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General Information

Today's Date _____

Name _____ Age ____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Phone (Home) _____ (Cell)_____ Email _____

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? _____

Current Health Concerns

Please rank current and ongoing health concerns in order of priority

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Current Prescription Medications

Name of Medication	*Dosage/Strength*	*Directions*

Current Supplements

Name of Supplements (including brand name)	*Dosage/Strength*	*Directions*

Allergies

Name of Medication/Supplement/Food	*Reaction*

Surgical History

Type	*Date*	*Comments*
Appendectomy		
Dental		
Gallbladder		
Hernia		
Tonsillectomy		
Joint Replacement		
Heart Surgery		
Hysterectomy		
Other:		
Other:		

Hospitalizations

Date	*Reason*

Diagnostic Studies

	Date	*Comments*
Bone Density		
CT Scan		
Colonoscopy		
Cardiac stress test		
EKG		
MRI		
Upper endoscopy		
Upper GI series		
Chest X-ray		
Other X-rays		
Other:		

Family History

Please check below if any blood relatives have any of the following:

	Relationship		*Relationship*
☐ Cancer		☐ Depression	
☐ Heart disease		☐ Asthma	
☐ Hypertension		☐ Allergies	
☐ Obesity		☐ Eczema	
☐ Diabetes		☐ ADHD	
☐ Stroke		☐ Autism	
☐ Autoimmune disease		☐ Irritable Bowel Syndrome	
☐ Arthritis		☐ Dementia	
☐ Kidney disease		☐ Substance abuse	
☐ Thyroid problems		☐ Genetic disorders	
☐ Seizures/Epilepsy		☐ Other: _____	
☐ Psychiatric disorder		☐ Other: _____	
☐ Anxiety		☐ Other: _____	

History

Patient's Birth/Childhood History:

You were born: □ Term □Premature □Unknown

Were there any pregnancy or birth complications? □ Yes □ No □Unkown

If yes, explain: _____

You were: □ Breast-fed/ How long? _____ □ Bottle-fed/type of formula?_____ □Unknown

Age of introduction of: Solid food _____ Wheat _____ Dairy _____

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

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

If yes, what foods and what symptoms? (example: Milk - gas and diarrhea) _____

_____

_____

What were your eating habits like as a child? (List types of food) _____

_____

_____

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 and how many _____

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 □ Paint

□ Harsh chemicals *(solvents, glues, gas,acids, etc)* □ Cleaning chemicals □ Airplane Travel

□ Heavy metals *(lead, mercury, etc.)* □ 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

Sex History: *(complete applicable questions)*

Age at first period _____ Date of last menstrual period _____

Length of cycle _____ Time between cycles _____

Cramping? □ Yes □ No Pain? □ Yes □ No

Have you ever had premenstrual problems (*bloating, breast tenderness, irritability, etc.*)? □ Yes □ No

If yes, please describe: _____

_____

Do you have other problems with your periods (*heavy, irregular, spotting, skipping, etc)*? □ Yes □ No

If yes, please describe: _____

_____

Use of hormonal birth control: □ Birth Control Pills □ Patch □ Nuvaring □ IUD

□ Other _____ How long? _____

Any problems with hormonal birth control? □ Yes □ No

If yes, explain _____

Use of other contraception? □Yes □ No □ Condoms □ Diaphragm □ Partner vasectomy □ Other _____

Are you in menopause? □ Yes □ No If yes, age at last period _____

Was it surgical menopause? □ Yes □ No If yes, explain surgery _____

_____

Do you currently have symptomatic problems with menopause? (*Check all that apply)*

□ Hot flashes □ Mood swings □ Concentration/memory problems □ Headaches □ Joint pain □ Weight gain

□ Vaginal dryness □ Decreased libido □ Loss of control of urine □ Palpitations

Are you on hormone replacement therapy? □ Yes □ No

If yes, for how long and for what reason (hot flashes, osteoporosis, prevention, etc.)? _____

_____

Do you or have you ever had any sexually transmitted disease? □ Yes □ No

If yes, describe _____

Other Gynecological Symptoms: *(Check all that apply)*

□ Endometriosis □ Infertility □ Fibrocystic breasts □ Vaginal infection □ Fibroids □ Ovarian cysts

