



**TOTAL APPROACH**  
— HEALTH —

# Health Questionnaire

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TOTAL APPROACH  
HEALTH

GENERAL INFORMATION

Name	<i>First</i>	<i>Middle</i>	<i>Last</i>
Preferred Name			
Date of Birth			
Age			
Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
Genetic Background	<input type="checkbox"/> African <input type="checkbox"/> Asian	<input type="checkbox"/> European <input type="checkbox"/> Ashkenazi	<input type="checkbox"/> Native American <input type="checkbox"/> Middle Eastern <input type="checkbox"/> Mediterranean <input type="checkbox"/> _____
Highest Education Level	<input type="checkbox"/> High School	<input type="checkbox"/> Under-Graduate	<input type="checkbox"/> Post-Graduate
Job Title			
Nature of Business			
Primary Address	<i>Number, Street</i>		<i>Apt. No.</i>
	<i>City</i>	<i>State</i>	<i>Zip</i>
Alternate Address	<i>Number, Street</i>		<i>Apt. No.</i>
	<i>City</i>	<i>State</i>	<i>Zip</i>
Home Phone 1			
Home Phone 2			
Work Phone			
Cell Phone			
Fax			
Email			
Emergency Contact	<i>Name</i>	<i>Phone Number</i>	
	<i>Address</i>		<i>Apt.</i>
	<i>No. City</i>	<i>State</i>	<i>Zip</i>
Physician	<i>Name</i>	<i>Phone Number</i>	
	<i>Fax</i>		
Referred by	<input type="checkbox"/> Website	<input type="checkbox"/> Friend or Family	<input type="checkbox"/> Other _____

## PHARMACY INFORMATION

Primary Pharmacy

Name

Phone Number

Address

City

State

Zip

E-mail

Fax\*

*\* It is extremely important that you list the pharmacy's fax number.*

## CREDIT CARD INFORMATION

Patient \_\_\_\_\_ Date \_\_\_\_\_

DOB \_\_\_\_\_

Preferred Method of Payment (please circle one): Cash / Check / Credit Card

If paying by credit card, we accept American Express, MasterCard, Visa and Discover

*\*Note: If Discover is your primary card, please provide another card (i.e., AMEX, MasterCard or Visa) for transactions (i.e., supplement orders, etc.) that we may need to process. Some pharmacies do not accept Discover.*

### PRIMARY CARD

Name on Card \_\_\_\_\_

Card Type  AMEX  Visa  MasterCard  Discover

Account Number \_\_\_\_\_

Expiration Date (mm/yy) \_\_\_\_\_

CVV# \_\_\_\_\_

### SECONDARY CARD

Name on Card \_\_\_\_\_

Card Type  AMEX  Visa  MasterCard  Discover

Account Number \_\_\_\_\_

Expiration Date (mm/yy) \_\_\_\_\_

CVV# \_\_\_\_\_

# Medical Questionnaire

## ALLERGIES

medication/supplement/food	reaction
_____	_____
_____	_____
_____	_____
_____	_____

## COMPLAINTS/CONCERNS

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

If you had a magic wand and could erase three problems, what would they be?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

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

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

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

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

Please list current and ongoing problems in order of priority:

Describe Problem	Mild	Moderate	Severe	Prior Treatment/Approach	Success		
					Excellent	Good	Fair
<i>Example: Post Nasal Drip</i>		X		<i>Elimination Diet</i>	X		
_____							
_____							
_____							
_____							
_____							
_____							

## MEDICAL HISTORY

### DISEASES/DIAGNOSIS/CONDITIONS

Check appropriate box, provide date of onset and whether it is a past or ongoing condition.

