

# Male Intake Questionnaire

## Total Wellness Health Care

### General Information

Name \_\_\_\_\_ Age \_\_\_\_\_ Today's Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Work) \_\_\_\_\_

Genetic Background:  African American  Hispanic  Mediterranean  Asian  
 Native American  Caucasian  Northern European  
 Other \_\_\_\_\_

When, where and from whom did you last receive medical or health care? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Work) \_\_\_\_\_

### How did you hear about our practice?

Clinic website  IFM website  Referral from doctor  Referral from friend/family member  
 Social media  Other \_\_\_\_\_

### Current Health Concerns

Please rank current and ongoing health concerns in order of priority

Describe Problem	Severity	Severity			Prior Treatment/Approach	Success	Success		
		Mild	Moderate	Severe			Excellent	Good	Fair
<i>Example: Post Nasal Drip</i>		X			<i>Elimination Diet</i>		X		
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									

## Allergies

Name of Medication/Supplement/Food:	Reaction:
1.	
2.	
3.	
4.	
5.	

## Lifestyle Review

### Sleep

How many hours of sleep do you get each night on average? \_\_\_\_\_

Do you have problems falling asleep?  Yes  No      Staying asleep?  Yes  No

Do you have problems with insomnia?  Yes  No      Do you snore?  Yes  No

Do you feel rested upon awakening?  Yes  No

Do you use sleeping aids?  Yes  No

If yes, explain: \_\_\_\_\_

### Exercise

Current Exercise Program:

Activity	Type	# of Times Per Week	Time/Duration (Minutes)
Cardio/Aerobic			
Strength/Resistance			
Flexibility/Stretching			
Balance			
Sports/Leisure (e.g., golf)			
Other:			

Do you feel motivated to exercise?  Yes  A little  No

Are there any problems that limit exercise?  Yes  No

If yes, explain: \_\_\_\_\_

Do you feel unusually fatigued or sore after exercise?  Yes  No

If yes, explain: \_\_\_\_\_

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## Nutrition

Do you currently follow any of the following special diets or nutritional programs? *(Check all that apply)*

- Vegetarian    Vegan    Allergy    Elimination    Low Fat    Low Carb    High Protein  
 Blood Type    Low sodium    No Dairy    No Wheat    Gluten Free  
 Other: \_\_\_\_\_

Do you have sensitivities to certain foods?    Yes    No

If yes, list food and symptoms: \_\_\_\_\_

Do you have an aversion to certain foods?    Yes    No

If yes, explain: \_\_\_\_\_

Do you adversely react to: *(Check all that apply)*

- Monosodium glutamate (MSG)    Artificial sweeteners    Garlic/onion    Cheese    Citrus foods  
 Chocolate    Alcohol    Red wine    Sulfite-containing foods (wine, dried fruit, salad bars)  
 Preservatives    Food colorings    Other food substances: \_\_\_\_\_

Are there any foods that you crave or binge on?    Yes    No

If yes, what foods? \_\_\_\_\_

Do you eat 3 meals a day?    Yes    No   If no, how many \_\_\_\_\_

Does skipping a meal greatly affect you?    Yes    No

How many meals do you eat out per week?    0–1    1–3    3–5    >5 meals per week

Check the factors that apply to your current lifestyle and eating habits:

- |   |   |
|---|---|
| <input type="checkbox"/> Fast eater   | <input type="checkbox"/> Significant other or family members have special dietary needs |
| <input type="checkbox"/> Eat too much   | <input type="checkbox"/> Love to eat  |
| <input type="checkbox"/> Late-night eating  | <input type="checkbox"/> Eat because I have to  |
| <input type="checkbox"/> Dislike healthy foods  | <input type="checkbox"/> Have negative relationship to food                             |
| <input type="checkbox"/> Time constraints   | <input type="checkbox"/> Struggle with eating issues                                    |
| <input type="checkbox"/> Travel frequently  | <input type="checkbox"/> Emotional eater (eat when sad, lonely, bored, etc.)            |
| <input type="checkbox"/> Eat more than 50% of meals away from home                    | <input type="checkbox"/> Eat too much under stress                                      |
| <input type="checkbox"/> Healthy foods not readily available                          | <input type="checkbox"/> Eat too little under stress                                    |
| <input type="checkbox"/> Poor snack choices   | <input type="checkbox"/> Don't care to cook   |
| <input type="checkbox"/> Significant other or family members don't like healthy foods | <input type="checkbox"/> Confused about nutrition advice                                |

