What Is Functional Medicine?

Functional medicine is an evolution in the practice of medicine that better addresses the healthcare needs of the 21st century. By shifting the traditional disease-centered focus of medical practice to a more patient-centered approach, functional medicine addresses the whole person, not just an isolated set of symptoms. Functional medicine practitioners spend time with their patients, listening to their histories and evaluating the interactions among genetic, environmental, and lifestyle factors that can influence long-term health and complex, chronic disease. In this way, functional medicine supports the unique expression of health and vitality for each individual.

Why Do We Need Functional Medicine?

- **Our society is experiencing a sharp increase in the number of people who suffer from complex, chronic diseases**, such as diabetes, heart disease, cancer, mental illness, and autoimmune disorders like rheumatoid arthritis and fibromyalgia.
- **The system of medicine practiced by most physicians is oriented toward acute care,** the diagnosis and treatment of trauma or illness that is of short duration and in need of urgent care, such as appendicitis or a broken leg. Physicians apply specific, prescribed treatments such as drugs or surgery that aim to treat the immediate problem or symptom.
- **Unfortunately, the acute-care approach to medicine lacks the proper methodology and tools for preventing and treating complex, chronic disease.** In most cases it does not take into account the unique genetic makeup of each individual or factors such as environmental exposures to toxins and the aspects of today's lifestyle that have a direct influence on the rise in chronic disease in modern Western society.
- **There's a huge gap between research and the way doctors practice.** The gap between emerging research in basic sciences and integration into medical practice is enormous—as long as 50 years—particularly in the area of complex, chronic illness. Functional medicine's aim is to evaluate, assess, and carefully enfold emerging research in a practical, efficient, and safe manner.
- **Most physicians are not adequately trained to assess the underlying causes** of complex, chronic disease and to apply strategies such as nutrition, diet, and exercise to both treat and prevent these illnesses in their patients.

How Is Functional Medicine Different?

Functional medicine involves understanding the *origins, prevention, and treatment* of complex, chronic disease. Hallmarks of a functional medicine approach include:

- **Patient-centered care.** The focus of functional medicine is on patient-centered care, promoting health as a positive vitality, beyond just the absence of disease. By listening to the patient and learning his or her story, the practitioner brings the patient into the discovery process and tailors treatments that address the individual's unique needs.
- **An integrative, science-based healthcare approach.** Functional medicine practitioners look "upstream" to consider the complex web of interactions in the patient's history, physiology, and lifestyle that can lead to illness. The unique genetic makeup of each patient is considered, along with both internal (mind, body, and spirit) and external (physical and social environment) factors that affect total functioning.
- **Integrating best medical practices.** Functional medicine integrates traditional Western medical practices with what are sometimes considered "alternative" or "integrative" medicine, creating a focus on prevention through nutrition, diet, and exercise; use of the latest laboratory testing and other diagnostic techniques; and prescribed combinations of drugs and/or botanical medicines, supplements, therapeutic diets, detoxification programs, or stress-management techniques.

Working with a Applied Kinesiologist / Functional Medicine Practitioner

Functional medicine practitioners promote wellness by focusing on the fundamental underlying factors that influence every patient's experience of health and disease.

The Functional Medicine Approach to Assessment

The Institute for Functional Medicine teaches practitioners how to assess the patient's fundamental clinical imbalances through careful history taking, physical examination, and laboratory testing. The functional medicine practitioner will consider multiple factors, including:

- **Environmental inputs –** The air you breathe and the water you drink, the particular diet you eat, the quality of the food available to you, your level of physical exercise, and toxic exposures or traumas you have experienced all affect your health.
- **Mind-body connections –** Psychological, spiritual, and social factors all can have a profound influence on your health. Considering these areas helps the functional medicine practitioner see your health in the context of you as a whole person, not just your physical symptoms.
- **Genetic makeup –** Although individual genes may make you more susceptible to some diseases, your DNA is not an unchanging blueprint for your life. Emerging research shows that your genes may be influenced by everything in your environment, as well as your experiences, attitudes, and beliefs. That means it is possible to change the way genes are activated and expressed.

Through assessment of these underlying causes and triggers of dysfunction, the functional medicine practitioner is able to understand how key processes are affected. These are the body's processes that keep you alive. Some occur at the cellular level and involve how cells function, repair, and maintain themselves. These processes are related to larger functions, such as:

- how your body rids itself of toxins
- regulation of hormones and neurotransmitters
- immune system function
- inflammatory responses
- digestion and absorption of nutrients and the health of the digestive tract
- structural integrity
- psychological and spiritual equilibrium
- how you produce energy

All of these processes are influenced by both environmental factors and your genetic make-up; when they are disturbed or imbalanced, they lead to symptoms, which can lead to disease if effective interventions are not applied.

A Comprehensive Approach to Treatment

Most imbalances in functionality can be addressed; some can be completely restored to optimum function, and others can be substantially improved.