#### GASTROINTESTINAL

- Irritable Bowel Syndrome \_\_\_\_\_
- Inflammatory Bowel Disease \_\_\_\_\_
- Crohn's \_\_\_\_\_
- Ulcerative Colitis \_\_\_\_\_
- Gastritis or Peptic Ulcer Disease \_\_\_\_\_
- GERD (reflux) \_\_\_\_\_
- Celiac Disease \_\_\_\_\_
- Other \_\_\_\_\_

#### CARDIOVASCULAR

- Heart Attack \_\_\_\_\_
- Other Heart Disease \_\_\_\_\_
- Stroke \_\_\_\_\_
- Elevated Cholesterol \_\_\_\_\_
- Arrhythmia (irregular heart rate) \_\_\_\_\_
- Hypertension (high blood pressure) \_\_\_\_\_
- Rheumatic Fever \_\_\_\_\_
- Mitral Valve Prolapse \_\_\_\_\_
- Other \_\_\_\_\_

#### METABOLIC/ENDOCRINE

- Type 1 Diabetes \_\_\_\_\_
- Type 2 Diabetes \_\_\_\_\_
- Hypoglycemia \_\_\_\_\_
- Metabolic Syndrome \_\_\_\_\_  
(Insulin Resistance or Pre-Diabetes)
- Hypothyroidism (low thyroid) \_\_\_\_\_
- Hyperthyroidism (overactive thyroid) \_\_\_\_\_
- Endocrine Problems \_\_\_\_\_
- Polycystic Ovarian Syndrome (PCOS) \_\_\_\_\_
- Infertility \_\_\_\_\_
- Weight Gain \_\_\_\_\_
- Weight Loss \_\_\_\_\_
- Frequent Weight Fluctuations \_\_\_\_\_
- Bulimia \_\_\_\_\_
- Anorexia \_\_\_\_\_
- Binge Eating Disorder \_\_\_\_\_
- Night Eating Syndrome \_\_\_\_\_
- Eating Disorder (non-specific) \_\_\_\_\_
- Other \_\_\_\_\_

#### CANCER

- Lung Cancer \_\_\_\_\_
- Breast Cancer \_\_\_\_\_
- Colon Cancer \_\_\_\_\_
- Ovarian Cancer \_\_\_\_\_
- Prostate Cancer \_\_\_\_\_
- Skin Cancer \_\_\_\_\_
- Other \_\_\_\_\_

#### GENITAL AND URINARY SYSTEMS

- Kidney Stones \_\_\_\_\_
- Gout \_\_\_\_\_
- Interstitial Cystitis \_\_\_\_\_
- Frequent Urinary Tract Infections \_\_\_\_\_
- Frequent Yeast Infections \_\_\_\_\_
- Erectile or Sexual Dysfunction \_\_\_\_\_
- Other \_\_\_\_\_

#### MUSCULOSKELETAL/PAIN

- Osteoarthritis \_\_\_\_\_
- Fibromyalgia \_\_\_\_\_
- Chronic Pain \_\_\_\_\_
- Other \_\_\_\_\_

#### INFLAMMATORY/AUTOIMMUNE

- Chronic Fatigue Syndrome \_\_\_\_\_
- Autoimmune Disease \_\_\_\_\_
- Rheumatoid Arthritis \_\_\_\_\_
- Lupus SLE \_\_\_\_\_
- Immune Deficiency Disease \_\_\_\_\_
- Herpes-Genital \_\_\_\_\_
- Severe Infectious Disease \_\_\_\_\_
- Food Allergies \_\_\_\_\_
- Environmental Allergies \_\_\_\_\_
- Poor Immune Function \_\_\_\_\_  
(frequent infections)
- Multiple Chemical Sensitivities \_\_\_\_\_
- Latex Allergy \_\_\_\_\_
- Other \_\_\_\_\_

#### RESPIRATORY DISEASES

- Asthma \_\_\_\_\_
- Chronic Sinusitis \_\_\_\_\_
- Bronchitis \_\_\_\_\_
- Emphysema \_\_\_\_\_
- Pneumonia \_\_\_\_\_
- Tuberculosis \_\_\_\_\_
- Sleep Apnea \_\_\_\_\_
- Other \_\_\_\_\_

#### SKIN DISEASES

- Eczema \_\_\_\_\_
- Psoriasis \_\_\_\_\_
- Acne \_\_\_\_\_
- Melanoma \_\_\_\_\_
- Skin Cancer \_\_\_\_\_
- Other \_\_\_\_\_

## MEDICAL HISTORY (CONTINUED)

### NEUROLOGIC/MOOD

- Depression \_\_\_\_\_
- Anxiety \_\_\_\_\_
- Bipolar Disorder \_\_\_\_\_
- Schizophrenia \_\_\_\_\_
- Headaches \_\_\_\_\_
- Migraines \_\_\_\_\_
- ADD/ADHD \_\_\_\_\_
- Autism \_\_\_\_\_