## Diet

Please record what you eat in a typical day:

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks \_\_\_\_\_

Fluids \_\_\_\_\_

How many servings do you eat in a typical week of these foods:

Fruits (not juice) \_\_\_\_\_ Vegetables (not including white potatoes) \_\_\_\_\_

Legumes (beans, peas, etc) \_\_\_\_\_ Red meat \_\_\_\_\_ Fish \_\_\_\_\_

Dairy/Alternatives \_\_\_\_\_ Nuts & Seeds \_\_\_\_\_ Fats & Oils \_\_\_\_\_

Cans of soda (regular or diet) \_\_\_\_\_ Sweets (candy, cookies, cake, ice cream, etc.) \_\_\_\_\_

Do you drink caffeinated beverages?  Yes  No If yes, check amounts:

Coffee (cups per day)  1  2-4  >4 Tea (cups per day)  1  2-4  >4

Caffeinated sodas—regular or diet (cans per day)  1  2-4  >4

Do you have adverse reactions to caffeine?  Yes  No

If yes, explain: \_\_\_\_\_

When you drink caffeine do you feel:  Irritable or wired  Aches or pains

## Smoking

Do you smoke currently?  Yes  No Packs per day: \_\_\_\_\_ Number of years \_\_\_\_\_

What type?  Cigarettes  Smokeless  Pipe  Cigar  E-Cig

Have you attempted to quit?  Yes  No

If yes, using what methods: \_\_\_\_\_

If you smoked previously: Packs per day: \_\_\_\_\_ Number of years \_\_\_\_\_

Are you regularly exposed to second-hand smoke?  Yes  No

## Alcohol

How many alcoholic beverages do you drink in a week? (1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits)

1-3  4-6  7-10  >10  None

Previous alcohol intake?  Yes ( Mild  Moderate  High)  None

Have you ever had a problem with alcohol?  Yes  No

If yes, when? \_\_\_\_\_

Explain the problem: \_\_\_\_\_

Have you ever thought about getting help to control or stop your drinking?  Yes  No

## Other Substances

Are you currently using any recreational drugs?  Yes  No

If yes, type: \_\_\_\_\_

Have you ever used IV or inhaled recreational drugs?  Yes  No

**Stress**

Do you feel you have an excessive amount of stress in your life?  Yes  No

Do you feel you can easily handle the stress in your life?  Yes  No

How much stress do each of the following cause on a daily basis (Rate on scale of 1-10, 10 being highest)

Work \_\_\_\_ Family \_\_\_\_ Social \_\_\_\_ Finances \_\_\_\_ Health \_\_\_\_ Other \_\_\_\_

Do you use relaxation techniques?  Yes  No

If yes, how often? \_\_\_\_\_

Which techniques do you use? (Check all that apply)

Meditation  Breathing  Tai Chi  Yoga  Prayer  Other: \_\_\_\_\_

Have you ever sought counseling?  Yes  No

Are you currently in therapy?  Yes  No

If yes, describe: \_\_\_\_\_

Have you ever been abused, a victim of crime, or experienced a significant trauma?  Yes  No

What are your hobbies or leisure activities? \_\_\_\_\_

**Relationships**

Marital status:  Single  Married  Divorced  Gay/Lesbian  Long-Term Partner  Widow/er

With whom do you live? (Include children, parents, relatives, friends, pets) \_\_\_\_\_