- **Prevention is paramount.** Virtually every complex, chronic disease is preceded by long-term disturbances in functionality that can be identified and effectively managed.
- **Changing how the systems function can have a major impact on the patient's health.** The functional medicine practitioner examines a wide array of available interventions and customizes a treatment plan including those with the most impact on underlying functionality.
- **Functional medicine expands the clinician's tool kit.** Treatments may include combinations of drugs, botanical medicines, nutritional supplements, therapeutic diets, or detoxification programs. They may also include counseling on lifestyle, exercise, or stress-management techniques.
- **The patient becomes a partner.** As a patient, you become an active partner with your functional medicine practitioner. This allows you to really be in charge of improving your own health and changing the outcome of disease.

Patient Acknowledgement or Receipt
Of the
Notice of Privacy Practices

Highland Wellness Center
5606 Wilson Mills Rd.
Highland Heights, OH 44143

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

By signing this document, I acknowledge that you have a provided me with a copy of your *Notice or Privacy Practices*. The *Notice of Privacy Practices* contains a more complete description of the uses and disclosures of my health information.

I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound by such restrictions.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Date_____ Referred by _____

Cell phone _____

Name _____Home phone _____

Last *First* *Middle* Email_____

Address _____ City/ State/ Zip _____

DOB _____Sex _____ SS# _____ Marital Status M S D W

Contact Friend/ Relative _____ Phone _____

Address _____ City/ State/ Zip _____

Name of Employer _____

Address _____ City/ State/ Zip _____

Phone _____ Position _____

Spouse's Name _____ Phone _____

Name of Employer _____

Address _____ City/ State/ Zip _____

Phone _____ DOB _____

Primary Care Provider _____ Phone _____

PLEASE READ & SIGN

Failure to cancel appointments without 24-hour notice will result in full appointment fee.

If my insurance covers a portion or none of my medical bills incurred at this office, I understand that I am responsible for the balance due. If my insurance benefits have been utilized or utilized else where, I understand that I am responsible for all accruing charges.

Signature *Date*

I authorize release of any medical information necessary to process any insurance claims.

Signature *Date*

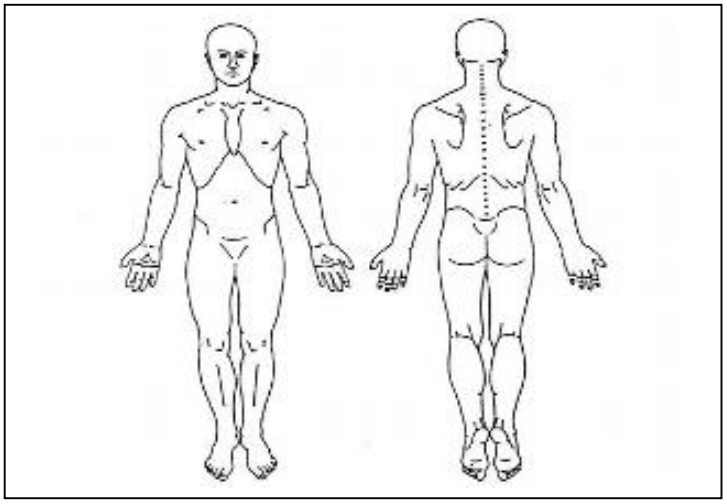
NAME_____DATE_____

	PROBLEM #1	PROBLEM #2
List and describe major problems in order of importance.		
When did it occur? Date?		
Accident related? Give details.		
What makes it better? (Medications, position, hot, cold, etc.)		
What makes it worse?		
Have you had this before? When?		
Have you seen another physician for this problem? Who?		
Were X-rays taken? Of what?		

Were you disabled from work? Y N Date last worked? _____Date Returned to work?_____

Please describe pain and location on the diagram.

Ache	Burn	Numbness	Pins & Needles	Stabbing	Other
XXX	ZZZ	OOO	. . .	/////	***



Place an "X" through the line indicating your current level of pain.

No Pain 0---1---2---3---4---5---6---7---8---9---10 Worst Possible Pain

Financial Responsibility

Payment is due at the time of service unless prior arrangement has been made with our billing department.

- We accept cash, Visa, Mastercard, American Express or Discover.
- We will process your insurance forms upon receipt of your insurance card (copy).
- You will be responsible for meeting your deductibles, co-pays or costs of non-covered services at the time of visit.
- Returned checks and balances due over 30 days will be subject to collection fees and interest charges of **3.0% per month**.
- Your insurance is a contract between you, your employer and your insurance company.
- Our fees are considered usual, customary and reasonable. (UCR)
- Insurance coverage vary widely. We are participating providers for most insurance companies including Cigna, Aetna, Emerald, Medical Mutual, United Healthcare, Humana, PHCS and Medicare, we are not participating in any HMOs. Most insurance companies cover chiropractic, however deductibles and co-pays do vary.

Failure to cancel appointments without 24 hour notice will result in full appointment fee.

I have read and agree to the above terms.

Signature_____Date_____

ADULT MEDICAL 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 clinician 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 underlying causes of illness and will also assist us to formulate a treatment plan.

First Name: _____Middle Name: _____Last Name: _____

Address:_____ City: _____ State: _____ ZIP: _____

Home Phone: (_____) _____-_____ Birth Date: _____/____/____ Age: _____
month day year

Work Phone: (_____) _____-_____

Place of Birth:_____
City or town & country if not US

Occupation: _____

Referred by: _____ 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 APPROACH	SUCCESS
Example: Post Nasal Drip	Moderate	Elimination Diet	Moderate
a.			
b.			
c.			
d.			
e.			
f.			
g.			