### PREVENTIVE TESTS

Check box if yes and provide date of last test

- Full Physical Exam \_\_\_\_\_
- Bone Density \_\_\_\_\_
- Colonoscopy \_\_\_\_\_
- Cardiac Stress Test \_\_\_\_\_
- EBT Heart Scan \_\_\_\_\_
- EKG \_\_\_\_\_
- Hemocult Test-stool test for blood \_\_\_\_\_
- MRI \_\_\_\_\_
- CT Scan \_\_\_\_\_
- Upper Endoscopy \_\_\_\_\_
- Upper GI Series \_\_\_\_\_
- Ultrasound \_\_\_\_\_

### INJURIES

Check box if yes

- Back Injury       Head Injury
- Neck Injury       Broken Bones
- Other \_\_\_\_\_

### HOSPITALIZATIONS

None

Date	Reason

### COMMENTS

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### NEUROLOGIC/MOOD (CONTINUED)

- Mild Cognitive Impairment \_\_\_\_\_
- Memory Problems \_\_\_\_\_
- Parkinson's Disease \_\_\_\_\_
- Multiple Sclerosis \_\_\_\_\_
- ALS \_\_\_\_\_
- Seizures \_\_\_\_\_
- Other Neurological Problems \_\_\_\_\_

### SURGERIES

Check box if yes and provide date of surgery

- Appendectomy \_\_\_\_\_
- Hysterectomy +/- Ovaries \_\_\_\_\_
- Gall Bladder \_\_\_\_\_
- Hernia \_\_\_\_\_
- Tonsillectomy \_\_\_\_\_
- Dental Surgery \_\_\_\_\_
- Joint Replacement-Knee/Hip \_\_\_\_\_
- Heart Surgery-Bypass Valve \_\_\_\_\_
- Angioplasty or Stent \_\_\_\_\_
- Pacemaker \_\_\_\_\_
- Other \_\_\_\_\_
- None \_\_\_\_\_

**BLOOD TYPE:**  A     B     AB     O  
 Rh+     Rh-     Unknown

## GYNECOLOGIC HISTORY *(for women only)*

### OBSTETRIC HISTORY *Check box if yes and provide number of*

- Pregnancies \_\_\_\_\_  Miscarriage \_\_\_\_\_  Caesarean \_\_\_\_\_  
 Abortion \_\_\_\_\_  Vaginal Deliveries \_\_\_\_\_  Living Children \_\_\_\_\_  
 Post Partum Depression  Toxemia  Gestational Diabetes  Baby Over 8 Pounds  
 Breast Feeding For how long? \_\_\_\_\_

### MENSTRUAL HISTORY

Age at First Period: \_\_\_\_\_ Menses Frequency: \_\_\_\_\_ Length: \_\_\_\_\_

Pain:  Yes  No Clotting:  Yes  No

Has your period ever skipped?  Yes  No For how long? \_\_\_\_\_

Last Menstrual Period: \_\_\_\_\_

Use of hormonal contraception such as:  Birth Control Pills  Patch  Nuva Ring How long? \_\_\_\_\_

Do you use contraception?  Yes  No  Condom  Diaphragm  IUD  Partner Vasectomy

### WOMEN'S DISORDERS/HORMONAL IMBALANCES

- Fibrocystic Breasts  Endometriosis  Fibroids  Infertility  
 Painful Periods  Heavy periods  PMS

Last Mammogram: \_\_\_\_\_

Breast Biopsy/Date: \_\_\_\_\_

Last PAP Test: \_\_\_\_\_  Normal  Abnormal

Last Bone Density: \_\_\_\_\_ Results:  High  Low  Within Normal Range

Are you in menopause?  Yes  No

Age at Menopause: \_\_\_\_\_

- Hot Flashes  Mood Swings  Concentration/Memory Problems  Vaginal Dryness  Decreased Libido  
 Heavy Bleeding  Joint Pains  Headaches  Weight Gain  Loss of Control of Urine  Palpitations

