
Dr. Jon Widenbaum, DC, FAFICC

DUBLIN THYROID

INSTITUTE

Thyroid Recovery Program Application

Dear Prospective Thyroid Patient,

Welcome to the Dublin Thyroid Institute!

We specialize in helping thyroid patients naturally achieve their highest level health and function. Giving you more energy, more motivation, clearer thinking...yes, better days are ahead.

Complete and return the following pages and any lab and diagnostic test results you have received (in the last 6-12 months) to our office on the day of your appointment or if possible prior via fax (925) 829-8484 or email: dublinwellness@gmail.com.
The questions we ask provide important information that will help us determine how to best help you. You deserve the best, so please give us yours when you answer these questions.

Please feel free call us at 925-829-8484 if you need assistance.

Thank you. We look forward to serving you.

Sincerely,

Jonathan J. Widenbaum, DC, FAFICC

Health Questionnaire - THYROID

First Name _____ Middle Initial _____ Last Name _____

Home Phone _____ Cell Phone _____ Work Phone _____

Address _____ City _____

State _____ Zip _____ Email Address _____

Age _____ DOB _____/_____/_____ Male / Female Marital Status: Married / Single / Partnered /

Widowed / Divorced / Separated. Spouse / Partner Name: _____

Primary Care Physician _____ Physician Phone _____

Do we have permission to contact your doctor regarding your care in our office? _____YES / _____NO

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1. When were you diagnosed with a Thyroid Condition?

_____

What diagnostic tools were used to achieve your diagnosis?

_____

If not diagnosed, have you always thought you had a thyroid problem even without a diagnosis? YES / NO

2 Are you currently on thyroid hormones? YES / NO **OR** were you previously on them? YES / NO

3. Symptoms (list all): _____

_____

_____

_____

How long have you had these symptoms? _____

4. In spite of the fact that you are not a doctor, you are in fact the person who knows more about your condition than anyone else. In your own words and your opinion, what do you think the real problem is:

_____

_____

_____

_____

5. What relieves your symptoms or cause them to return?

_____

_____

_____

6. Severity of problem: (circle)

- MINIMAL (Annoying but causing NO limitations)
- SLIGHT (Tolerable but causing a little limitation)
- MODERATE (Sometimes tolerable but causing limitations)
- SEVERE (Causing significant limitations)
- EXTREME (Near constant limitations >80% of time)

7. Please list the symptoms of low thyroid that **persisted** after taking prescription thyroid hormones:

_____

_____

8. How often are you aware of your main problem? (circle)
   - Occasionally (25% of the time)
   - Intermittently (50% of the time)
   - Frequently (75% of the time)
   - Constantly (>90% of the time)
9. Have you ever been tested for auto-immune thyroid condition? (Hashimoto's) YES / NO
10. Have you ever been diagnosed as having an auto-immune thyroid? YES / NO
11. What are 3 things your condition has caused you to miss? _____

_____

_____

12. List your health goals in order of importance:
    1. _____
    2. _____
    3. _____
    4. _____
    5. _____
13. What are you hoping happens today as a results of your consultation? _____

_____

_____

_____

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Have you had or do you have any of the following conditions or diseases?

P = Previously / C = Currently

P C AD/HD
P C Adrenal disorder
P C Allergies
P C Anxiety
P C Arthritis
P C Asthma
P C Autoimmune disorder
P C Bleeding disorder
P C Blurred vision
P C Bowel/Bladder problems
P C Buzzing in ear
P C Cancer - type? _____
P C Carpal tunnel syndrome
P C Celiac disease (gluten)
P C Chest pains
P C Chronic fatigue
P C Cold hands or feet
P C Colitis/diverticulitis
P C Compression fractures
P C Connective tissue issues
P C COPD
P C Depression
P C Diabetes
P C Digestive/bowel problems
P C Dizziness or vertigo
P C Ear infections
P C Fibromyalgia
P C Food sensitivity
P C Fusions (spinal, joint)
P C Gout
P C Gall Bladder issue
P C Immune compromise
P C Infection Chronic
P C Heart disease
P C Hepatitis (A, B, C, etc.)
P C Herpes
P C High blood pressure
P C Hip replacement
P C HIV/AIDS
P C Kidney disease
P C Knee surgery
P C Liver disease
P C Multiple sclerosis
P C Osteoporosis/penia
P C Parkinson's disease
P C Rotator cuff problem
P C STI/STD
P C Shoulder surgery
P C Spinal surgery
P C Stroke/TIA
P C Thyroid problems
P C Tuberculosis