3. With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)
   Example: Wendy, age 7, sister
   _____
   _____
   _____

4. Do you have any pets or farm animals? Yes____ No____
   If yes, where do they live? 1. _____ indoors 2. _____ outdoors 3. _____ both indoors and outdoors

5. Have you lived or traveled outside of the United States? Yes____ No____
   If so, 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 so, please comment: _____
   _____

8. How important is religion (or spirituality) for you and your family's life?
   a. _____ not at all 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. Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress, illness, and immune system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life, it is very important that you feel safe telling us about it, so that we can support you and optimize your treatment outcomes.

    Please do your best to answer the following questions:
    a. Did you feel safe growing up?
       ☐ Yes ☐ No
    b. Have you been involved in abusive relationships in your life?
       ☐ Yes ☐ No
    c. Was alcoholism or substance abuse present in your childhood home, or is it present now in your relationships?
       ☐ Yes ☐ No

d. Do you currently feel safe in your home?
☐ Yes ☐ No

e. Do you feel safe, respected and valued in your current relationship?
☐ Yes ☐ No

f. Have you had any violent or otherwise traumatic life experiences, or have you witnessed any violence or abuse?
☐ Yes ☐ No

g. Would you feel safer discussing any of these issues privately?
☐ Yes ☐ No

12. Past Medical 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		
	ILLNESSES	**WHEN**	**COMMENTS**
m.	Heart attack/Angina		
n.	Heart failure		
o.	Hepatitis		
p.	High blood fats (cholesterol, triglycerides)		
q.	High blood pressure (hypertension)		
r.	Irritable bowel		
s.	Kidney stones		
t.	Mononucleosis		
u.	Pneumonia		
v.	Rheumatic fever		
w.	Sinusitis		
x.	Sleep apnea		
y.	Stroke		
z.	Thyroid disease		
aa.	Other (describe)		

	INJURIES	WHEN	COMMENTS
ab.	Back injury		
ac.	Broken (describe)		
ad.	Head injury		
ae.	Neck injury		
af.	Other (describe)		
	DIAGNOSTIC STUDIES	**WHEN**	**COMMENTS**
ag.	Barium Enema		
ah.	Bone Scan		
ai.	CAT Scan of Abdomen		
aj.	CAT Scan of Brain		
ak.	CAT Scan of Spine		
al.	Chest X-ray		
am.	Colonoscopy		
an.	EKG		
ao.	Liver scan		
ap.	Neck X-ray		
aq.	NMR/MRI		
ar.	Sigmoidoscopy		
as.	Upper GI Series		
at.	Other (describe)		
	OPERATIONS	**WHEN**	**COMMENTS**
au.	Appendectomy		
av.	Dental Surgery		
aw.	Gall Bladder		
ax.	Hernia		
ay.	Hysterectomy		
az.	Tonsillectomy		
ba.	Other (describe)		
bb.	Other (describe)		

13. Hospitalizations:

WHERE HOSPITALIZED	WHEN	FOR WHAT REASON
a.		
b.		
c.		
d.		
e.		

14. How often have you have taken antibiotics?

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

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

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

16. What medications are you taking now? Include non-prescription drugs.

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

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 now. Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible.

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

18. Childhood:

Question	**Yes**	**No**	**Don't Know**	**Comment**
1. Were you a full term baby?				
a. A preemie?				
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 gave you symptoms?
Yes____ No____
If yes, please: name the food and symptom (Example: milk – gas and diarrhea)
_____
_____
_____

20. 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	
l.	Milk		l.	Meat sandwich		l.	Pasta	
m.	Oat bran		m.	Milk		m.	Potato	
n.	Sugar		n.	Salad		n.	Poultry	
	Usual Breakfast	√		**Usual Lunch**	√		**Usual Dinner**	√
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)	

21. How much of the following do you consume each week?

a. Candy	
b. Cheese	
c. Chocolate	
d. Cups of coffee containing caffeine	

e.	Cups of decaffeinated coffee or tea	
f.	Cups of hot chocolate	
g.	Cups of tea containing caffeine	
h.	Diet sodas	
i.	Ice cream	
j.	Salty foods	
k.	Slices of white bread (rolls/bagels)	
l.	Sodas with caffeine	
m.	Sodas without caffeine	

22. Are you on a special diet? Yes____ No____

_____ ovo-lacto _____ vegetarian _____ other (describe):
_____ diabetic _____ vegan _____
_____ dairy restricted _____ blood type diet _____

23. Is there anything special about your diet that we should know? Yes____ No____
If yes, please explain:
_____

24. a. Do you have symptoms <u>immediately after</u> eating, such as belching, bloating, sneezing, hives, etc.?
Yes____ No____
b. If yes, are these symptoms associated with any particular food or supplement(s)?
Yes____ No____
c. Please name the food or supplement and symptom(s). Example: Milk – gas and diarrhea.
_____
_____