Use of hormone replacement therapy. How long? \_\_\_\_\_

## MEN'S HISTORY *(for men only)*

Have you had a PSA done?  Yes  No

PSA Level:  0-2  2-4  4-10  > 10

Prostate Enlargement  Prostate infection  Change in Libido  Impotence

Difficulty Obtaining an Erection  Difficulty Maintaining an Erection

Nocturia (urination at night). How many times at night? \_\_\_\_\_

Urgency/Hesitancy/Change in Urinary Stream  Loss of Control of Urine

## GI HISTORY

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Foreign Travel?  Yes  No Where? \_\_\_\_\_

Wilderness Camping?  Yes  No Where? \_\_\_\_\_

Have you ever had severe:  Gastroenteritis  Diarrhea

Do you feel like you digest your food well?  Yes  No

Do you feel bloated after meals?  Yes  No

## PATIENT BIRTH HISTORY

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Term  Premature

Pregnancy Complications: \_\_\_\_\_

Birth Complications: \_\_\_\_\_

Breast Fed How long? \_\_\_\_\_  Bottle-fed

Age at introduction of: Solid Foods: \_\_\_\_\_ Dairy: \_\_\_\_\_ Wheat: \_\_\_\_\_

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

## DENTAL HISTORY

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### DENTAL SURGERY

Silver Mercury Fillings How many? \_\_\_\_\_

Gold Fillings  Root Canals  Implants  Tooth Pain  Bleeding Gums

Gingivitis  Problems with Chewing

Do you floss regularly?  Yes  No





## FAMILY HISTORY

*Check family members that apply*

	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age (if still alive)												
Age at death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Spondylitis)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Diseases (such as Lupus)												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												

## SOCIAL HISTORY

### NUTRITION HISTORY

Have you ever had a nutrition consultation?  Yes  No

Have you made any changes in your eating habits because of your health?  Yes  No Describe: \_\_\_\_\_

Do you currently follow a special diet or nutritional program?  Yes  No

Check all that apply:

- Low Fat  Low Carbohydrate  High Protein  Low Sodium  Diabetic  No Dairy  No Wheat  
 Gluten Restricted  Vegetarian  Vegan  Ultrametabolism  
 Specific Program for Weight Loss/Maintenance Type: \_\_\_\_\_  Other\_

Height (feet/inches) \_\_\_\_\_

Usual Weight Range +/- 5 lbs \_\_\_\_\_ Highest adult weight \_\_\_\_\_ Current Weight \_\_\_\_\_

Desired Weight Range +/- 5 lbs \_\_\_\_\_ Lowest adult weight \_\_\_\_\_

Weight Fluctuations (> 10 lbs.)  Yes  No Body Fat % \_\_\_\_\_

How often do you weigh yourself?  Daily  Weekly  Monthly  Rarely  Never

Have you ever had your metabolism (resting metabolic rate) checked?  Yes  No If yes, what was it? \_\_\_\_\_

Do you avoid any particular foods?  Yes  No If yes, types and reason: \_\_\_\_\_

If you could only eat a few foods a week, what would they be? \_\_\_\_\_

Do you grocery shop?  Yes  No If no, who does the shopping? \_\_\_\_\_

Do you read food labels?  Yes  No

Do you cook?  Yes  No If no, who does the cooking? \_\_\_\_\_

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

Check all 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 or food preferences |
| <input type="checkbox"/> Erratic eating pattern                                       | <input type="checkbox"/> Love to eat  |
| <input type="checkbox"/> Eat too much   | <input type="checkbox"/> Eat because I have to  |
| <input type="checkbox"/> Late night eating  | <input type="checkbox"/> Have a negative relationship to food   |
| <input type="checkbox"/> Dislike healthy food   | <input type="checkbox"/> Struggle with eating issues  |
| <input type="checkbox"/> Time constraints   | <input type="checkbox"/> Emotional eater (eat when sad, lonely, depressed, bored)                           |
| <input type="checkbox"/> Eat more than 50% meals away from home                       | <input type="checkbox"/> Eat too much under stress  |
| <input type="checkbox"/> Travel frequently  | <input type="checkbox"/> Eat too little under stress  |
| <input type="checkbox"/> Non-availability of healthy foods                            | <input type="checkbox"/> Don't care to cook   |
| <input type="checkbox"/> Do not plan meals or menus                                   | <input type="checkbox"/> Eating in the middle of the night  |
| <input type="checkbox"/> Reliance on convenience items                                | <input type="checkbox"/> Confused about nutrition advice  |
| <input type="checkbox"/> Poor snack choices   |   |
| <input type="checkbox"/> Significant other or family members don't like healthy foods |   |