Other _____

Other _____

Are there any conditions that run in your family? Yes / No If yes, what condition(s) and which family member?

_____

_____

_____

_____

LIFESTYLE QUESTIONS

Are you currently pregnant or do you think you may be pregnant? Yes / No If yes, how many weeks?_____

Weight _____lbs. / Height _____What is your goal weight? _____lbs.

What is your energy level? (0=lowest, 10=highest) _____What time of day do you feel the most energy? _____

What percentage of time can you easily fall asleep (within 15 minutes)? 25% / 50% / 75% / 100%

How many times a night to you wake up? _____Do you feel refreshed upon waking? Yes / No

Do you exercise? Yes / No If yes, what type and how often? Type:_____Frequency: _____/wk

Do you feel energized after exercise? Yes / No Do you feel exhausted after exercise? Yes / No

Can you easily recover within a day or two after exercise? Yes / No

Do you experience any of the following? Bloating / GERD / Constipation / Diarrhea

How many hours per week do you typically work / attend school? _____hours

What are your typical duties and postures? _____

Do you smoke cigarettes? Yes / No Packs per day ____

The information I have provided is truthful and accurate:

_____

Patient Signature Date ____/____/____

My Current Diet

Name: _____ Date: ___/___/___

List your diet on an average day below. Don't worry about trying to impress us by telling the doctor what you think he wants to hear. Just think about how you eat on an average day.

Check all the meals that you eat each day (check all that apply):

___Breakfast ___Snack ___Lunch ___Snack ___Dinner ___Snack

A typical breakfast consists of _____

_____

A typical lunch consists of _____

_____

A typical dinner consists of _____

_____

A typical snack between meals consists of _____

_____

How much water to you drink/day? _____cups

Do you drink green/black tea? _____cups

Do you drink herbal tea? YES / NO What is it the tea? _____

How much coffee do you drink /day? _____cups

How much soda pop do you drink/day? _____cans

List any known food sensitivities or allergies: _____

List the foods that you crave: _____

My Surgical History

List the type of surgery, reason for the surgery and year performed. (ie: left breast surgery for cancer in 2004)

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

Medications

Name _____ Date ___/___/___

List the name of each current prescribed and over the counter medications, its prescribed use and any side-effects/reactions/positive responses. (example of use: BCP - birth control pills can be used to prevent pregnancy, manage menopause or acne, etc.). (example of side-effect could be Tylenol caused liver enzymes to increase).

	Medication	The name of the condition or purpose for taking this medication (i.e. - birth control pills for acne or endometriosis) (We don't need the number of pills or the dosage - mg/day info)	Any Side-effects
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

Metabolic Assessment Form

Name: _____ **Date:** _____

PART I **Please circle the appropriate number on all questions below.**
0 as the least/never to 3 as the most/always.