25. Do you feel you have <u>delayed</u> symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? Yes____ No____

26. Do you feel much **worse** when you eat a lot of :

_____high fat foods _____refined sugar (junk food)
_____high protein foods _____fried foods
_____high carbohydrate foods _____1 or 2 alcoholic drinks
(breads, pastas, potatoes) _____other _____

27. Do you feel much **better** when you eat a lot of :

_____high fat foods _____refined sugar (junk food)
_____high protein foods _____fried foods
_____high carbohydrate foods _____1 or 2 alcoholic drinks
(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, what food(s)? _____
_____

30. Do you have an aversion to certain foods? Yes____ No____

If yes, what foods? _____

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

a. Frequency	√	b. Color	√
More than 3x/day		Medium brown consistently	
1-3x/day		Very dark or black	
4-6x/week		Greenish color	
2-3x/week		Blood is visible.	
1 or fewer x/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? ___ 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 in your job or at home? Yes____ No____
If yes, which one(s)? _____lead _____cadmium
_____arsenic _____mercury
_____aluminum

41. Do odors affect you? Yes____ No____

42. How well have things been going for you?

	Very Well	Fair	Poorly	Very Poorly	Does not apply
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 so, when were you married? _____ Spouse's occupation _____
When were you separated? _____ Never _____
When were you divorced? _____ Never _____
When were you remarried? _____ Never _____ Spouse's occupation _____
Comments: _____

45. Hobbies and leisure activities: _____
_____

46. Do you exercise regularly? Yes____ No____

If so, how many times a week?
1._____1x
2._____2x
3._____3x
4._____4x or more

When you exercise, how long is each session?
1._____ ≤15 min
2._____ 16-30 min
3._____ 31-45 min
4._____ > 45 min

What type of exercise is it?
_____jogging/walking _____tennis
_____basketball _____water sports
_____home aerobics _____other _____

47. FAMILY HISTORY: For each member of your family, follow the grey or white line across the page and check the boxes for:

1. Their present state of health, and
2. Any illnesses they have had.

*(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 Trouble	High Blood Pressure	Kidney or Bladder Dis.	Nervous Breakdown	Rheumatism or Arthritis	Stomach or Duodenal 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):																			

48. Any other family history we should know about? Yes____ No____
If so, please comment: _____

49. What is the attitude of those close to you about your illness?
_____Supportive
_____Non-supportive

FOR WOMEN ONLY (questions 50-58):

50. Have you ever been pregnant? (If no, skip to question 53.) Yes____ No____

Number of miscarriages _____ Number of abortions _____ Number of preemies _____

Number of term births _____ Birth weight of largest baby _____ Smallest baby _____

Did you develop toxemia (high blood pressure)? Yes____ No____

Have you had other problems with pregnancy? Yes____ No____

If so, please comment: _____

_____

51. Age at first period _____ Date of last Pap Smear _____ Date of last Mammogram_____
Pap Smear: ___ Normal ___Abnormal
Mammogram: ___ Normal ___ Abnormal

52. Have you ever used birth control pills? Yes____ No____ If yes, when _____

53. Are you taking the pill now? Yes____ No____

54. Did taking the pill agree with you? Yes____ No____ Not applicable _____

55. Do you currently use contraception? Yes____ No____
If yes, what type of contraception do you use? _____

56. Are you in menopause? No _____ Yes _____ If yes, age at last period_____
Do you take: Estrogen?___ Ogen?___ Estrace?___ Premarin?___ Other (specify)_____
Progesterone?___ Provera? ___ Other (specify) _____

57. How long have you been on hormone replacement therapy (if applicable)? _____

58. In the second half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)? Yes____ No____ Not applicable _____

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

GENERAL:	Mild	Mod-erate	Severe
Cold hands & feet			
Cold intolerance			
Daytime sleepiness			
Difficulty falling asleep			
Early waking			
Fatigue			
Fever			
Flushing			
Heat intolerance			
Night waking			
Nightmares			
No dream recall			
HEAD, EYES & EARS:			
Conjunctivitis			
Distorted sense of smell			
Distorted taste			
Ear fullness			
Ear noises			
Ear pain			
Ear ringing/buzzing			
Eye crusting			
Eye pain			
Headache			
Hearing loss			
Hearing problems			
Lid margin redness			
Migraine			
Sensitivity to loud noises			
Vision problems			

MUSCULOSKELETAL:	Mild	Mod-erate	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:			
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			

MOOD/NERVES, Cont'd:	Mild	Mod-erate	Severe
Numbness			
Other Phobias			
Panic attacks			
Paranoia			
Seizures			
Suicidal thoughts			
Tingling			
Tremor/trembling			
Visual hallucinations			
EATING:			
Binge eating			
Bulimia			
Can't gain weight			
Can't lose weight			
Carbohydrate craving			
Carbohydrate intolerance			
Poor appetite			
Salt craving			
DIGESTION:			
Anal spasms			
Bad teeth			
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			

DIGESTION, Cont'd:	Mild	Mod-erate	Severe
Fissures			
Foods "repeat" (reflux)			
Heartburn			
Hemorrhoids			
Intolerance to: Lactose			
All milk products			
Intolerance to: Gluten (wheat)			
Corn			
Eggs			
Fatty foods			
Yeast			
Liver disease/jaundice (yellow eyes or skin)			
Lower abdominal pain			
Mucus in stools			
Nausea			
Periodontal disease			
Sore tongue			
Strong stool odor			
Undigested food in stools			
Upper abdominal pain			
Vomiting			
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			
Easy bruising			