Current occupation: \_\_\_\_\_

Previous occupations: \_\_\_\_\_

Do you have resources for emotional support?  Yes  No (Check all that apply)

Spouse  Family  Friends  Religious/Spiritual  Pets  Other: \_\_\_\_\_

Do you have a religious or spiritual practice?  Yes  No

If yes, what kind? \_\_\_\_\_

**How well have things been going for you?** (Mark on scale of 1–10, or N/A if not applicable)

	N/A	Poorly			Fine				Very Well		
Overall		1	2	3	4	5	6	7	8	9	10
At school		1	2	3	4	5	6	7	8	9	10
In your job		1	2	3	4	5	6	7	8	9	10
In your social life		1	2	3	4	5	6	7	8	9	10
With close friends		1	2	3	4	5	6	7	8	9	10
With sex		1	2	3	4	5	6	7	8	9	10
With your attitude		1	2	3	4	5	6	7	8	9	10
With your boyfriend/girlfriend		1	2	3	4	5	6	7	8	9	10
With your children		1	2	3	4	5	6	7	8	9	10
With your parents		1	2	3	4	5	6	7	8	9	10
With your spouse		1	2	3	4	5	6	7	8	9	10

## History

### Patient's Birth/Childhood History:

You were born:  Term  Premature  Don't know

Were there any pregnancy or birth complications?  Yes  No

If yes, explain: \_\_\_\_\_

You were:  Breast-fed/How long? \_\_\_\_\_  Bottle-fed/Type of formula: \_\_\_\_\_  Don't know

Age of introduction of: Solid food: \_\_\_\_\_ Wheat \_\_\_\_\_ Dairy \_\_\_\_\_

As a child, were there any foods that were avoided because they gave you symptoms?  Yes  No

If yes, what foods and what symptoms? (Example: milk—gas and diarrhea)

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

Did you eat a lot of sugar or candy as a child?  Yes  No

### Dental History:

Check if you have any of the following, and provide number if applicable:

- Silver mercury fillings \_\_\_\_\_  Gold fillings \_\_\_\_\_  Root canals \_\_\_\_\_  Implants \_\_\_\_\_  
 Caps/Crowns \_\_\_\_\_  Tooth pain \_\_\_\_\_  Bleeding gums \_\_\_\_\_  Gingivitis \_\_\_\_\_  
 Problems with chewing \_\_\_\_\_  Other dental concerns (explain): \_\_\_\_\_

Have you had any mercury fillings removed?  Yes  No If yes, when: \_\_\_\_\_

How many fillings did you have as a kid? \_\_\_\_\_

Do you brush regularly?  Yes  No Do you floss regularly?  Yes  No

### Environmental/Detoxification History

Do any of these significantly affect you?

- Cigarette smoke  Perfume/colognes  Auto exhaust fumes  Other: \_\_\_\_\_

In your work or home environment are you regularly exposed to: (Check all that apply)

- Mold  Water leaks  Renovations  Chemicals  Electromagnetic radiation  
 Damp environments  Carpets or rugs  Old paint  Stagnant or stuffy air  Smokers  
 Pesticides  Herbicides  Harsh chemicals (solvents, glues, gas, acids, etc)  Cleaning chemicals  
 Heavy metals (lead, mercury, etc.)  Paints  Airplane travel  Other \_\_\_\_\_

Have you had a significant exposure to any harmful chemicals?  Yes  No

If yes: Chemical name, length of exposure, date: \_\_\_\_\_

Do you have any pets or farm animals?  Yes  No

If yes, do they live:  Inside  Outside  Both inside and outside

### Men's History

(Check box if applicable)

- Testicular mass  Testicular pain  Prostate enlargement  Prostate infection  
 Change in sex drive  Impotence  Premature ejaculation  Difficulty obtaining an erection  
 Difficulty maintaining an erection  Loss of control of urine  Urinary urgency/hesitancy/change in stream  
 Vasectomy  Nocturia (urination at night) # of times per night \_\_\_\_\_  
 Sexually transmitted diseases (describe) \_\_\_\_\_