Category I				
Feeling that bowels do not empty completely	**0**	**1**	**2**	**3**
Lower abdominal pain relieved by passing stool or gas	**0**	**1**	**2**	**3**
Alternating constipation and diarrhea	**0**	**1**	**2**	**3**
Diarrhea	**0**	**1**	**2**	**3**
Constipation	**0**	**1**	**2**	**3**
Hard, dry, or small stool	**0**	**1**	**2**	**3**
Coated tongue or "fuzzy" debris on tongue	**0**	**1**	**2**	**3**
Pass large amount of foul-smelling gas	**0**	**1**	**2**	**3**
More than 3 bowel movements daily	**0**	**1**	**2**	**3**
Use laxatives frequently	**0**	**1**	**2**	**3**
Category II				
Increasing frequency of food reactions	**0**	**1**	**2**	**3**
Unpredictable food reactions	**0**	**1**	**2**	**3**
Aches, pains, and swelling throughout the body	**0**	**1**	**2**	**3**
Unpredictable abdominal swelling	**0**	**1**	**2**	**3**
Frequent bloating and distention after eating	**0**	**1**	**2**	**3**
Abdominal intolerance to sugars and starches	**0**	**1**	**2**	**3**
Category III				
Intolerance to smells	**0**	**1**	**2**	**3**
Intolerance to jewelry	**0**	**1**	**2**	**3**
Intolerance to shampoo, lotion, detergents, etc.	**0**	**1**	**2**	**3**
Multiple smell and chemical sensitivities	**0**	**1**	**2**	**3**
Constant skin outbreaks	**0**	**1**	**2**	**3**
Category IV				
Excessive belching, burping, or bloating	**0**	**1**	**2**	**3**
Gas immediately following a meal	**0**	**1**	**2**	**3**
Offensive breath	**0**	**1**	**2**	**3**
Difficult bowel movement	**0**	**1**	**2**	**3**
Sense of fullness during and after meals	**0**	**1**	**2**	**3**
Difficulty digesting fruits and vegetables; undigested food found in stools	**0**	**1**	**2**	**3**
Category V				
Stomach pain, burning, or aching 1-4 hours after eating	**0**	**1**	**2**	**3**
Use antacids	**0**	**1**	**2**	**3**
Feel hungry an hour or two after eating	**0**	**1**	**2**	**3**
Heartburn when lying down or bending forward	**0**	**1**	**2**	**3**
Temporary relief by using antacids, food, milk, or carbonated beverages	**0**	**1**	**2**	**3**
Digestive problems subside with rest and relaxation	**0**	**1**	**2**	**3**
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	**0**	**1**	**2**	**3**
Category VI				
Roughage and fiber cause constipation	**0**	**1**	**2**	**3**
Indigestion and fullness last 2-4 hours after eating	**0**	**1**	**2**	**3**

Category VI (continued)				
Excessive passage of gas	**0**	**1**	**2**	**3**
Nausea and/or vomiting	**0**	**1**	**2**	**3**
Stool undigested, foul smelling, mucous like, greasy, or poorly formed	**0**	**1**	**2**	**3**
Frequent urination	**0**	**1**	**2**	**3**
Increased thirst and appetite	**0**	**1**	**2**	**3**
Difficulty losing weight	**0**	**1**	**2**	**3**
Category VII				
Greasy or high-fat foods cause distress	**0**	**1**	**2**	**3**
Lower bowel gas and/or bloating several hours after eating	**0**	**1**	**2**	**3**
Bitter metallic taste in mouth, especially in the morning	**0**	**1**	**2**	**3**
Unexplained itchy skin	**0**	**1**	**2**	**3**
Yellowish cast to eyes	**0**	**1**	**2**	**3**
Stool color alternates from clay colored to normal brown	**0**	**1**	**2**	**3**
Reddened skin, especially palms	**0**	**1**	**2**	**3**
Dry or flaky skin and/or hair	**0**	**1**	**2**	**3**
History of gallbladder attacks or stones	**0**	**1**	**2**	**3**
Have you had your gallbladder removed?		**Yes**	**No**	
Category VIII				
Acne and unhealthy skin	**0**	**1**	**2**	**3**
Excessive hair loss	**0**	**1**	**2**	**3**
Overall sense of bloating	**0**	**1**	**2**	**3**
Bodily swelling for no reason	**0**	**1**	**2**	**3**
Hormone imbalances	**0**	**1**	**2**	**3**
Weight gain	**0**	**1**	**2**	**3**
Poor bowel function	**0**	**1**	**2**	**3**
Excessively foul-smelling sweat	**0**	**1**	**2**	**3**
Category IX				
Crave sweets during the day	**0**	**1**	**2**	**3**
Irritable if meals are missed	**0**	**1**	**2**	**3**
Depend on coffee to keep going/get started	**0**	**1**	**2**	**3**
Get light-headed if meals are missed	**0**	**1**	**2**	**3**
Eating relieves fatigue	**0**	**1**	**2**	**3**
Feel shaky, jittery, or have tremors	**0**	**1**	**2**	**3**
Agitated, easily upset, nervous	**0**	**1**	**2**	**3**
Poor memory/forgetful	**0**	**1**	**2**	**3**
Blurred vision	**0**	**1**	**2**	**3**
Category X				
Fatigue after meals	**0**	**1**	**2**	**3**
Crave sweets during the day	**0**	**1**	**2**	**3**
Eating sweets does not relieve cravings for sugar	**0**	**1**	**2**	**3**
Must have sweets after meals	**0**	**1**	**2**	**3**
Waist girth is equal or larger than hip girth	**0**	**1**	**2**	**3**
Frequent urination	**0**	**1**	**2**	**3**
Increased thirst and appetite	**0**	**1**	**2**	**3**
Difficulty losing weight	**0**	**1**	**2**	**3**

