CONFIDENTIAL CLIENT QUESTIONNAIRE

FOR OFFICE USE ONLY
DATE SENT ____/____/____
DATE REC'D ____/____/____
IC TECH SCORE ________

GENERAL INFORMATION - PLEASE PRINT

DATE ____/____/____

PATIENT NAME ______________________ HOME ADDRESS ______________________

CITY ______________ STATE ______ ZIP CODE ______ HOW LONG? ______

E-mail address ______________@______________ *We do not share your address.*

PREVIOUS ADDRESS IF LESS THAN 3 YEARS AT PRESENT

ADDRESS ______________________ CITY ______ STATE ______ ZIP CODE ______

BIRTH DATE ____/____/____ AGE ____ SEX M ____ F ____ MARITAL STATUS M ___ S ___ D ___ W ___

YOUR EMPLOYER ______________________ CITY ______________ YEARS WITH FIRM ______

OCCUPATION ______________________ SOCIAL SECURITY# ____/____/____

HOME PHONE ______________ WORK PHONE ______________ CELL PHONE ______________

SPOUSE'S NAME ______________ BIRTH DATE ____/____/____ OCCUPATION ______________

SPOUSE'S EMPLOYER ______________________ CITY ______________ PHONE ______________

YOUR MD ______________________ DATE OF LAST PHYSICAL ______________

DENTIST ______________________ DATE OF LAST VISIT ______________

DATE OF LAST CHIROPRACTIC ADJUSTMENT ____/____/____ GIVEN BY DR ______________

WHO MAY WE CONTACT IN CASE OF EMERGENCY ______________________ PHONE ______________

WHO MAY WE THANK FOR REFERRING YOU TO US? ______________________ PHONE ______________

PLEASE FILL OUT THE FOLLOWING AS COMPLETELY AS YOU CAN. USE ADDITIONAL BLANK SHEETS. OBTAINING THE BEST HEALTH POSSIBLE IS A PROCESS THAT CAN ONLY OCCUR WITH YOUR PARTICIPATION. THE INFORMATION YOU PROVIDE WILL HELP YOUR DOCTOR MAKE INFORMED RECOMMENDATIONS. THANK YOU.

YOUR HEALTH HISTORY

GIVE THE PRIMARY REASON YOU ARE CONSULTING WITH OUR DOCTOR. BE SURE TO GIVE A DETAILED ACCOUNT INCLUDING WHEN AND WHY IT STARTED, WHAT HAS BEEN DONE TO DATE, THE RESULTS YOU HAVE HAD AND IF THE PROBLEM IS GETTING BETTER, WORSE OR IS THE SAME.

GIVE ANY SECONDARY HEALTH PROBLEMS YOU ARE EXPERIENCING. LIST THE MOST SEVERE FIRST.

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LIST ALL NUTRITIONAL SUPPLEMENT PRODUCTS YOU ARE TAKING. INCLUDE THE NAME OF THE COMPANY, AMOUNT, WHY YOU ARE TAKING THEM AND HOW LONG YOU HAVE BEEN TAKING. WE ASK THAT YOU BRING ALL BOTTLES TO YOUR CONSULTATION.

NAME	COMPANY	AMOUNT	WHY TAKING	HOW LONG

LIST ALL DRUGS (PRESCRIPTION OR NOT) YOU ARE TAKING. INCLUDE THE REASON TAKEN, AMOUNT, LENGTH OF TIME TAKEN AND RESULTS. LIST ALL OTHER DRUGS YOU HAVE TAKEN IN THE PAST.

NAME	AMOUNT	WHY TAKING	HOW LONG	RESULTS

LIST ALL SURGERIES YOU HAVE HAD INCLUDING THE DATE, WHY IT WAS DONE AND THE RESULTS.

SURGERY	DATE	WHY DONE	RESULTS

LIST ANY ALLERGIES YOU HAVE TO FOOD, DRUGS OR OTHER SUBSTANCES ALONG WITH THE SYMPTOMS THEY PRODUCE AND INDICATE HOW LONG YOU HAVE SUFFERED FROM EACH ITEM.