□ Pelvic inflammatory disease □ Reproductive Cancer

Other Male History: (*Check all that apply)*

□ 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 _____

Screenings/Procedures (*If applicable, provide date)*

Last pap test: _____ □ Normal □ Abnormal

Last mammogram: _____ □ Normal □ Abnormal

Last bone density: _____ Results: □ High □ Low □ With Normal Range

Last PSA test: _____ PSA Levels: □ 0-2 □ 2-4 □ 4-10 □ >10

Other tests/procedures (list type and date) _____

_____

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: _____

Do you wake up during the night? □ Yes □ No

If yes, what time(s)? _____

What time do you go to bed? _____ What time do you typically wake-up? _____

Exercise

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 _____

Current Exercise Program:

Cardio/Aerobic:

Type:_____
(e.g walking, jogging, swimming)

Frequency: _____ Time/duration:_____
(#of times per week) *(minutes each day)*

Intensity: □ Low (*able to talk and/or sing)* □ Moderate *(able to talk but not sing)*
□ Vigorous/hard (*difficulty talking)*

Strength/Resistance:

Type:_____
(e.g walking, jogging, swimming)

Frequency: _____ Time/duration:_____
(#of times per week) *(minutes each day)*

Intensity: □ Low (*able to talk and/or sing)* □ Moderate *(able to talk but not sing)*
□ Vigorous/hard (*difficulty talking)*

Flexibility/Stretching:

Type:_____
(e.g walking, jogging, swimming)

Frequency: _____ Time/duration:_____
(#of times per week) *(minutes each day)*

Intensity: □ Low (*able to talk and/or sing)* □ Moderate *(able to talk but not sing)*

□ Vigorous/hard (*difficulty talking)*

Balance:

Type:_____
(e.g walking, jogging, swimming)

Frequency: _____ Time/duration:_____
(#of times per week) *(minutes each day)*

Intensity: □ Low (*able to talk and/or sing)* □ Moderate *(able to talk but not sing)*

□ Vigorous/hard (*difficulty talking)*

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 □ No Dairy

□ Low Sodium □ No Wheat □ Gluten Free □ Blood Type _____ □ 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 crave sugar? □ Yes □ No Do you crave salt? □ Yes □ No

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

How many meals are home cooked per week? □ 0-1 □ 1-3 □ 3-5 □ >5 meals per week

What are the three worst foods you eat each week? _____

_____

What are the three healthiest foods you eat each week? _____

_____

Do you feel tired, bloated and/or gassy after meals? □ Yes □ No

If yes, please explain _____

_____

Do you feel excessively hungry? □ Yes □ No

If yes, please explain _____

Do you have a poor appetite? □ Yes □ No

If yes, please explain _____

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

□ Fast eater □ Eat too much □ Late-night eating □ Dislike healthy foods □ Time constraints

□ Travel frequently □ Eat more than 50% of meals away from home □ Poor snack choices

□ Health foods not readily available □ Significant other or family members don't like healthy foods

□ Significant other or family members have special dietary needs □ Eat because I have to □ Love to eat

□ Have a negative relationship to food □ Struggle with eating issues □ Don't care to cook

□ Emotional eater (eat when sad, longley, bored, etc) □ Confused about nutrition advice

□ Eat too much under stress □ Eat too little under stress

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

Fruits (not juice) _____ Vegetables (not including white potatoes) _____

Red meat _____ Legumes (beans, peas, etc) _____

Nuts & Seeds _____ Dairy/Alternatives _____

Fats & Oils _____ Cans of soda (regular or diet) _____

Fish _____ 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 □ Wired □ Aches or pains

<u>Smoking</u>

Do you smoke currently? □ Yes □ No # packs per day _____ # 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 _____ # 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 oz of wine, 12 oz of beer, 1.5 oz of 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, please explain _____

_____

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 and frequency: _____

_____

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 the highest)*

Work _____ Family _____ Social _____ Finances _____ Health _____

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 significant trauma? □ Yes □ No