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XI

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIII

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XIV

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XV

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVI

Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XVII

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting" - type headaches	0	1	2	3

Category XVIII *(Males Only)*

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XIX *(Males Only)*

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XX *(Menstruating Females Only)*

Perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle (greater than 32 days)	Yes	No		
Shortened menstrual cycle (less than 24 days)	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XXI *(Menopausal Females Only)*

How many years have you been menopausal?	_____ years			
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART II

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times do you eat raw nuts or seeds per week? _____

Rate your stress level on a scale of 1-10 during the average week: _____

How many times do you eat fish per week? _____

How many times do you work out per week? _____

List the three worst foods you eat during the average week: _____ _____ _____

List the three healthiest foods you eat during the average week: _____ _____ _____

Health Questionnaire (NTAF)

Name: _____ Age: _____ Sex: _____ Date: _____

*** Please circle the appropriate number "0 - 3" on all questions below. 0 as the least/never to 3 as the most/always.**

SECTION A

Is your memory noticeably declining? **0 1 2 3**
Are you having a hard time remembering names and phone numbers? **0 1 2 3**
Is your ability to focus noticeably declining? Has **0 1 2 3**
it become harder for you to learn things? How **0 1 2 3**
often do you have a hard time remembering your appointments? **0 1 2 3**
Is your temperament getting worse in general? **0 1 2 3**
Are you losing your attention span endurance? **0 1 2 3**
How often do you find yourself down or sad? **0 1 2 3**
How often do you fatigue when driving compared to the past? **0 1 2 3**
How often do you fatigue when reading compared to the past? **0 1 2 3**
How often do you walk into rooms and forget why? **0 1 2 3**
How often do you pick up your cell phone and forget why? **0 1 2 3**

SECTION B

How high is your stress level? **0 1 2 3**
How often do you feel that you have something that must be done? **0 1 2 3**
Do you feel you never have time for yourself? **0 1 2 3**
How often do you feel you are not getting enough sleep or rest? **0 1 2 3**
Do you find it difficult to get regular exercise? **0 1 2 3**
Do you feel uncared for by the people in your life? **0 1 2 3**
Do you feel you are not accomplishing your life's purpose? **0 1 2 3**
Is sharing your problems with someone difficult for you? **0 1 2 3**

SECTION C

SECTION C1

How often do you get irritable, shaky, or have lightheadedness between meals? **0 1 2 3**
How often do you feel energized after eating? **0 2 3**
How often do you have difficulty eating large meals in the morning? **0 1 2 3**
How often does your energy level drop in the afternoon? **0 1 2 3**
How often do you crave sugar and sweets in the afternoon? **0 1 2 3**
How often do you wake up in the middle of the night? **0 1 2 3**
How often do you have difficulty concentrating before eating? **0 1 2 3**
How often do you depend on coffee to keep yourself going? **0 1 2 3**
How often do you feel agitated, easily upset, and nervous between meals? **0 1 2 3**