SKIN PROBLEMS, Cont'd:	Mild	Mod-erate	Severe
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			
SKIN, ITCHING:			
Anus			
Arms			
Ear canals			
Eyes			
Feet			
Hands			
Legs			
Nipples			
Nose			
Penis			
Roof of mouth			
Scalp			
Skin in general			
Throat			

SKIN, DRYNESS OF:	Mild	Mod-erate	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:			
Enlarged/neck			
Tender/neck			
Other enlarged/tender lymph nodes			
NAILS:			
Bitten			
Brittle			
Curve up			
Frayed			
Fungus - fingers			
Fungus - toes			
Pitting			
Ragged cuticles			
Ridges			
Soft			
Thickening of: Finger nails			
Toenails			
White spots/lines			

RESPIRATORY:	Mild	Mod-erate	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:			
Angina/chest pain			
Breathlessness			
Heart attack			
Heart murmur			
High blood pressure			
Irregular pulse			
Mitral valve prolapse			
Palpitations			
Phlebitis			
Swollen ankles/feet			
Varicose veins			

URINARY:	Mild	Mod-erate	Severe
Bed wetting			
Hesitancy			
Infection			
Kidney disease			
Kidney stone			
Leaking/incontinence			
Pain/burning			
Prostate enlargement			
Prostate infection			
Urgency			
MALE REPRODUCTIVE:			
Discharge from penis			
Ejaculation problem			
Genital pain			
Impotence			
Infection			
Lumps in testicles			
Poor libido (sex drive)			
FEMALE REPRODUCTIVE:			
Breast cysts			
Breast lumps			
Breast tenderness			
Ovarian cyst			
Poor libido (sex drive)			
Endometriosis			
Fibroids			
Infertility			
Vaginal discharge			
Vaginal odor			
Vaginal itch			
Vaginal pain			

FEMALE REPRODUCTIVE, Cont'd:	Mild	Mod-erate	Severe
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			

Name_____ Date_____

Diet History

*Approximately how many of the following foods do you consume **EACH WEEK**? When possible put Figures in blank spaces. If a food is eaten on only an occasion write **OCC** in the blank. If you do not consume a certain food write **NONE** in the blank. If a **YES or NO** answer is required, check the appropriate box.*

Glasses of:
Whole milk _____
Skim milk _____
Buttermilk _____
Half & half _____
Servings of cheese _____
Kind of cheese? _____

Servings of:
Eggs _____
Beef _____
Pork _____
Bacon _____
Liver _____
Fowl _____
Fish _____
Lunch meat_____
Canned meat_____
Cereals _____
Pancakes _____
Waffles _____
Crackers _____
Rice _____
Macaroni_____
Spaghetti_____
Soup _____

Servings or portions of:
Pie/cake _____
Jell-O _____
Candy _____
Cookies _____
Doughnuts_____
Ice cream_____
Other desserts most commonly eaten:_____
_____

Servings of Vegetables:
Potatoes: white, red or sweet_____
Carrots_____
Beans_____
Corn _____
Parsley_____
Squash_____
Spinach_____
Greens_____
Lettuce_____
Celery_____
Green Peas_____
Broccoli_____
Asparagus_____
Cole Slaw_____
Onions_____
Tomatoes_____
Green Peppers_____
Cabbage_____
Turnips_____
Others:_____
_____

Servings of fruit:
Oranges_____
Grapefruit_____
Pineapple_____
Apples_____
Bananas_____
Prunes_____
Dates_____
Raisins_____
Figs_____
Grapes_____
Dried Apricots_____
Apple Sauce_____
Canned fruits_____
What dried or frozen fruits?_____
Other fruits?_____
_____

Popcorn_____
Peanut butter_____
Nuts_____
Honey_____
Soda_____
Orange juice_____
Grapefruit juice_____
Tomato juice_____
Other juices?_____
_____
What vegetable oils, fats or compounds do you use in cooking?_____
_____
What vegetable oil do you use in salads?_____

What did you eat for breakfast yesterday?_____
_____
_____
What did you eat for lunch yesterday?_____
_____
_____
What did you have for supper yesterday?_____
_____
_____

What beverages did you have?
_____

What did you have in between meals?
_____
_____

How many per day?
Pats of butter _____
Pats of margarine _____
White bread _____
Wheat bread _____
Rye bread _____
Corn bread _____
Other breads? _____
Sweet rolls _____

Glasses of water _____
Alcoholic beverages _____
Cups of coffee _____
Cups of Decaf _____
Cups of Tea _____
Cream in coffee, tea, etc. **Yes** **No**
How much sugar do you add to coffee or tea?_____
Do you use salt?
Sparingly_____
Freely _____
Moderately_____
Do you use vinegar?_____
Is this your average diet for the past three or four years? **Yes** **No**
What foods, if any, disagree with you?_____