**Men's History** *(cont.)*

**Screening/Procedures:** *(If applicable, provide date)*

Last PSA test: \_\_\_\_\_ PSA Level:  0–2  2–4  4–10  >10

Other tests/procedures (list type and dates) \_\_\_\_\_

**Family History:**

**Check family members** that have/had any of the following

	Mother	Father	Brother (s)	Sister (s)	Child	Child	Child	Child	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other
Age (if still alive)													
Age at death (if deceased)													
Cancer													
Heart disease													
Hypertension													
Obesity													
Diabetes													
Stroke													
Autoimmune disease													
Arthritis													
Kidney disease													
Thyroid problems													
Seizures/epilepsy													
Psychiatric disorders													
Anxiety													
Depression													
Asthma													
Allergies													
Eczema													
ADHD													
Autism													
Irritable Bowel Syndrome													
Dementia													
Substance abuse													
Genetic disorders													
Other: _____													

## Medical History: Illnesses/Conditions

**Check YES** = a condition you currently have, **Check PAST** = a condition you've had in the past.

<b>Gastrointestinal</b>	<b>Yes</b>	<b>Past</b>
Irritable bowel syndrome		
GERD (reflux)		
Crohn's disease/ulcerative colitis		
Peptic ulcer disease		
Celiac disease		
Gallstones		
Other:		
<b>Respiratory</b>		
Bronchitis		
Asthma		
Emphysema		
Pneumonia		
Sinusitis		
Sleep apnea		
Other:		
<b>Urinary/Genital</b>		
Kidney stones		<input type="checkbox"/>
Gout		
Interstitial cystitis		
Frequent yeast infections		
Frequent urinary tract infections		
Sexual dysfunction		
Sexually transmitted diseases		
Other:		
<b>Endocrine/Metabolic</b>		
Diabetes		
Hypothyroidism (low thyroid)		
Hyperthyroidism (overactive thyroid)		
Infertility		
Metabolic syndrome/insulin resistance		
Eating disorder		
Hypoglycemia		
Other:		
<b>Inflammatory/Immune</b>		
Rheumatoid arthritis		
Chronic fatigue syndrome		
Food allergies		
Environmental allergies		
Multiple chemical sensitivities		
Autoimmune disease		
Immune deficiency		
Mononucleosis		
Hepatitis		
Other:		

<b>Musculoskeletal</b>	<b>Yes</b>	<b>Past</b>
Fibromyalgia		
Osteoarthritis		
Chronic pain		
Other:		
<b>Skin</b>		
Eczema		
Psoriasis		
Acne		
Skin cancer		
Other:		
<b>Cardiovascular</b>		
Angina		
Heart attack		
Heart failure		
Hypertension (high blood pressure)		
Stroke		
High blood fats (cholesterol, triglycerides)		
Rheumatic fever		
Arrhythmia (irregular heart rate)		
Murmur		
Mitral valve prolapse		
Other:		
<b>Neurologic/Emotional</b>		
Epilepsy/Seizures		
ADD/ADHD		
Headaches		
Migraines		
Depression		
Anxiety		
Autism		
Multiple sclerosis		
Parkinson's disease		
Dementia		
Other:		
<b>Cancer</b>		
Lung		
Breast		
Colon		
Prostate		
Skin		
Other:		



**Medical History** *(cont.)*

<b>Diagnostic Studies</b>	<b>Date</b>	<b>Comments</b>
Bone density		
CT scan		
Colonoscopy		
Cardiac stress test		
EKG		
MRI		
Upper endoscopy		
Upper GI series		
Chest X-ray		
Other X-rays		
Barium enema		
Other:		
<b>Injuries</b>		
Broken bone(s)		
Back injury		
Neck injury		
Head injury		
Other:		
<b>Surgeries</b>		
Appendectomy		
Dental		
Gallbladder		
Hernia		
Tonsillectomy		
Joint replacement		
Heart surgery		
Other:		
<b>Hospitalizations</b>	<b>Date</b>	<b>Reason</b>