SECTION C2

Do you get fatigued after meals? **1 2 3**
Do you crave sugar and sweets after meals? **0 1 2 3**
Do you feel you need stimulants such as coffee after meals? **0 1 2 3**
Do you have difficulty losing weight? **0 1 2 3**
How much larger is your waist girth compared to your hip girth? **0 1 2 3**
How often do you urinate? **0 1 2 3**
Ha your thirst and appetite been increased? **0 1 2 3**
Do you have weight gain when under stress? **0 1 2 3**
Do you have difficulty falling asleep? **0 1 2 3**

SECTION 1 - S

Are you losing your pleasure in hobbies and interests? **0 1 2 3**
How often do you feel overwhelmed with ideas to manage? **0 1 2 3**
How often do you have feelings of inner rage (anger)? **0 1 2 3**
How often do you have feelings of paranoia? **0 1 2 3**
How often do you feel sad or down for no reason?
How often do you feel like you are **not** enjoying life? **0 1 2 3**
How often do you feel you lack artistic appreciation? **0 1 2 3**
How often do you feel depressed in overcast weather? **0 1 2 3**
How much re you losing your enthusiasm for your favorite activities? **0 1 2 3**
How much are you losing enjoyment for your favorite foods? **0 1 2 3**
How much are you losing your enjoyment of friendships and relationships? **0 1 2 3**
How often do you have difficulty falling into deep restful sleep? **0 1 2 3**
How often do you have feeling of dependency on others? **0 1 2 3**
How ften do you feel more susceptible to pain? **0 1 2 3**
How often do you have feelings of unprovoked anger? **0 1 2 3**
How much re you losing interest in life? **0 1 2 3**

SECTION 2 - D

How often do you have feelings of hopelessness? **0 1 2 3**
How often d you have self-destructive thoughts? **0 1 2 3**
How often d you have an inability to handle stress? **0 1 2 3**
How often d you have anger and aggression while under stress? **0 1 2 3**
How often d you feel you are not rested even after long hours of sleep? **0 1 2 3**
How often d you prefer to isolate yourself from others? **0 1 2 3**
How often d you have unexplained lack of concern for family and friends? **0 1 2 3**
How easily are you distracted from your tasks? **0 1 2 3**
How often d you have an inability to finish tasks? **0 1 2 3**
How often d you feel the need to consume caffeine to stay alert? **0 1 2 3**
How often d you feel your libido has been decreased? **0 1 2 3**
How often d you lose your temper for minor reasons? **0 1 2 3**
How often d you have feelings of worthlessness? **0 1 2 3**

SECTION 3 - G

How often d you feel anxious or panic for no reason? **0 1 2 3**
How often d you have feelings of dread impending doom? **0 1 2 3**
How often d you feel knots in you stomach? **0 1 2 3**
How often d you have feelings of being overwhelmed for no reason? **0 1 2 3**
How often d you have feelings of guilt about everyday decisions? **0 1 2 3**
How often does your mind feel restless? **0 1 2 3**
How difficult is it to turn your mind off when you want to relax? **0 1 2 3**
How often do you have disorganized attention? **0 1 2 3**
How often do you worry about things you were not worried about before? **0 1 2 3**
How often do you have feelings of inner tension and inner excitability? **0 1 2 3**

SECTION 4 - ACH

Do you feel your visual memory (shapes & images) is decreased? **0 1 2 3**
Do you feel your verbal memory is decreased? **0 1 2 3**
Do you have memory lapses? **0 1 2 3**
Has your creativity been decreased? **0 1 2 3**
Has your comprehension been diminished? **0 1 2 3**
Do you have difficulty calculating numbers? **0 1 2 3**
Do you have difficulty recognizing objects & faces? **0 1 2 3**
Do you feel like your opinion about yourself has changed? **0 1 2 3**
Are you experiencing excessive urination? **0 1 2 3**
Are you experiencing slower mental response? **0 1 2 3**

Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition.
For nutritional purposes only.

SMGEPQNTAF04(1009).INDD