What lifts your spirits and gives you strength? _____

_____

_____

Relationships

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

With whom do you live? (*Include children, parents, relatives,friends, pets)* _____

_____

Current occupation: _____

Previous occupation: _____

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

□ Spouse/Partner □ Family □ Friends □ Religious/Spiritual □ Pets □ Other _____

Do you have a religious or spiritual practice? □ Yes □ No

If yes, what kinds? _____

How well have things been going to 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

Health Goals

What results or outcome do you hope to achieve from working together? _____

When was the last time you felt well? _____

Did something trigger your change in health? _____

What makes you feel better? _____

What makes you feel worse? _____

How does your condition affect you? _____

What do you think is happening and why? _____

_____

_____

What do you feel needs to happen for you to get better? _____

_____

_____

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 every 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

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 _____

_____

**** Please include age/year of onset in space next to condition ****

Medical History: Illnesses/Conditions

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

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

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

**** If symptoms present longer than 6 months, please include age/year of onset in space next to condition ****

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 *(cont.)*	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	☐	☐	☐

Symptom Review *(cont.)*

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

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	☐	☐	☐
Lymph Nodes			
Enlarged/neck	☐	☐	☐
Tender/neck	☐	☐	☐
Other enlarged/tender	☐	☐	☐
lymph nodes			
Skin, Dryness of			
Eyes	☐	☐	☐
Feet	☐	☐	☐
Any cracking?	☐	☐	☐
Any peeling?	☐	☐	☐
Hair	☐	☐	☐
And unmanageable?	☐	☐	☐
Hands	☐	☐	☐
Any cracking?	☐	☐	☐
Any peeling?	☐	☐	☐
Mouth/throat	☐	☐	☐
Scalp	☐	☐	☐
Any dandruff?	☐	☐	☐
Skin in general	☐	☐	☐
Skin Problems			
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	☐	☐	☐

Skin Problems *(cont.)*	Mild	Moderate	Severe
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	☐	☐	☐
Itching Skin			
Anus	☐	☐	☐
Arms	☐	☐	☐
Ear canals	☐	☐	☐
Eyes	☐	☐	☐
Feet	☐	☐	☐
Hands	☐	☐	☐
Legs	☐	☐	☐
Nipples	☐	☐	☐
Nose	☐	☐	☐
Genitals	☐	☐	☐
Roof of mouth	☐	☐	☐
Scalp	☐	☐	☐
Skin in general	☐	☐	☐
Throat	☐	☐	☐
Male Reproductive			
Discharge from penis	☐	☐	☐
Ejaculation problem	☐	☐	☐
Genital pain	☐	☐	☐
Impotence	☐	☐	☐
Infection	☐	☐	☐
Lumps in testicles	☐	☐	☐
Poor libido (low sex drive)	☐	☐	☐

Symptom Review *(cont.)*

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

Female Reproductive	Mild	Moderate	Severe
Breast cysts	☐	☐	☐
Breast lumps	☐	☐	☐
Breast tenderness	☐	☐	☐
Ovarian cyst	☐	☐	☐
Poor libido (sex drive)	☐	☐	☐
Endometriosis	☐	☐	☐
Fibroids	☐	☐	☐
Infertility	☐	☐	☐
Vaginal discharge	☐	☐	☐
Vaginal odor	☐	☐	☐
Vaginal itch	☐	☐	☐
Vaginal pain	☐	☐	☐
Premenstrual:	☐	☐	☐
Bloating	☐	☐	☐
Breast tenderness	☐	☐	☐
Carbohydrate craving	☐	☐	☐
Chocolate craving	☐	☐	☐
Constipation	☐	☐	☐
Decreased sleep	☐	☐	☐
Diarrhea	☐	☐	☐
Fatigue	☐	☐	☐
Increased sleep	☐	☐	☐
Irritability	☐	☐	☐
Menstrual:	☐	☐	☐
Cramps	☐	☐	☐
Heavy periods	☐	☐	☐
Irregular periods	☐	☐	☐
No periods	☐	☐	☐
Scanty periods	☐	☐	☐
Spotting between	☐	☐	☐