## Symptom Review

**Please check** if these symptoms occur presently or have occurred in the last 6 months

General	Mild	Moderate	Severe
Cold hands and feet			
Cold intolerance			
Daytime sleepiness			
Difficulty falling asleep			
Early waking			
Fatigue			
Fever			
Flushing			
Heat intolerance			
Night waking			
Nightmares			
Can't remember dreams			
Low body temperature			
Head, Eyes, and Ears			
Conjunctivitis			
Distorted sense of smell			
Distorted taste			
Ear fullness			
Ear ringing/buzzing			
Eye crusting			
Eye pain			
Eyelid margin redness			
Headache			
Hearing loss			
Hearing problems			
Migraine			
Sensitivity to loud noises			
Vision problems			
Musculoskeletal			
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			

Musculoskeletal (cont.)	Mild	Moderate	Severe
Neck muscle spasm			
Tendonitis			
Tension headache			
TMJ problems			
Mood/Nerves			
Agoraphobia			
Anxiety			
Auditory hallucinations			
Blackouts			
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			
Cardiovascular			
Angina/chest pain			
Breathlessness			
Heart attack			
Heart murmur			
High blood pressure			
Irregular pulse			
Mitral valve prolapse			
Palpitations			
Phlebitis			
Swollen ankles/feet			
Varicose veins			

## Symptom Review *(cont.)*

**Please check** if these symptoms occur presently or have occurred in the last 6 months

Urinary	Mild	Moderate	Severe
Bed wetting			
Hesitancy			
Infection			
Kidney disease			
Kidney stone			
Leaking/incontinence			
Pain/burning			
Prostate enlargement			
Prostate infection			
Urgency			
Digestion			
Anal spasms			
Bad teeth			
Bleeding gums			
Bloating of:			
Lower abdomen			
Whole abdomen			
Bloating after meals			
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 dairy products			
Gluten (wheat)			
Corn			
Eggs			
Fatty foods			
Yeast			
Liver disease/jaundice (yellow eyes or skin)			

Digestion <i>(cont.)</i>	Mild	Moderate	Severe
Lower abdominal pain			
Mucus in stools			
Nausea			
Periodontal disease			
Sore tongue			
Strong stool odor			
Undigested food in stools			
Upper abdominal pain			
Vomiting			
Eating			
Binge eating			
Bulimia			
Can't gain weight			
Can't lose weight			
Carbohydrate craving			
Carbohydrate intolerance			
Poor appetite			
Salt cravings			
Frequent dieting			
Sweet cravings			
Caffeine dependency			
Respiratory			
Bad breath			
Bad odor in nose			
Cough - dry			
Cough - productive			
Hayfever:			
Spring			
Summer			
Fall			
Change of season			
Hoarseness			
Nasal stuffiness			
Nose bleeds			
Post nasal drip			
Sinus fullness			
Sinus infection			
Snoring			
Sore throat			
Wheezing			
Winter stuffiness			

## Symptom Review *(cont.)*

**Please check** if these symptoms occur presently or have occurred in the last 6 months

<b>Nails</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>
Bitten			
Brittle			
Curve up			
Frayed			
Fungus – fingers			
Fungus – toes			
Pitting			
Ragged cuticles			
Ridges			
Soft			
Thickening of:			
Finger nails			
Toenails			
White spots/lines			
<b>Lymph Nodes</b>			
Enlarged/neck			
Tender/neck			
Other enlarged/tender lymph nodes			
<b>Skin, Dryness of</b>			
Eyes			
Feet			
Any cracking?			
Any peeling?			
Hair			
And unmanageable?			
Hands			
Any cracking?			
Any peeling?			
Mouth/throat			
Scalp			
Any dandruff?			
Skin in general			
<b>Skin Problems</b>			
Acne on back			
Acne on chest			
Acne on face			
Acne on shoulders			
Athlete’s foot			
Bumps on back of upper arms			
Cellulite			
Dark circles under eyes			
Ears get red			