Do you get indigestion? **Yes** **No**

Fond of fats? **Yes** **No**

Fond of sweets? **Yes** **No**

Fond of vegetables? **Yes** **No**

Fond of fruits? **Yes** **No**

Fond of bread? **Yes** **No**

Fond of butter? **Yes** **No**

Fond of cereal? **Yes** **No**

Signature

SYMPTOM SURVEY FORM

(Restricted to Professional Use)

PATIENT_____ DOCTOR _____ DATE _____

AGE_____ PHONE (_____)_____ VEGETARIAN ____ Yes ____ No

INSTRUCTIONS: Circle the number that applies to you. **If symptom doesn't apply, leave blank.** Use **(1)** for **MILD** symptoms (occurs once or twice a month), **(2)** for **MODERATE** symptoms (occurs several times a month), and **(3)** for **SEVERE** symptoms (you are aware of it almost constantly).

GROUP ONE

1 - **1 2 3** Acid foods upset
2 - **1 2 3** Get chilled, often
3 - **1 2 3** "Lump" in throat
4 - **1 2 3** Dry mouth-eyes-nose
5 - **1 2 3** Pulse speeds after meal
6 - **1 2 3** Keyed up – fail to calm
7 - **1 2 3** Cuts heal slowly
8 - **1 2 3** Gag easily
9 - **1 2 3** Unable to relax; startles easily
10 - **1 2 3** Extremities cold, clammy
11 - **1 2 3** Strong light irritates
12 - **1 2 3** Urine amount reduced
13 - **1 2 3** Heart pounds after retiring
14 - **1 2 3** "Nervous" stomach
15 - **1 2 3** Appetite reduced
16 - **1 2 3** Cold sweats often
17 - **1 2 3** Fever easily raised
18 - **1 2 3** Neuralgia-like pains
19 - **1 2 3** Staring, blinks little
20 - **1 2 3** Sour stomach frequent

GROUP TWO

21 - **1 2 3** Joint stiffness after arising
22 - **1 2 3** Muscle-leg-toe cramps at night
23 - **1 2 3** "Butterfly" stomach, cramps
24 - **1 2 3** Eyes or nose watery
25 - **1 2 3** Eyes blink often
26 - **1 2 3** Eyelids swollen, puffy
27 - **1 2 3** Indigestion soon after meals
28 - **1 2 3** Always seems hungry; feels "lightheaded" often
29 - **1 2 3** Digestion rapid
30 - **1 2 3** Vomiting frequent
31 - **1 2 3** Hoarseness frequent
32 - **1 2 3** Breathing irregular
33 - **1 2 3** Pulse slow; feels "irregular"
34 - **1 2 3** Gagging reflex slow
35 - **1 2 3** Difficulty swallowing
36 - **1 2 3** Constipation, diarrhea alternating
37 - **1 2 3** "Slow starter"
38 - **1 2 3** Get "chilled" infrequently
39 - **1 2 3** Perspire easily
40 - **1 2 3** Circulation poor, sensitive to cold
41 - **1 2 3** Subject to colds, asthma, bronchitis

GROUP THREE

42 - **1 2 3** Eat when nervous
43 - **1 2 3** Excessive appetite
44 - **1 2 3** Hungry between meals
45 - **1 2 3** Irritable before meals
46 - **1 2 3** Get "shaky" if hungry
47 - **1 2 3** Fatigue, eating relieves
48 - **1 2 3** "Lightheaded" if meals delayed
49 - **1 2 3** Heart palpitates if meals missed or delayed
50 - **1 2 3** Afternoon headaches
51 - **1 2 3** Overeating sweets upsets
52 - **1 2 3** Awaken after few hours sleep – hard to get back to sle ep
53 - **1 2 3** Crave candy or coffee in afternoons
54 - **1 2 3** Moods of depression – "blues" or melancholy
55 - **1 2 3** Abnormal craving for sweets or snacks

GROUP FOUR

56 - **1 2 3** Hands and feet go to sleep easily, numbness
57 - **1 2 3** Sigh frequently, "air hunger"
58 - **1 2 3** Aware of "breathing heavily"
59 - **1 2 3** High altitude discomfort
60 - **1 2 3** Opens windows in closed room
61 - **1 2 3** Susceptible to colds and fevers
62 - **1 2 3** Afternoon "yawner"
63 - **1 2 3** Get "drowsy" often
64 - **1 2 3** Swollen ankles worse at night
65 - **1 2 3** Muscle cramps, worse during exercise; get "charley hor ses"
66 - **1 2 3** Shortness of breath on exertion
67 - **1 2 3** Dull pain in chest or radiating into left arm, worse on exertion.
68 - **1 2 3** Bruise easily, "black and blue" spots
69 - **1 2 3** Tendency to anemia
70 - **1 2 3** "Nose bleeds" frequent
71 - **1 2 3** Noises in head, or "ringing in ears"
72 - **1 2 3** Tension under the breastbone, or feeling of "tightness" worse on exertion