The most important thing I should change about my diet to improve my health is:

**SMOKING**

Currently Smoking?  Yes  No How many years? \_\_\_\_\_ Packs per day: \_\_\_\_\_

Attempts to quit: \_\_\_\_\_

Previous Smoking?  Yes  No How many years? \_\_\_\_\_ Packs per day: \_\_\_\_\_

Second Hand Smoke Exposure? \_\_\_\_\_

**ALCOHOL INTAKE**

How many drinks currently per week? *1 drink = 5 ounces wine, 12 ounces beer or 1.5 ounces spirits*

None  1-3  4-6  7-10  > 10 *If "None," skip to Other Substances*

Previous alcohol intake?  Yes ( Mild  Moderate  High)  None

Have you ever been told you should cut down your alcohol intake?  Yes  No

Do you get annoyed when people ask you about your drinking?  Yes  No

Do you ever feel guilty about your alcohol consumption?  Yes  No

Do you ever take an eye-opener?  Yes  No

Do you notice a tolerance to alcohol (can you "hold" more than others)?  Yes  No

Have you ever been unable to remember what you did during a drinking episode?  Yes  No

Do you get into arguments or physical fights when you have been drinking?  Yes  No

Have you ever been arrested or hospitalized because of drinking?  Yes  No

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

**OTHER SUBSTANCES**

Caffeine Intake:  Yes  No | Coffee cups/day:  1  2-4  > 4 | Tea cups/day:  1  2-4  > 4

Caffeinated Sodas or Diet Sodas Intake:  Yes  No

12-ounce can/bottle  1  2-4  > 4 per day

List favorite type (Ex. Diet Coke, Pepsi, etc.): \_\_\_\_\_

Are you currently using any recreational drugs?  Yes  No Type \_\_\_\_\_

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

**EXERCISE**

Current Exercise Program: *(List type of activity, number of sessions/week, and duration)*

Activity	Type	Frequency per Week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength			
Other (yoga, pilates, gyrotonics, etc.)			
Sports or Leisure Activities (golf, tennis, rollerblading, etc.)			

Rate your level of motivation for including exercise in your life?  Low  Medium  High

List problems that limit activity: \_\_\_\_\_

Do you feel unusually fatigued after exercise?  Yes  No

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

Do you usually sweat when exercising?  Yes  No

**PSYCHOSOCIAL**

Do you feel significantly less vital than you did a year ago?  Yes  No  
Are you happy?  Yes  No  
Do you feel your life has meaning and purpose?  Yes  No  
Do you believe stress is presently reducing the quality of your life?  Yes  No  
Do you like the work you do?  Yes  No  
Have you ever experienced major losses in your life?  Yes  No  
Do you spend the majority of your time and money to fulfill responsibilities and obligations?  Yes  No  
Would you describe your experience as a child in your family as happy and secure?  Yes  No

**STRESS/COPING**

Have you ever sought counseling?  Yes  No  
Are you currently in therapy?  Yes  No Describe: \_\_\_\_\_  
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  
Daily Stressors: Rate on scale of 1-10  
Work \_\_\_\_\_ Family \_\_\_\_\_ Social \_\_\_\_\_ Finances \_\_\_\_\_ Health \_\_\_\_\_ Other \_\_\_\_\_  
Do you practice meditation or relaxation techniques?  Yes  No How often? \_\_\_\_\_  
Check all that apply:  Yoga  Meditation  Imagery  Breathing  Tai Chi  Prayer  Other:  
Have you ever been abused, a victim of a crime, or experienced a significant trauma?  Yes  No

**SLEEP/REST**

Average number of hours you sleep per night:  >10  8-10  6-8  < 6  
Do you have trouble falling asleep?  Yes  No  
Do you feel rested upon awakening?  Yes  No  
Do you have problems with insomnia?  Yes  No  
Do you snore?  Yes  No  
Do you use sleeping aids?  Yes  No Explain: \_\_\_\_\_

**ROLES/RELATIONSHIP**

Marital status  Single  Married  Divorced  Gay/Lesbian  Long Term Partnership  Widow

List Children:

Child's Name	Age	Gender

Who is Living in Household? Number: \_\_\_\_\_ Names: \_\_\_\_\_

Their Employment/Occupations: \_\_\_\_\_

Resources for emotional support?

