

Name: _____ **Age:** _____ **Sex:** _____ **Height:** _____ **Weight:** _____ **Date:** _____

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

- 1
- 2
- 3
- 4
- 5

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

Category 1

- Feeling that bowels do not empty completely 0 1 2 3
- Lower abdominal pain relief 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
- Do you use laxatives frequently 0 1 2 3

Category 2

- 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 fruits/vegetables; undigested foods found in stools 0 1 2 3

Category 3

- Stomach pain, burning or aching 1-4 hours after eating 0 1 2 3
- Do you frequently use antacids 0 1 2 3
- Feeling hungry an hour or two after eating 0 1 2 3
- Heartburn when lying down or bending forward 0 1 2 3
- Temporary relief from antacids, food, milk, 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 4

- Roughage and fiber cause constipation 0 1 2 3
- Indigestion and fullness lasts 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, mucous-like, greasy or poorly formed 0 1 2 3
- Frequent urination 0 1 2 3
- Increased thirst and appetite 0 1 2 3
- Difficulty losing weight 0 1 2 3

Category 5

- Greasy or high fat foods cause distress 0 1 2 3
- Lower bowel gas and or bloating several hours after eating 0 1 2 3
- Bitter metallic taste in mouth, especially in the morning 0 1 2 3
- Unexplained itchy skin 0 1 2 3
- Yellowish cast to eyes 0 1 2 3
- Stool color alternates from clay colored to normal brown 0 1 2 3
- Reddened skin, especially palms 0 1 2 3
- Dry or flaky skin and/or hair 0 1 2 3
- History of gallbladder attacks or stones 0 1 2 3
- Have you had your gallbladder removed Yes No

Category 6

- Crave sweets during the day 0 1 2 3
- Irritable if meals are missed 0 1 2 3
- Depend on coffee to keep yourself going or started 0 1 2 3
- Get lightheaded if meals are missed 0 1 2 3
- Eating relieves fatigue 0 1 2 3
- Feel shaky, jittery, tremors 0 1 2 3
- Agitated, easily upset, nervous 0 1 2 3
- Poor memory, forgetful 0 1 2 3
- Blurred vision 0 1 2 3

Category 7

- 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
- Increased thirst & appetite 0 1 2 3
- Difficulty losing weight 0 1 2 3

Category 8

- 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

Please turn the form over and complete the reverse side. Thank you.

Category 9

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts 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 10

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 gain 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, 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 falling out	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category 11

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

Category 12

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

Category 13

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

Females Only

Have you had your ovaries removed	Yes	No
Have you had your uterus removed	Yes	No

How many alcoholic beverages do you consume per week?

How many times do you eat out per week?

How many times a week do you eat fish?

List the three worst foods you eat during the average week

List the three healthiest foods you eat during the average week

Rate your stress levels on a scale of 1-10 during the average week

Category 14 (Male Only)

Urination difficulty or dribbling	0	1	2	3
Urination frequent	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

Category 15 (Males Only)

Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in 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
Decrease in 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 16 (Menstruating Females Only)

Are you perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle, greater than 32 days	Yes	No		
Shortened menstrual cycle, less than every 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 break outs	0	1	2	3

Category 17 (Menopausal Females Only)

How many years have you been menopausal?	0	1	2	3
Do you ever have uterine bleeding since menopause?	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

How many caffeinated beverages do you consumer per day?

How many times a week do you work out?

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

/ /

/ /

Circle any of the following medications you are currently taking:

Antacids	Antibiotics	Antidepressants	Antifungals	Antihistamines	Anti-Inflammatory
Anxiety Medications	Aspirin/Tylenol	Diuretics	High Blood Pressure	High Cholesterol	Hormone Replacement
Hydrocortisone Cream	Oral Contraceptives	Thyroid Hormone	Other:		