GROUP FIVE

73 - **1 2 3** Dizziness
74 - **1 2 3** Dry Skin
75 - **1 2 3** Burning feet
76 - **1 2 3** Blurred vision
77 - **1 2 3** Itching skin and feet
78 - **1 2 3** Excessive falling hair
79 - **1 2 3** Frequent skin rashes
80 - **1 2 3** Bitter, metallic taste in mouth in mornings
81 - **1 2 3** Bowel movements painful or difficult
82 - **1 2 3** Worrier, feels insecure
83 - **1 2 3** Feeling queasy; headache over eyes
84 - **1 2 3** Greasy foods upset
85 - **1 2 3** Stools light-colored
86 - **1 2 3** Skin peels on foot soles
87 - **1 2 3** Pain between shoulder blades
88 - **1 2 3** Use laxatives
89 - **1 2 3** Stools alternate from soft to watery
90 - **1 2 3** History of gallbladder attacks or gallstones
91 - **1 2 3** Sneezing attacks
92 - **1 2 3** Dreaming, nightmare type bad dreams
93 - **1 2 3** Bad breath (halitosis)
94 - **1 2 3** Milk products cause distress
95 - **1 2 3** Sensitive to hot weather
96 - **1 2 3** Burning or itching anus
97 - **1 2 3** Crave sweets

GROUP SIX

98 - **1 2 3** Loss of taste for meat
99 - **1 2 3** Lower bowel gas several hours after eating
100 - **1 2 3** Burning stomach sensations, eating relieves
101 - **1 2 3** Coated tongue
102 - **1 2 3** Pass large amounts of foul-smelling gas
103 - **1 2 3** Indigestion ½ - 1 hour after eating; may be up to 3 – 4 hrs.
104 - **1 2 3** Mucous colitis or "irritable bowel"
105 - **1 2 3** Gas shortly after eating
106 - **1 2 3** Stomach "bloating" after eating

GROUP SEVEN

(A)

107 - **1 2 3** Insomnia
108 - **1 2 3** Nervousness
109 - **1 2 3** Can't gain weight
110 - **1 2 3** Intolerance to heat
111 - **1 2 3** Highly emotional
112 - **1 2 3** Flush easily
113 - **1 2 3** Night sweats
114 - **1 2 3** Thin, moist skin
115 - **1 2 3** Inward trembling
116 - **1 2 3** Heart palpitates
117 - **1 2 3** Increased appetite without weight gain
118 - **1 2 3** Pulse fast at rest
119 - **1 2 3** Eyelids and face twitch
120 - **1 2 3** Irritable and restless
121 - **1 2 3** Can't work under pressure

(B)

122 - **1 2 3** Increase in weight
123 - **1 2 3** Decrease in appetite
124 - **1 2 3** Fatigue easily
125 - **1 2 3** Ringing in ears
126 - **1 2 3** Sleepy during day
127 - **1 2 3** Sensitive to cold
128 - **1 2 3** Dry or scaly skin
129 - **1 2 3** Constipation
130 - **1 2 3** Mental sluggishness
131 - **1 2 3** Hair coarse, falls out
132 - **1 2 3** Headaches upon arising wear off during day
133 - **1 2 3** Slow pulse, below 65
134 - **1 2 3** Frequency of urination
135 - **1 2 3** Impaired hearing
136 - **1 2 3** Reduced initiative

(C)

137 - **1 2 3** Failing memory
138 - **1 2 3** Low blood pressure
139 - **1 2 3** Increased sex drive
140 - **1 2 3** Headaches, "splitting or rending" type
141 - **1 2 3** Decreased sugar tolerance

(D)

142 - **1 2 3** Abnormal thirst
143 - **1 2 3** Bloating of abdomen
144 - **1 2 3** Weight gain around hips or waist
145 - **1 2 3** Sex drive reduced or lacking
146 - **1 2 3** Tendency to ulcers, colitis 147 - **1 2 3** Increased sugar tolerance 148 - **1 2 3** Women: menstrual disorders
149 - **1 2 3** Young girls: lack of menstrual function

(E)

150 - **1 2 3** Dizziness
151 - **1 2 3** Headaches
152 - **1 2 3** Hot flashes
153 - **1 2 3** Increased blood pressure
154 - **1 2 3** Hair growth on face or body (female)
155 - **1 2 3** Sugar in urine (not diabetes)
156 - **1 2 3** Masculine tendencies (female)

(F)

157 - **1 2 3** Weakness, dizziness
158 - **1 2 3** Chronic fatigue
159 - **1 2 3** Low blood pressure
160 - **1 2 3** Nails weak, ridged
161 - **1 2 3** Tendency to hives
162 - **1 2 3** Arthritic tendencies
163 - **1 2 3** Perspiration increase
164 - **1 2 3** Bowel disorders
165 - **1 2 3** Poor circulation
166 - **1 2 3** Swollen ankles
167 - **1 2 3** Crave salt
168 - **1 2 3** Brown spots or bronzing of skin
169 - **1 2 3** Allergies – tendency to asthma
170 - **1 2 3** Weakness after colds, influenza
171 - **1 2 3** Exhaustion – muscular and nervous
172 - **1 2 3** Respiratory disorders