Check all that apply:  Spouse  Family  Friends  Religious/Spiritual  Pets  Other: \_\_\_\_\_

Are you satisfied with your sex life?  Yes  No

How well have things been going for you?	Very Well	Fine	Poorly	Does Not Apply
Overall				
At school				
In your job				
In your social life				
With close friends				
With sex				
With your attitude				
With your boyfriend/girlfriend				
With your children				
With your parents				
With your spouse				

## ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

Do you have known adverse food reactions or sensitivities?  Yes  No If yes, describe symptoms: \_\_\_\_\_

Do you have any food allergies or sensitivities?  Yes  No List all: \_\_\_\_\_

Do you have an adverse reaction to caffeine?  Yes  No

When you drink caffeine do you feel:  Irritable or Wired  Aches & Pains

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

- Monosodium glutamate (MSG)  Aspartame (NutraSweet)  Caffeine  Bananas  Garlic  Onion
- Cheese  Citrus Foods  Chocolate  Alcohol  Red Wine
- Sulfite Containing Foods (wine, dried fruit, salad bars)  Preservatives (ex. sodium benzoate)
- Other: \_\_\_\_\_

Which of these significantly affect you? Check all that apply:

- Cigarette Smoke  Perfumes/Colognes  Auto Exhaust Fumes  Other: \_\_\_\_\_

In your work or home environment, are you exposed to:  Chemicals  Electromagnetic Radiation  Mold

Have you ever turned yellow (jaundiced)?  Yes  No

Have you ever been told you have Gilbert's syndrome or a liver disorder?  Yes  No

Explain: \_\_\_\_\_

Do you have a known history of significant exposure to any harmful chemicals such as the following:

- Herbicides  Insecticides (frequent visits of exterminator)  Pesticides  Organic Solvents
- Heavy Metals  Other \_\_\_\_\_

Chemical Name, Date, Length of Exposure: \_\_\_\_\_

Do you dry clean your clothes frequently?  Yes  No

Do you or have you lived or worked in a damp or moldy environment or had other mold exposures?  Yes  No

Do you have any pets or farm animals?  Yes  No

## SYMPTOM REVIEW

Please check all current symptoms occurring or present in the past 6 months.

### GENERAL

- Cold Hands & Feet
- Cold Intolerance
- Low Body Temperature
- Low Blood Pressure
- 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 Pain
- Ear Ringing/Buzzing
- Lid Margin Redness
- Eye Crusting
- Eye Pain
- Hearing Loss
- Hearing Problems
- Headache
- Migraine
- Sensitivity to Loud Noises
- Vision problems (other than glasses)
- Macular Degeneration
- Vitreous Detachment
- Retinal Detachment

### 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 and 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
- 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
- Can't Maintain Healthy Weight
- Frequent Dieting
- Poor Appetite
- Salt Cravings
- Carbohydrate Craving (breads, pastas)
- Sweet Cravings (candy, cookies, cakes)
- Chocolate Cravings
- Caffeine Dependency

### 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
- Cramps
- Dentures w/Poor Chewing
- Diarrhea
- Alternating Diarrhea & Constipation
- Difficulty Swallowing
- Dry Mouth
- Excess Flatulence/Gas
- Fissures
- Foods "Repeat" (Reflux)
- Gas
- Heartburn
- Hemorrhoids
- Indigestion
- Nausea
- Upper Abdominal Pain
- Vomiting

#### Intolerance to:

- Lactose
- All Dairy Products
- Wheat
- Gluten (Wheat, Rye, Barley)
- Corn
- Eggs
- Fatty Foods
- Yeast
- Liver Disease/Jaundice-Yellow Eyes/Skin
- Abnormal Liver Function Tests
- Lower Abdominal Pain
- Mucus in Stools
- Periodontal Disease
- Sore Tongue
- Strong Stool Odor
- Undigested Food in Stools

### 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
- Lack Of Sweating
- Eczema
- Hives
- Jock Itch
- Lackluster Skin
- Moles w/Color/Size Change
- Oily Skin

- Pale Skin
- Patchy Dullness
- Rash
- Red Face
- Sensitivity to Bites
- Sensitivity to Poison Ivy/Oak
- Shingles
- Skin Darkening
- 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
- Strong Body Odor
- Hair Loss
- Vitiligo

### ITCHING SKIN

- Skin in General
- Anus
- Arms
- Ear Canals
- Eyes
- Feet
- Hands
- Legs
- Nipples
- Nose
- Penis
- Roof of Mouth
- Scalp
- Throat

### 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:

- Fingernails
- Toenails
- White Spots/Lines

### RESPIRATORY

- Bad Breath
- Bad Odor in Nose
- Cough-Dry
- Cough-Productive
- Hoarseness
- Sore Throat
- Hay Fever:
  - Spring
  - Summer
  - Fall
  - Change Of Season
- Nasal Stuffiness
- Nose Bleeds
- Post Nasal Drip
- Sinus Fullness
- Sinus Infection
- Snoring
- Wheezing
- Winter Stuffiness

### CARDIOVASCULAR

- Angina/chest pain
- Breathlessness
- Heart Murmur
- Irregular Pulse
- Palpitations
- Phlebitis
- Swollen Ankles/Feet
- Varicose Veins

### URINARY

- Bed Wetting
- Hesitancy (trouble getting started)
- Infection
- Kidney Disease
- Leaking/Incontinence
- Pain/Burning
- Prostate Infection
- Urgency

### MALE REPRODUCTIVE

- Discharge From Penis
- Ejaculation Problem
- Genital Pain
- Impotence
- Prostate or Urinary Infection
- Lumps In Testicles
- Poor Libido (Sex Drive)

### FEMALE REPRODUCTIVE

- Breast Cysts
- Breast Lumps

- Breast Tenderness
- Ovarian Cyst
- Poor Libido (Sex Drive)
- Vaginal Discharge
- Vaginal Odor
- Vaginal Itch
- Vaginal Pain with Sex

### Premenstrual:

- Bloating Breast Tenderness
- Carbohydrate Cravings
- Chocolate Cravings
- Constipation
- Decreased Sleep
- Diarrhea
- Fatigue
- Increased Sleep
- Irritability

### Menstrual:

- Cramps
- Heavy Periods
- Irregular Periods
- No Periods
- Scanty Periods
- Spotting Between



## 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
- Have periodic lab tests to assess your progress . . . . .  5  4  3  2  1

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 fully engage in the above activities? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

How much on-going support and contact (e.g., telephone consults, e-mail) from our professional staff would be helpful to you as you implement your personal health program?  5  4  3  2  1

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 3-DAY DIET DIARY INSTRUCTIONS

It is important to keep an accurate record of your usual food and beverage intake as a part of your treatment plan. Please complete this Diet Diary for 3 consecutive days including one weekend day.

- Do not change your eating behavior at this time, as the purpose of this food record is to analyze your present eating habits.
- Record information as soon as possible after the food has been consumed
- Describe the food or beverage as accurately as possible e.g., milk - what kind? (whole, 2%, nonfat); toast (whole wheat, white, buttered); chicken (fried, baked, breaded); coffee (decaffeinated with sugar and ½ & ½).
- Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, ½ cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.
- Record all beverages, including water, coffee, tea, sports drinks, sodas/diet sodas, etc.
- Include any additional comments about your eating habits on this form (ex. craving sweet, skipped meal and why, when the meal was at a restaurant, etc).
- Please note all bowel movements and their consistency (regular, loose, firm, etc.)

### DIET DIARY

Name: \_\_\_\_\_

Date: \_\_\_\_\_

#### DAY 1

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Bowel Movements (#, form, color) \_\_\_\_\_

Stress/Mood/Emotions \_\_\_\_\_

Other Comments \_\_\_\_\_



# MSQ - MEDICAL SYMPTOM/TOXICITY QUESTIONNAIRE

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are completing this after your first time, then record your symptoms for the last 48 hours ONLY.