ALLERGY	SYMPTOMS	HOW LONG

ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY. IF YOU DON'T KNOW THE ANSWER, LEAVE BLANK:

()YES ()NO MY MOTHER WAS HEALTHY WHILE PREGNANT WITH ME. IF NO,DESCRIBE____________________

()YES ()NO WAS YOUR BIRTH NATURAL? IF NO, PLEASE CHECK ()ANESTHESIA ()FORCEPS ()C-SECTION

()YES ()NO WERE YOU BREAST FED FOR AT LEAST THE FIRST 6 MOS? ____________________

()YES ()NO WERE YOU FED ANYTHING OTHER THAN BREAST OR COW FORMULA MILK IN THE FIRST 6 MOS? LIST ITEMS ____________________

()YES ()NO WERE YOU A COLICKY BABY? UNTIL WHAT AGE?____________________

()YES ()NO HAVE YOU BEEN TO OR LIVED IN A FOREIGN COUNTRY? LIST____________________

()YES ()NO HAVE YOU EVER FAINTED OR HAD A CONVULSION? DESCRIBE____________________

MARK ANY YOU HAVE HAD: ()MEASLES ()CHICKEN POX ()MUMPS ()GERMAN MEASLES ()HEPATITIS ()SCARLET FEVER ()RHEUMATIC FEVER ()LYMES DISEASE ()MONONUCLEOSIS ()HERPES ()SHINGLES ()VENEREAL DISASE ()HIV/AIDS

DIET HISTORY MARK EACH ONE USING A "0" OR NONE WHEN APPROPRIATE

GIVE THE AMOUNT OF EACH YOU CONSUME:

_____OUNCES WATER		_____DAY	_____NOT DAILY
_____OUNCES ALCOHOL		_____DAY	_____NOT DAILY
_____OUNCES COFFEE/TEA		_____DAY	_____NOT DAILY
_____OUNCES SODA		_____DAY	_____NOT DAILY
_____OUNCES JUICE		_____DAY	_____NOT DAILY
_____OTHER	_____________	_____DAY	_____NOT DAILY

LIST YOUR 10 MOST FAVORITE FOODS EATEN MOST FREQUENTLY. ______________________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

GIVE PERCENTAGE FOR EACH OF THE FOLLOWING. Total for each line to equal 100%

WHERE DAILY DIET PREPARED: _____HOME _____RESTAURANT _____FAST FOOD _____VENDING MACHINE

HOW FOOD PREPARED: _____BAKED _____ROILED _____BOILED _____RIED _____STEAMED _____ MICROWAVE

FOOD PREPARED FROM: _____FRESH _____CANNED _____FROZEN _____PREPACKAGED

MY APPETITE IS: () NORMAL () EXCESSIVE () POOR () NONE

I CRAVE: () SWEETS () SALT () CHOCOLATE () WATER () DIRT () OTHER__________

TYPE OF WATER USED FOR DRINKING/COOKING: () TAP OR CITY () SPRING () WELL () RAIN () BOTTLED DISTILLED () BOTTLED FILTERED () REVERSE OSMOSIS

IF PURCHASE WATER, IS IT IN: () SOFT PLASTIC () HARD PLASTIC () GLASS

FOODS THAT DISAGREE WITH YOU: () RAW VEGETABLES () RAW FRUIT () FATS () FRIED () MILK/DAIRY () GREASY () EGGS () ONIONS () HIGHLY SPICED () BEANS () CABBAGE () SUGAR

() OTHER______________________________________

WHAT SYMPTOMS DO YOU GET FROM FOODS THAT DISAGREE WITH YOU?______________________

____

DO YOU FAST? () YES () NO IF YES, HOW OFTEN AND HOW LONG?____________________

HAVE YOU EVER DONE A DETOXIFICATION PROGRAM? () YES () NO EXPLAIN______________

CHECK ANY OF THE FOLLOWING DIETS YOU HAVE EVER TRIED?

() LOW CHOLESTEROL	() LOW SALT	() LOW PURINE	() ALL ENERGY
() LOW FAT	() DIABETIC	() RENAL/KIDNEY	() HIGH FIBER
() ULCER	() DIVERTICULITIS	() COMPLEX CARBOHYDRATE	() HIGH PROTEIN

() WEIGHT LOSS (LIST WHICH ONES)______________________________________

HOW MANY DAYS A WEEK DO YOU EXERCISE?____ HOW LONG EACH TIME?____ TYPE OF EXRCISE?________

BOWEL HEALTH BM = BOWEL MOVEMENT OR STOOL

HOW MANY TIMES DO YOU HAVE A BM? _____ X A DAY ______ X A WEEK

() YES () NO DO YOU USE LAXATIVES? HOW OFTEN ________________ BRAND ________________

() YES () NO DO YOU GET THE URGE TO HAVE A BM? () YES () NO DO YOU HAVE PAIN WITH BM?

Answer key for the following tables: 0 = never 1 = rarely 2 = frequently 3 = always

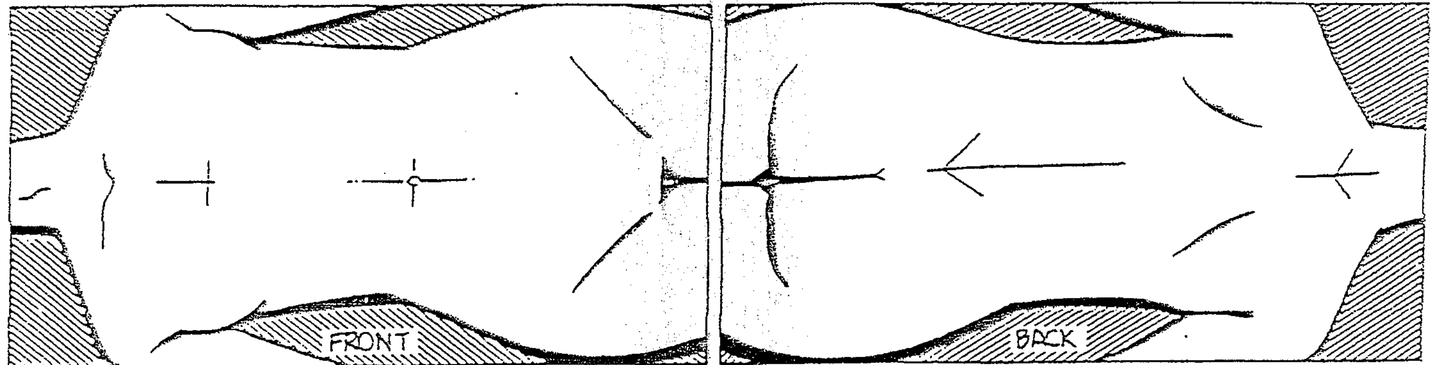
STOOL SIZE	STOOL CONSISTENCY	STOOL COLOR
___2" wide & 6+″ length	___Float like a submarine	___Med/dark brown
___1" wide & 4+″ length	___Float on top of water	___Very dark/black
___Thin, long or narrow	___Sink to bottom	___Yellow/tan/clay
___Small, hard	___Loose but not watery	___Greenish
___Large, hard	___Diarrhea	___Blood is visible
___Difficult to pass	___Alternate hard/diarrhea	___*Mucus in or around*

() YES () NO HAVE YOU EVER HAD WORMS OR PARASITES? HOW TREATED? ________________

() YES () NO DO YOU PRESENTLY HAVE RECTAL ITCHING? () DAY () NIGHT () CONTINUOUSLY

DIGESTION

MARK ANY AREAS OF DISTRESS ASSOCIATED WITH FOOD INTAKE ON THE DIAGRAMS



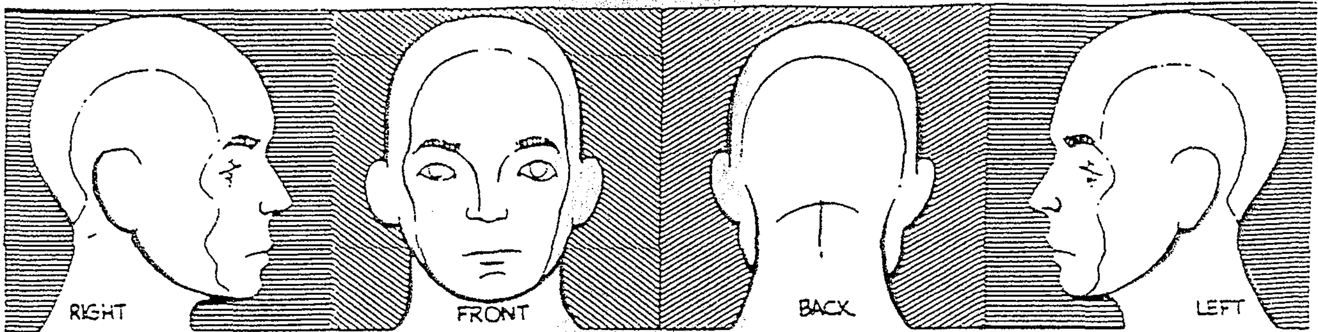
I GET PAIN/HEARTBURN: () BEFORE EATING () AFTER EATING () WHEN LIE DOWN () UPON ARISING

I HAVE: () INDIGESTION () BELCHING () GERD () INTESTINAL GAS () BLOATING
() IMMEDIATELY AFTER EATING () 1 - 2 HOURS () 3 - 5 HOURS () 6 + HOURS
() NO ODOR () SOME ODOR () ODOR USUALLY () FOWL SMELLING
() HIATAL HERNIA () ESOPHAGEAL BURNING/REFLUX () RAISE HEAD OF BED TO SLEEP

LIST ANY DRUGS (PERSCRIPTION OR OTC) OR NATURAL REMEDIES YOU TAKE FOR ANY STOMACH OR BOWEL SYMPTOMS

PRODUCT	DOSE	HOW FREQUENTLY	RESULTS

HEAD, MOUTH, THROAT MARK ANY AREAS OF HEADACHE OR PAIN MARK ALL THAT APPLY



MY TEETH ARE: () GOOD () SOME FILLINGS) BAD () SOME MISSING () ALL MISSING () ROOT CANAL
I WEAR DENTURES: () UPPER () LOWER () PARTIALS () CROWNS () MORE THAN 1 METAL TYPE IN MOUTH
MY BREATH IS: () GOOD () SLIGHT ODOR () ODOR OFF/ON () OFFENSIVE ODOR USUALLY
MY TONGUE IS: () COVERED WITH SMALL TASTE BUDS () SORE () FURROWED () COATED _______ COLOR
MY TONGUE COLOR IS: () PINK () RED () RED BLOTCHY () PINK WITH RED TIP
MY TONSILS ARE: () NORMAL () REMOVED AT AGE _____ () ENLARGED () SPOTTED
MY SENSE OF TASTE IS: () NORMAL () POOR () NO TASTE () OVERSALT FOOD () CANKER SORES

MY LIPS ARE: () NORMAL () DRY () PEEL A LOT () FEVER BLISTERS OFTEN () CRACKED IN CORNERS

I GET HEADACHES: () DAILY () WEEKLY () RARELY) NEVER
() WAKE UP WITH () GET IN AM () GET IN PM
() OF DIFFERENT TYPES () WITH SOME FOODS OR DRINKS
() WITH AURA () WITH NAUSEA/VOMITING

MUSCLE, LIGAMENT, JOINT, NERVES

I HAVE PAIN IN: () NECK () MID BACK () LOW BACK
() HIP () KNEE () ANKLE () FEET
() SHOULDER () ELBOW () WRIST () HANDS
() OTHER ____________________

I GET: () SWOLLEN JOINTS () SORE JOINTS () JOINTS POP OR CRACK () JAW POPS
() LEG CRAMPS AT REST () LEG CRAMPS WITH ACTIVITY () WORSE AT NIGHT
() FOOT CRAMPS AT REST () FOOT CRAMPS WITH ACTIVITY () FLAT FEET () BURNING FEET

() TINGLING IN FEET OR HANDS () RESTLESS LEG SYNDROME

I HAVE: () NERVOUS TIC OR TWITCHING - WHERE ____________________ () BELL'S PALSY
() RINGING IN EARS () PARKINSON'S () SCIATIC NEURITIS () MULTIPLE SCLEROSIS
() HAD SPINAL SURGERY - WHERE ____________________ RESULTS ____________________

HAIR, NAILS, SKIN

HAIR: () COURSE () FINE () FALLS OUT EXCESSIVELY () TURNED GREY AT AGE _____ () OILY () DRY

MALE BEARD: () HEAVY () LIGHT OR SPARSE () NONE ETHNIC BACKGROUND __________________

FEMALE: () FACIAL HAIR ALWAYS () FACIAL HAIR STARTED AT AGE__ () HAIR ON ABDOMEN OR BREASTS

FINGER NAILS: () NORMAL () BRITTLE/BREAK EASILY () SOFT () RIDGED VERTICALLY () WHITE SPOTS
() RIDGED HORIZONTALLY () GROW FAST () GROW SLOW () SHAPED ODDLY () HANGNAILS

SKIN: () NORMAL () OILY () DRY () FLAKY () ACNE () PSORIASIS () BOILS
() SMALL BUMPS ON UPPER ARMS () SKIN CANCER REMOVED ON__________
(DATE)
() ANTIBIOTICS FOR ACNE AT WHAT AGE ______ HOW LONG TAKEN _______

SPOTS ON SKIN: () WARTS () MOLES () SMALL RED () LARGE RED () BROWN () WHITE

HANDS AND FEET: () DRY CRACKED OR BLEEDING AREAS ON () HANDS () HEELS () FEET
() INGROWN TOENAILS () FUNGUS ON FEET OR NAILS () ATHLETE'S FOOT

CHEST AND HEART MARK ANY AREAS OF PAIN OR DISCOMFORT ON DIAGRAM

I HAVE CHEST PAIN THAT IS: () SHARP () DULL () SEVERE
() RADIATES TO MY ARM, NECK, OR BACK
() WORSE AT REST () WORSE ON EXERTION
() BETTER WITH EXERCISE () NO CHANGE WITH EXERCISE

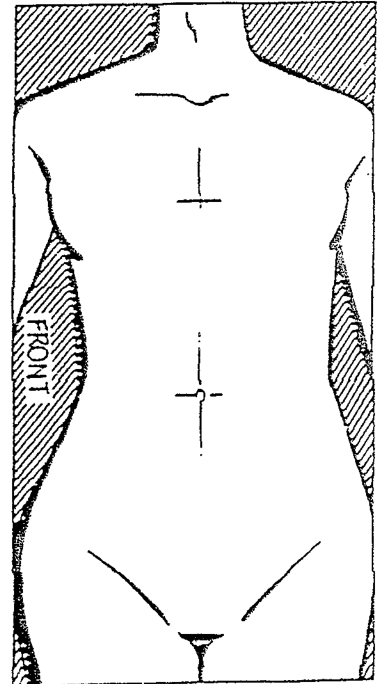
MY PULSE/ HEARTBEAT IS: () TOO FAST () TOO SLOW () SKIPS BEATS

I HAVE: () HIGH BLOOD PRESSURE () LOW BLOOD PRESSURE
I AM: () ON HBP MEDICINE () ON DIURETICS

I HAVE HAD: () HAD A HEART ATTACK () HAD A STROKE
() ANGIOPLASTY () BYPASS SURGERY

I HAVE BEEN TOLD I HAVE: () HEART DISEASE () LUNG DISEASE
() CLOGGED ARTERIES

I HAVE: () VARICOSE VEINS () SPIDER VEINS
() HEMORRHOIDS () HAD VESSEL SURGERY



RESPIRATORY, LUNGS

I HAVE NASAL CONGESTION: ()DAILY ()SEVERAL TIMES A WEEK ()ONLY ON OCCASION

I HAVE NASAL DISCHARGE: ()DAILY ()SEVERAL TIMES A WEEK ()ONLY ON OCCASION
()CLEAR ()YELLOW ()GREEN ()BLOOD TINGED ()OTHER ________

I HAVE: ()NON-PRODUCTIVE COUGH {W/O MUCUS} ()PRODUCTIVE COUGH {WITH MUCUS}
()ALLERGIES TO ________________ ()HOARSENESS OF VOICE ()POST-NASAL DRIP
()HAYFEVER ()ASTHMA ()WHEEZING ()SNORING

I HAVE/HAVE HAD: ()FREQUENT COLDS ()FLU ONCE OR MORE A YEAR
()PNEUMONIA ()SINUS INFECTIONS
()ANTIBIOTICS 3 OR MORE TIMES IN MY LIFE
()ALLERGIC TO ______________

I TAKE: ()ALLERGY SHOTS ()ALLERGY MEDICINE ()DECONGESTANTS ()NASAL SPRAYS ()STEROIDS

I USE: ()CIGARETTES ___PACK/DAY ()SNUFF/CHEW ()CIGARS ()EXPOSED TO 2ND HAND SMOKE

I HAVE BEEN TOLD I HAVE: ()LUNG DISEASE ______________ ()EMPHYSEMA ()COPD

EMOTIONAL, NERVOUS AND METABOLISM MARK ALL THAT APPLY

I AM/HAVE: ()NERVOUS ()ANXIOUS ()DEPRESSED ()SENSITIVE TO NOISE
()CONFUSED EASILY ()SLEEPY DURING DAY ()EXHAUSTED A LOT ()FATIGUE EASILY

()LOSS OF APPETITE ()RAGE ()FEARFUL ()HEAR VOICES
()WEAKNESS ()POOR MEMORY ()IRRITABILITY ()MORBID THOUGHTS

I AM/HAVE: ()SUSPICIONS OF OTHERS ()THOUGHTS OF SUICIDE ()QUICK MOOD CHANGES
()FEAR OF INSANITY ()FEAR SERIOUS DISEASE LIKE ____________________
()AVOID CROWDS ()FRIENDS AVOID ME ()HAVE HYPOGLYCEMIA OR LOW BLOOD SUGAR
()HAD GLUCOSE TOLERANCE TEST AND IT WAS ()POSITIVE ()NEGATIVE

I: ()TAKE DAYTIME NAPS ()DREAM TOO MUCH ()HAVE NO DREAMS AT ALL ()HAVE NIGHTMARES

I: ()WAKE UP TIRED ()AM COLD WHEN OTHER ARE COMFORTABLE ()FEEL TOO HOT
()HAVE COLD HANDS ()HAVE COLD FEET
()PERSPIRE TOO MUCH ()HAVE INADEQUATE PERSPIRATION WHEN EXERCISE

DO YOU FEEL WELL RESTED WHEN YOU WAKE UP IN THE MORNING ()YES ()NO

_____ RATE THE QUALITY OF YOUR SLEEP (1 BEING AWFUL AND 10 BEING GREAT)

FEMALE SPECIFIC

MY MENSTRUAL PERIODS ARE: AGE OF FIRST PERIOD____

()NORMAL ()PAINFUL FIRST DAY ()PAINFUL BEFORE AND DURING
()FLOW IS EXCESSIVE ()HAVE CLOTS OR HEMORRHAGE ()FLOW IS SCANTY
()REGULAR EVERY ____DAYS ()IRREGULAR
()NO PERIOD IN ____MONTHS ()TWO OR MORE PER MONTH
()ABNORMAL SINCE ____YEARS OF AGE
()MENSTRUAL PROBLEMS BEFORE FIRST CHILD ()MENSTRUAL PROBLEMS AFTER FIRST CHILD

MENSTRUAL BLOOD COLOR IS: ()PINK ()RED ()BROWN ()BLACK ()OTHER______________

I HAVE/HAVE HAD: ()ENDOMETRIOSIS ()CONSTIPATION WITH PERIODS ()DIARRHEA WITH PERIODS

ORGAN DROP: ()UTERUS IN POSITION ()UTERUS OUT OF POSITION ()BLADDER PROLAPSED

I AM/HAVE BEEN: ()ON BIRTH CONTROL PILL __________ ()TOTAL YEARS ON BCP_____
Name
()MENOPAUSE AT AGE ____ ()HYSTERECTOMY AT AGE____

I AM ON HORMONE REPLACEMENT: ()ESTROGEN ()PROGESTIN ()ORAL ()PATCH
()WILD YAM CREAM ()BIO-IDENTICAL FORMULATION

I HAVE BREAST SORENESS: ()BEFORE PERIOD ()DURING PERIOD ()AFTER PERIOD ()ALL MONTH LONG
I HAVE: ()FIBROCYSTIC BREASTS ()HAD BREAST CANCER
()PRODUCE MILK BUT NOT PREGNANT OR NURSING
MY BREASTS ARE: ()FIRM ()SOFT AND SAGGY ()HAVE IMPLANTS ()HAD REDUCTION SURGERY

I: ()HAVE_____CHILDREN ()BEEN PREGNANT ____ TIMES ()LIKE CHILDREN ()DISLIKE CHILDREN
()WANT MORE ()DON'T WANT MORE ()AM STERILE ()HAVE FEAR OF PREGNANCY

I GET: ()BLADDER INFECTIONS ()YEAST INFECTIONS ()YEAST INFECTIONS AFTER ANTIBIOTICS
()VAGINAL BURNING/ITCHING ON ()INSIDE ()OUTSIDE
()VAGINAL DRYNESS ()PAINFUL INTERCOURSE

I URINATE: ()____TIMES PER DAY ()____TIMES AT NIGHT ()MORE FREQUENTLY THAN NORMAL
()WITH PAIN ()WITH DIFFICULTY STARTING/STOPPING ()WITH ITCHING OR BURNING

MY URINE COLOR IS: ()PALE YELLOW ()BRIGHT YELLOW ()DARK YELLOW ()OTHER__________
()CLEAR ()CLOUDY ()WITH MUCUS IN IT ()VARIES A LOT

MY URINE HAS: ()ODOR DESCRIBE______________________________

I HAVE / HAD: ()VENEREAL DISEASE ()GENITAL HERPES ()HERPES I ()HIV/AIDS

MY LIBIDO IS: ()NORMAL ()EXCESSIVE ()INCREASED ()DIMINISHED ()ABSENT
LIBIDO MEANS DESIRE FOR SEXUAL RELATIONS.

continue at diagram on next page

MALE SPECIFIC

I AM: ()OVERLY TIRED ()EXHAUSTED ()GETTING TOO OLD FOR ANYTHING ()IMPOTENT

MY PROSTATE: ()NORMAL ()ENLARGED ()HAD CANCER ()REMOVED

I HAVE: ()PAIN ON URINATION ()DIFFICULTY STARTING URINE FLOW ()DIFFICULTY STOPPING FLOW
()DRIBBLING OF URINE ()DECREASED STREAM SIZE ()PAIN OR PRESSURE AFTER SEX
()GET UP TO URINATE ____TIMES PER NIGHT ()BURNING DISCHARGE

MY URINE COLOR IS: ()PALE YELLOW ()BRIGHT YELLOW ()DARK YELLOW ()OTHER____________
()CLEAR ()CLOUDY ()WITH MUCUS IN IT ()VARIES A LOT

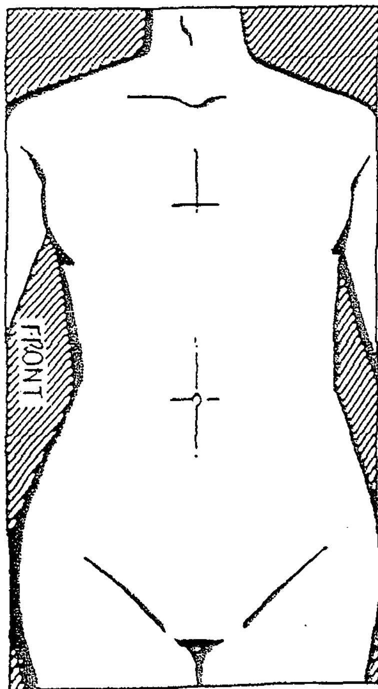
MY URINE HAS ()ODOR DESCRIBE ____

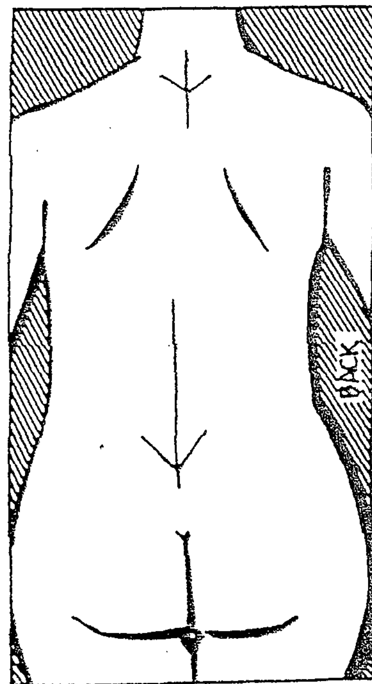
I HAVE: ()HERNIA____________ ()PAIN IN TESTICLES OR SCROTUM

I HAVE / HAD: ()VENEREAL DISEASE ()GENITAL HERPES ()HERPES I ()HIV/AIDS

MY LIBIDO IS: ()NORMAL ()EXCESSIVE ()INCREASED ()DIMINISHED ()ABSENT
LIBIDO MEANS DESIRE FOR SEXUAL RELATIONS

USE THE DIAGRAMS BELOW TO MARK ALL AREAS OF PAIN OR DISCOMFORT YOU HAVE EXPERIENCED IN THE PAST 90 DAYS. DESCRIBE YOUR PAIN/DISCOMFORT IN THE MARGINS AND CONNECT WITH ARROW TO EACH AREA THE DESCRIPTION APPLIES TO.





ARE YOU CURRENTLY SEEING ANY OTHER HEALTHCARE PROFESSIONAL SUCH AS DENTIST, MASSAGE THERAPIST, ACUPUNCTURIST, PSYCHOLOGIST, ETC? PLEASE EXPLAIN.

PLEASE FILL OUT YOUR FAMILY HEALTH HISTORY ON THE CHART BELOW
PUT AN "N" IN THE BOX IF HAVE IT NOW OR A "P" IF HAD IN THE PAST

	ALCOHOLISM	ALLERGIES	ALZEHIMER'S DISEASE	ARTHRITIS	ASHTMA	ATHEROSCLEROSIS	CANCER	DIABETES	EPILEPSY	GLAUCOMA	HEADACHES	HIGH BLOOD PRESSURE	KIDNEY DISEASE	OBESITY	OSTEOPOROSIS	SINUS PROBLEMS	STROKE	THYROID PROBLEM	TUBERCULOSIS	ULCERS
YOU																				
SPOUSE																				
CHILDREN																				
MOTHER																				
FATHER																				
MATERNAL GRANDPARENTS																				
PATERNAL GRANDPARENTS																				
SISTERS																				
BROTHERS																				

USE THIS SPACE TO ADD ANYTHING ELSE YOU WOULD LIKE TO SHARE ABOUT YOUR HEALTH CONCERNS OR THAT YOU THINK THE DOCTOR SHOULD KNOW

Please review this form to be sure your answers are accurate and sign below. Thank you for choosing our clinic. We look forward to working with you on your health goals.

Signature__________________________ Date_______________

Metabolic Assessment Form

Name: ____________________ **Age:** ______ **Sex:** _____ **Date:** ______________

PART I

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

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

PART II **Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.**

Category I

Symptom				
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

Symptom				
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
Abdominal intolerance to sugars and starches	0	1	2	3

Category III

Symptom				
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

Symptom				
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 movement	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3

Category V

Symptom				
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use 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

Symptom				
Roughage and fiber cause constipation	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

Category VI (continued)

Symptom				
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

Category VII

Symptom				
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
Difficulty losing weight	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 VIII

Symptom				
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 IX

Symptom				
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	0	1	2	3
Blurred vision	0	1	2	3

Category X

Symptom				
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 XI

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 XII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under 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 XIII

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 XIV

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 XV

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

Category XVI

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 XVII

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

Category XVIII *(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 XIX *(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 XX *(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 XXI *(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:

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