<b>Skin Problems <i>(cont.)</i></b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>
Easy bruising			
Eczema			
Herpes – genital			
Hives			
Jock itch			
Lackluster skin			
Moles w color/size change			
Oily skin			
Pale skin			
Patchy dullness			
Psoriasis			
Rash			
Red face			
Sensitive to bites			
Sensitive to poison ivy/oak			
Shingles			
Skin cancer			
Skin darkening			
Strong body odor			
Thick calluses			
Vitiligo			
<b>Itching Skin</b>			
Anus			
Arms			
Ear canals			
Eyes			
Feet			
Hands			
Legs			
Nipples			
Nose			
Genitals			
Roof of mouth			
Scalp			
Skin in general			
Throat			
<b>Male Reproductive</b>			
Discharge from penis			
Ejaculation problem			
Genital pain			
Impotence			
Infection			
Lumps in testicles			
Poor libido (low sex drive)			

## Medications/Supplements

### Current medications (include prescription and over-the-counter)

Medication	Dosage	Start Date (mo/yr)	Reason for Use

### Nutritional supplements (vitamins/minerals/herbs etc.)

Name and Brand	Dosage	Start Date (mo/yr)	Reason for Use

Have medications or supplements ever caused unusual side effects or problems?  Yes  No

If yes, describe: \_\_\_\_\_

Have you used any of these regularly or for a long time:

NSAIDs (Advil, Aleve, etc.), Motrin, Aspirin?  Yes  No Tylenol (acetaminophen)?  Yes  No

Acid-blocking drugs (Zantac, Prilosec, Nexium, etc.)?  Yes  No

### How many times have you taken antibiotics?

	< 5	> 5	Reason for Use
Infancy/Childhood			
Teen			
Adulthood			

Have you ever taken long term antibiotics?  Yes  No

If yes, explain: \_\_\_\_\_

### How often have you taken oral steroids (e.g., cortisone, prednisone, etc.)?

	< 5	> 5	Reason for Use
Infancy/Childhood			
Teen			
Adulthood			

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## Readiness Assessment and Health Goals

### Readiness Assessment

**Rate on a scale of 5 (very willing) to 1 (not willing):**

In order to improve your health, how willing are you to:

Significantly modify your diet

5  4  3  2  1

Take several nutritional supplements each day

5  4  3  2  1

Keep a record of everything you eat each day

5  4  3  2  1

Modify your lifestyle (e.g., work demands, sleep habits)

5  4  3  2  1

Practice a relaxation technique

5  4  3  2  1

Engage in regular exercise

5  4  3  2  1

**Rate on a scale of 5 (very confident) to 1 (not confident at all):**

How confident are you of your ability to organize and follow through on the above health-related activities?

5  4  3  2  1

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to follow through? \_\_\_\_\_

**Rate on a scale of 5 (very supportive) to 1 (very unsupportive):**

At the present time, how supportive do you think the people in your household will be to your implementing the above changes?

5  4  3  2  1

**Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact):**

How much ongoing support (e.g., telephone consults, email correspondence) from our professional staff would be helpful to you as you implement your personal health program?

5  4  3  2  1

Comments \_\_\_\_\_

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## Health Goals

What do you hope to achieve in your visit with us? \_\_\_\_\_

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When was the last time you felt well? \_\_\_\_\_

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Did something trigger your change in health? \_\_\_\_\_

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What makes you feel better? \_\_\_\_\_

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What makes you feel worse? \_\_\_\_\_

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How does your condition affect you? \_\_\_\_\_

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What do you think is happening and why? \_\_\_\_\_

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What do you feel needs to happen for you to get better? \_\_\_\_\_

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