____	_____	I am chronically fatigued; a tiredness that is not usually relieved by sleep.*
13	_____	_____	I feel unwell much of the time.
14	_____	_____	I notice that my ankles are sometimes swollen, and the swelling is worse in the evening.
15	_____	_____	I usually need to lie down or rest after sessions of psychological or emotional pressure/stress.
16	_____	_____	My muscles sometimes feel weaker than they should.

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	Past	Now	
17	_____	_____	My hands and legs get restless or experience meaningless body movements.
18	_____	_____	I have become allergic or have increased frequency/severity of allergic reactions.
19	_____	_____	When I scratch my skin, a white line remains for a minute or more.
20	_____	_____	Small irregular dark brown spots have appeared on my forehead, face, neck, and shoulders.
21	_____	_____	I sometimes feel weak all over. *
22	_____	_____	I have unexplained and frequent headaches.
23	_____	_____	I am frequently cold.
24	_____	_____	I have decreased tolerance for cold. *
25	_____	_____	I have low blood pressure. *
26	_____	_____	I often become hungry, confused, shaky, or somewhat paralyzed under stress.
27	_____	_____	I have lost weight without reason.
28	_____	_____	I have feelings of hopelessness or despair.
29	_____	_____	I have decreased tolerance and I am more irritable.
30	_____	_____	The lymph nodes in my neck are frequently swollen (I get swollen glands in my neck).
31	_____	_____	I have times of nausea and vomiting for no apparent reason. *
	_____	_____	Total

Energy Patterns

	Past	Now	
1	_____	_____	I often have to force myself in order to keep going.
2	_____	_____	I am easily fatigued.
3	_____	_____	I have difficulty getting up in the morning.
4	_____	_____	I suddenly run out of energy.
5	_____	_____	I usually feel much better and fully awake after the noon meal.
6	_____	_____	I often have an afternoon low between 3:00-5:00pm.
7	_____	_____	I get low energy, moody or foggy if I do not eat regularly.
8	_____	_____	I usually feel my best after 6:00pm.
9	_____	_____	I am often tired at 9-10:00pm, but resist going to bed.
10	_____	_____	I like to sleep late in the morning.
11	_____	_____	My best, most refreshing sleep often comes between 7:00-9:00am.
12	_____	_____	I often do my best work late at night (early in the morning).
13	_____	_____	If I do not go to bed by 11:00pm, I get a second burst of energy around 11:00pm, often lasting until 1:00-2:00am.
	_____	_____	Total

Frequently Observed Events

	Past	Now	
1	_____	_____	I get coughs/colds that stay around for several weeks.
2	_____	_____	I have frequent or recurring bronchitis, pneumonia or other respiratory infections.
3	_____	_____	I get asthma, colds, and other respiratory involvements two or more times per year.
4	_____	_____	I frequently get rashes, dermatitis, or other skin conditions.
5	_____	_____	I have rheumatoid arthritis.
6	_____	_____	I have allergies to several things in the environment.
7	_____	_____	I have multiple chemical sensitivities.
8	_____	_____	I have chronic fatigue syndrome.
9	_____	_____	I get pain in the muscles of my upper back and lower neck for no apparent reason.
10	_____	_____	I get pains in the muscles on the sides of my neck.
11	_____	_____	I have insomnia or difficulty sleeping.
12	_____	_____	I have been diagnosed with fibromyalgia.
13	_____	_____	I suffer from asthma.
14	_____	_____	I suffer from hay fever.
15	_____	_____	I suffer from nervous breakdowns.
16	_____	_____	My allergies are becoming worse (more severe and/or frequent or diverse).

17	_____	_____	The fat pads on palms of my hands and/or tips of my fingers are often red.
18	_____	_____	I bruise more easily than I used to.
19	_____	_____	I have tenderness in my back near my spine at the bottom of my rib cage when pressed.
20	_____	_____	I have swelling under my eyes upon rising that goes away after I have been up for a couple of hours.

The next 2 questions are for women only

21	_____	_____	I have increasing symptoms of premenstrual syndrome (PMS) such as cramps, bloating, moodiness, irritability, emotional instability, headaches, tiredness, and/or intolerance before my period (only some of these need be present).
22	_____	_____	My periods are generally heavy but they often stop, or almost stop, on the fourth day, only to start up profusely on the 5th or 6th day.
	_____	_____	Total

Food Patterns

	Past	Now	
1	_____	_____	I need coffee or some other stimulant to get going in the morning.
2	_____	_____	I often crave food high in fat and feel better with high fat foods.
3	_____	_____	I use high fat foods to drive myself.
4	_____	_____	I often use high fat foods and caffeine containing drinks (coffee, colas, and chocolate) to drive myself.
5	_____	_____	I often crave salt and/or foods high in salt.
6	_____	_____	I feel worse if I eat high potassium foods (bananas, figs, and raw potatoes), especially if I eat them in the morning.
7	_____	_____	I crave high protein foods (meats, cheeses).
8	_____	_____	I crave sweet foods (pies, cakes, pastries, doughnuts, dried fruits, candies, or desserts).
9	_____	_____	I feel worse if I miss or skip a meal.
	_____	_____	Total

Aggravating Factors

	Past	Now	
1	_____	_____	I have constant stress in my life or work.
2	_____	_____	My dietary habits tend to be sporadic and unplanned.
3	_____	_____	My relationships at work and/or home are unhappy.
4	_____	_____	I do not exercise regularly.
5	_____	_____	I eat lots of fruit.
6	_____	_____	My life contains insufficient enjoyable activities.
7	_____	_____	I have little control over how I spend my time.
8	_____	_____	I restrict my salt intake.
9	_____	_____	I have gum and/or tooth infections or abscesses.
10	_____	_____	I have meals at irregular times.
	_____	_____	Total

Relieving Factors

1	_____	_____	I feel better almost right away once a stressful situation is resolved.
2	_____	_____	Regular meals decrease the severity of my symptoms.
3	_____	_____	I often feel better after spending a night out with friends.
4	_____	_____	I often feel better if I lie down.
5	_____	_____	Other relieving factors_.
	_____	_____	Total

ADDITIONAL QUESTIONS: (Please answer, even if repetitive. Thank you).

1. Are you currently taking any medications? If yes, please list:
2. Are you currently taking any supplements? If yes, please list:
3. Do you currently have any existing medical conditions? If yes, please list:
4. Are you allergic to any medications? If yes, please list:
5. Do you have environmental allergies (dust, mold, chemicals, etc.)? If yes, please list:
6. Do you have a history of thyroid disease?