## POINT SCALE

0 = Never or almost never have the symptom

1 = Occasionally have it, effect is not severe

2 = Occasionally have, effect is severe

3 = Frequently have it, effect is not severe

4 = Frequently have it, effect is severe

## DIGESTIVE TRACT

- \_\_\_ Nausea or vomiting
- \_\_\_ Diarrhea
- \_\_\_ Constipation
- \_\_\_ Bloating feeling
- \_\_\_ Belching or passing gas
- \_\_\_ Heartburn
- \_\_\_ Intestinal/Stomach pain
- Total \_\_\_\_\_

## EARS

- \_\_\_ Itchy ears
- \_\_\_ Earaches, ear infections
- \_\_\_ Drainage from ear
- \_\_\_ Ringing in ears, hearing loss
- Total \_\_\_\_\_

## EMOTIONS

- \_\_\_ Mood swings
- \_\_\_ Anxiety, fear or nervousness
- \_\_\_ Anger, irritability or aggressiveness
- \_\_\_ Depression
- Total \_\_\_\_\_

## ENERGY/ACTIVITY

- \_\_\_ Fatigue, sluggishness
- \_\_\_ Apathy, lethargy
- \_\_\_ Hyperactivity
- \_\_\_ Restlessness
- Total \_\_\_\_\_

## EYES

- \_\_\_ Watery or itchy eyes
- \_\_\_ Swollen, reddened or sticky eyelids
- \_\_\_ Bags or dark circles under eyes
- \_\_\_ Blurred or tunnel vision (does not include near or far-sightedness)
- Total \_\_\_\_\_

## HEAD

- \_\_\_ Headaches
- \_\_\_ Faintness
- \_\_\_ Dizziness
- \_\_\_ Insomnia
- Total \_\_\_\_\_

## HEART

- \_\_\_ Irregular or skipped heartbeat
- \_\_\_ Rapid or pounding heartbeat
- \_\_\_ Chest pain
- Total \_\_\_\_\_

## JOINTS/MUSCLES

- \_\_\_ Pain or aches in joints
- \_\_\_ Arthritis
- \_\_\_ Stiffness or limitation of movement
- \_\_\_ Pain or aches in muscles
- \_\_\_ Feeling of weakness or tiredness
- Total \_\_\_\_\_

## LUNGS

- \_\_\_ Chest congestion
- \_\_\_ Asthma, bronchitis
- \_\_\_ Shortness of breath
- \_\_\_ Difficult breathing
- Total \_\_\_\_\_

## MIND

- \_\_\_ Poor memory
- \_\_\_ Confusion, poor comprehension
- \_\_\_ Poor concentration
- \_\_\_ Poor physical coordination
- \_\_\_ Difficulty in making decisions
- \_\_\_ Stuttering or stammering
- \_\_\_ Slurred speech
- \_\_\_ Learning disabilities
- Total \_\_\_\_\_

## MOUTH/THROAT

- \_\_\_ Chronic coughing
- \_\_\_ Gagging, frequent need to clear throat
- \_\_\_ Sore throat, hoarseness, loss of voice
- \_\_\_ Swollen/discolored tongue, gum, lips
- \_\_\_ Canker sores
- Total \_\_\_\_\_

## NOSE

- \_\_\_ Stuffy nose
- \_\_\_ Sinus problems
- \_\_\_ Hay fever
- \_\_\_ Sneezing attacks
- \_\_\_ Excessive mucus formation
- Total \_\_\_\_\_

## SKIN

- \_\_\_ Acne
- \_\_\_ Hives, rashes or dry skin
- \_\_\_ Hair loss
- \_\_\_ Flushing or hot flushes
- \_\_\_ Excessive sweating
- Total \_\_\_\_\_

## WEIGHT

- \_\_\_ Binge eating/drinking
- \_\_\_ Craving certain foods
- \_\_\_ Excessive weight
- \_\_\_ Compulsive eating
- \_\_\_ Water retention
- \_\_\_ Underweight
- Total \_\_\_\_\_

## OTHER

- \_\_\_ Frequent illness
- \_\_\_ Frequent or urgent urination
- \_\_\_ Genital itch or discharge
- Total \_\_\_\_\_

**GRAND TOTAL** \_\_\_\_\_

## KEY TO QUESTIONNAIRE

Add individual scores and total each group. Add each group score and give a grand total.

- Optimal is less than 10
- Mild Toxicity: 10-50
- Moderate Toxicity: 50-100
- Severe Toxicity: over 100