GROUP EIGHT

173 - **1 2 3** Apprehension
174 - **1 2 3** Irritability
175 - **1 2 3** Morbid fears
176 - **1 2 3** Never seems to get well
177 - **1 2 3** Forgetfulness
178 - **1 2 3** Indigestion
179 - **1 2 3** Poor appetite
180 - **1 2 3** Craving for sweets
181 - **1 2 3** Muscular soreness
182 - **1 2 3** Depression; feelings of dread
183 - **1 2 3** Noise sensitivity
184 - **1 2 3** Acoustic hallucinations
185 - **1 2 3** Tendency to cry without reason
186 - **1 2 3** Hair is coarse and/or thinning
187 - **1 2 3** Weakness
188 - **1 2 3** Fatigue
189 - **1 2 3** Skin sensitive to touch
190 - **1 2 3** Tendency toward hives
191 - **1 2 3** Nervousness
192 - **1 2 3** Headache
193 - **1 2 3** Insomnia
194 - **1 2 3** Anxiety
195 - **1 2 3** Anorexia
196 - **1 2 3** Inability to concentrate; confusion
197 - **1 2 3** Frequent stuffy nose; sinus infections
198 - **1 2 3** Allergy to some foods
199 - **1 2 3** Loose joints

FEMALE ONLY

200 - **1 2 3** Very easily fatigued
201 - **1 2 3** Premenstrual tension
202 - **1 2 3** Painful menses
203 - **1 2 3** Depressed feelings
204 - **1 2 3** Menstruation excessive and prolonged
205 - **1 2 3** Painful breasts
206 - **1 2 3** Menstruate too frequently
207 - **1 2 3** Vaginal discharge
208 - **1 2 3** Hysterectomy/ovaries removed
209 - **1 2 3** Menopausal hot flashes
210 - **1 2 3** Menses scanty or missed
211 - **1 2 3** Acne, worse at menses
212 - **1 2 3** Depression of long standing

MALE ONLY

213 - **1 2 3** Prostate trouble
214 - **1 2 3** Urination difficult or dribbling
215 - **1 2 3** Night urination frequent
216 - **1 2 3** Depression
217 - **1 2 3** Pain on inside of legs or heels
218 - **1 2 3** Feeling of incomplete bowel evacuation
219 - **1 2 3** Lack of energy
220 - **1 2 3** Migrating aches and pains
221 - **1 2 3** Tire too easily
222 - **1 2 3** Avoids activity
223 - **1 2 3** Leg nervousness at night
224 - **1 2 3** Diminished sex drive

IMPORTANT

TO THE PATIENT: Please list below the five main physical and or health complaints you have in order of their importance:

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

(TO BE COMPLETED BY DOCTOR)

Postural Blood Pressure: Recumbent_____ Standing_____ Pulse_____

Hema-Combistix Urine readings: pH_____ Albumin per cent _____ Glucose per cent_____

Occult Blood_____ pH of Saliva_____ pH of Stool specimen_____ Weight _____

Hemoglobin_____ Blood Clotting Time _____

BARNES THYROID TEST

This test was developed by Dr. Broda Barnes, M.D. and is a measurement of the underarm temperature to determine hypo and hyperthyroid states. The test is conducted by the patient in the a.m. before leaving bed - with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test - getting up for any reason, shaking down the thermometer, etc. It is important that the test be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.

PRE-MENSES FEMALES AND MENOPAUSAL FEMALES

Any two days during the month

FEMALES HAVING MENSTRUAL CYCLES

The 2nd and 3rd day of flow OR any 5 days in a row.

MALES

Any 2 days during the month.

You can do the following test at home to see if you may have a functional low thyroid. Use an oral thermometer or a digital one. When you use a digital one, place the probe under your arm for 5 minutes then turn your machine on; continue on for an additional 5 minutes. When using a regular one, shake down the night before.

Date: _____Temperature: _____
Date: _____Temperature: _____
Date: _____Temperature: _____
Date: _____Temperature: _____
Date: _____Temperature: _____
Date: _____Temperature: _____
Date: _____Temperature: _____

BP SIT_____ BP STAND_____
PULSE SIT_____ PULSE STAND_____
SALIVA PH_____ BLOOD TYPE_____

Metabolic Assessment Form™

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

PART I

Please list your 5 major health concerns in order of importance:

1. _____ **4.** _____

2. _____ **5.** _____

3. _____

PART II **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

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 movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting proteins and meats; 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 of 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

Difficulty digesting roughage and fiber	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0	1	2	3
Frequent loss of appetite	0	1	2	3

Category VII

Abdominal distention after consumption of fiber, starches, and sugar	0	1	2	3
Abdominal distention after certain probiotic or natural supplements	0	1	2	3
Decreased gastrointestinal motility, constipation	0	1	2	3
Increased gastrointestinal motility, diarrhea	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Suspicion of nutritional malabsorption	0	1	2	3
Frequent use of antacid medication	0	1	2	3

Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/ Diverticulitis, or Leaky Gut Syndrome? **Yes** **No**

Category VIII

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
Burpy, fishy taste after consuming fish oils	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 IX

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 X

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 between meals	0	1	2	3
Blurred vision	0	1	2	3

Category XI

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

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

Category XII

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 XIII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a 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 XIV

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 XV

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 XVI

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

Category XVI *(Cont.)*

Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVII *(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 XVIII *(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 XIX *(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 XX *(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 III

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: _____ _____ _____

PART IV

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions: