



Health Questionnaires

We want to hear your story!

Mulberry Clinics
5328 Main Street, Suite K
Spring Hill, TN 37174

Phone: 615-614-2500
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GENERAL INFORMATION

Your story is important to us. Please fill out this form carefully. Incomplete form may delay your appointment.

Name : *First* _____ *Middle* _____ *Last* _____

Preferred Name: _____

Date of Birth: _____

Age: _____

Gender: Male Female

Genetic Background: African European Native American Mediterranean

Asian Ashkenazi Middle Eastern _____

Highest Education Level: High School Under-Graduate Post-Graduate

Job Title: _____

Nature of Business: _____

Primary Address: *Number, Street* _____

City _____ *State* _____ *Zip* _____

Alternate Address: *Number, Street* _____

City _____ *State* _____ *Zip* _____

Phone: *Cell* _____ *Work* _____ *Fax* _____

Email: _____

Emergency Contact: *Name* _____ *Phone Number* _____

Relationship: _____ *Cell Phone* _____

Address _____ *Work Phone* _____

City _____ *State* _____ *Zip* _____

Primary Care Physician: *Name* _____ *Phone* _____ *Fax* _____

Referred By: Book Website Media Family or Friend
 PCP Other

ALLERGIES

Medication/ Supplement / Food	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

COMPLAINTS/CONCERNS

What do you hope to achieve with 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? _____

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

MEDICAL HISTORY

DISEASES/DIAGNOSIS/CONDITIONS *Check appropriate box and provide date of onset*

Poor
Condition

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)
- Hyperthyroidism (overactive thyroid) _____
- Hypothyroidism (low 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 _____

Poor
Condition

Ongoing
Condition

GENITAL AND URINARY SYSTEM

- Kidney Stones _____
- Gout _____
- Interstitial Cystitis _____
- Frequent Urinary Tract Infection _____
- Frequent Yeast Infection _____
- Erectile Dysfunction _____
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 _____
- Poor Immune Function _____
(frequent infections)
- Food Allergies _____
- Environmental Allergies _____
- 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)

<i>Past Condition</i>	<i>Ongoing Condition</i>	
		NEUROLOGICAL
<input type="checkbox"/>	<input type="checkbox"/>	Depression _____
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety _____
<input type="checkbox"/>	<input type="checkbox"/>	Bipolar Disorder _____
<input type="checkbox"/>	<input type="checkbox"/>	Schizophrenia _____
<input type="checkbox"/>	<input type="checkbox"/>	Headaches _____
<input type="checkbox"/>	<input type="checkbox"/>	Migraines _____
<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD _____
<input type="checkbox"/>	<input type="checkbox"/>	Autism _____

<i>Past Condition</i>	<i>Ongoing Condition</i>	
		<input type="checkbox"/> Mild Cognitive Impairment _____ <input type="checkbox"/> Memory Problems _____ <input type="checkbox"/> Parkinson's Disease _____ <input type="checkbox"/> Multiple Sclerosis _____ <input type="checkbox"/> ALS _____ <input type="checkbox"/> Seizures _____ <input type="checkbox"/> Other Neurological Problems _____

PREVENTATIVE TESTS AND DATE OF LAST TEST
Check box if yes and provide date

<input type="checkbox"/>	Full Physical Exam _____
<input type="checkbox"/>	Bone Density _____
<input type="checkbox"/>	Colonoscopy _____
<input type="checkbox"/>	Cardiac Stress Test _____
<input type="checkbox"/>	EBT Heart Scan _____
<input type="checkbox"/>	EKG _____
<input type="checkbox"/>	Hemoccult Test-stool for blood _____
<input type="checkbox"/>	MRI _____
<input type="checkbox"/>	CT Scan _____
<input type="checkbox"/>	Upper Endoscopy _____
<input type="checkbox"/>	Upper GI Series _____
<input type="checkbox"/>	Ultrasound _____

INJURIES

<input type="checkbox"/> Back Injury	<input type="checkbox"/> Head Injury
<input type="checkbox"/> Neck Injury	<input type="checkbox"/> Broken Bones
<input type="checkbox"/> Other _____	

SURGERIES
Check box if yes and provide date of surgery

<input type="checkbox"/>	Appendectomy _____
<input type="checkbox"/>	Hysterectomy +/- Ovaries _____
<input type="checkbox"/>	Gall Bladder _____
<input type="checkbox"/>	Hernia _____
<input type="checkbox"/>	Tonsillectomy _____
<input type="checkbox"/>	Dental Surgery _____
<input type="checkbox"/>	Joint Replacement-Knee/Hip _____
<input type="checkbox"/>	Heart Surgery-Bypass Valve _____
<input type="checkbox"/>	Angioplasty or Stent _____
<input type="checkbox"/>	Pacemaker _____
<input type="checkbox"/>	Other _____
<input type="checkbox"/>	None

BLOOD TYPE

<input type="checkbox"/> A	<input type="checkbox"/> B
<input type="checkbox"/> AB	<input type="checkbox"/> O
<input type="checkbox"/> Rh+	<input type="checkbox"/> Unknown

HOSPITALIZATION
 None

<i>Date</i>	<i>Reason</i>

COMMENTS

GYNECOLOGIC HISTORY (for women only) _____

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

- Pregnancies _____ Caesarean _____ Vaginal Deliveries _____
- Miscarriage _____ Abortion _____ Living Deliveries _____
- Postpartum Depression Toxemia Gestational Diabetes Baby over 8 pounds
- Breastfeeding for how long? _____

MENSTRUAL HISTORY

Age first period: _____ Menses Frequency: _____ Length: _____ Pain: Yes No Clotting: Yes No

Has your period ever skipped? _____ 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 Greater than 10

Prostate Enlargement Prostate Infection Change in Libido Impotence

Difficulty Obtaining an Erection Difficulty Maintaining an Erection

Nocturia (urination at night) How Many times a night? _____

Urgency/Hesitancy/Change in urinary stream Loss of control of urine

GI

HISTORY _____

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 _____

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 _____

Silver Mercury Fillings How many? _____

Gold Fillings Root Canals Implants Tooth Pain Bleeding Gums

Gingivitis Problems with Chewing

Do you floss regularly? Yes No

ANY OTHER MEDICAL HISTORY TO TELL US _____

MEDICATIONS

CURRENT MEDICATIONS

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

PREVIOUS MEDICATION (*Last 10 years*)

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

Supplement & Brand	Dose	Frequency	Start Date (month/year)	Reason For Use

Have your medicine or supplements ever caused you unusual side effects or problems? Yes No

Describe: _____

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.) Motrin, Aspirin? Yes No

Have you had prolonged use of Tylenol? Yes No

Have you had prolonged or regular use of acid blocking drugs (Tagamet, Zantac, Prilosec, etc.) Yes No

Frequent antibiotics Yes No

Long term antibiotics Yes No

Use of steroids (prednisone, nasal allergy inhalers) in the past Yes No

Use of oral contraceptives Yes No

FAMILY HISTORY

<i>Check family members that apply</i>	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandfather	Maternal Grandmother	Paternal Grandfather	Paternal Grandmother	Aunt	Uncle	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, etc.)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Autoimmune Diseases (ex. 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												
Substance Abuse												
Genetic Disorders												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												

SOCIAL HISTORY

NUTRITION HISTORY

Have you ever had a nutrition consultation? Yes No

Have you ever made changes to your eating habits because of your health? Yes No Describe: _____

Do you currently follow a special diet or nutritional plan? 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) _____	Current Weight _____
Usual Weight Range +/- 5 lbs _____	Designated Weight Range +/- 5 lbs _____
Highest Adult Weight _____	Lowest Adult Weight _____
Weight Fluctuations (> 10 lbs) <input type="checkbox"/> Yes <input type="checkbox"/> No	Lowest 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 More than 5

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 restrictions or food preferences |
| <input type="checkbox"/> Erratic eating problem | <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 with 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 nutritional 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 If yes, how many years? _____ Packs per day: _____

Attempts to quit: _____

Previous Smoking: 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, 1.5 ounces spirits*

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

Previous alcohol intake Yes (Mild Moderate High) None

Have you ever been told that you need to 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 thought about getting help to 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

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

Are you currently using any recreational drugs? Yes No If yes, 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, gyrotomics, etc.)			
Sports or Leisure Activities (golf, tennis, etc.)			

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

List your problems that limit activity: _____

Do you usually feel fatigued after exercise? Yes No If yes, please describe: _____

Do you usually sweat while exercising? Yes No

PSYCHOLOGICAL

- 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 feel 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 a scale of 1-10
 Work:_____ Family:_____ Social:_____ Finances:_____ Health:_____ Other:_____
- Do you practice meditation or relaxation techniques? Yes No How often? _____
- Have you ever been abused, a victim of a crime, or experienced significant trauma? Yes No

SLEEP/REST

- Average number of hours you sleep per night: Greater than 10 8-10 6-8 Less than 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 Long term partnership Widow

List Children: Child's Full Name	Age	Gender

- Who is living in the 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	N/A
- 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 any 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 and 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, and salad bars) Preservatives (ex. Sodium Benzoate)

Other: _____

Which of the following 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 jaundiced (yellow)? 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 Pesticides Organic Solvents Heavy Metals Other: _____

Chemical Name, Date, and Length of Exposure: _____

Do you dry clean your clothes frequently? Yes No | Do you have pets or farm animals? Yes No

Have you ever lived or worked in a damp or moldy environment or had other mold exposure? Yes No

Have you ever had a concerning tick bite? Yes No

Could you have Lyme Disease or a similar disease? Yes No

READINESS ASSESSMENT

Rate on a scale of 5 (very willing) to 1 (not willing):

- Significantly modify your diet. 5 4 3 2 1
- Take several nutrition 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
- Practice a brain retraining exercise 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?
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 (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 correspondence) from our professional staff would be helpful to you as you implement your personal health program? 5 4 3 2 1

Comments _____

PTOM REVIEW

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

GENERAL

- Cold hands and 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
- Muscle twitches - arms or legs

- Muscle Weakness
- Tendonitis
- Tension Headache
- TMJ Problems

MOOD/NERVES

- Agoraphobia
- Anxiety
- Auditory Hallucinations
- Black-out
- Depression

DIFFICULTY

- Concentrating
- With balance
- With thinking
- With judgement
- 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 a healthy weight
- Frequent dieting
- Poor appetite
- Salt cravings
- Carbohydrate cravings
- Sweet cravings
- Chocolate cravings
- Caffeine dependency
- Fatty foods
- Liver disease/Jaundice (yellow eyes/skin)
- Yeast

DIGESTION

- Anal Spasms
- Bad Teeth
- Bleeding Gums
- Bloating of lower abdomen
- Bloating of 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 and constipation
- Difficulty swallowing
- Dry mouth
- Excess flatulence/gas
- Fissures
- Food "repeat" (Reflux)
- Gas
- Heartburn
- Hemorrhoids
- Indigestion
- Nausea
- Upper abdominal pain
- Vomiting

INTOLERANCE TO:

- Lactose
- All dairy products
- Wheat
- Gluten (wheat, rye, barley)
- Corn
- Eggs
- Abnormal liver function tests
- Mucus in stools
- Periodontal disease
- Sore tongue
- Strong stool odor
- Undigested food in stools
- Lower abdominal pain

SKIN ISSUES

- 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
- 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

- Sinus infection

SKIN, DRYNESS OF

- Eyes
- Feet
- Cracking-Feet
- Peeling-Feet
- Hair

- Hair unmanageable?
- Hands
- Cracking-Hands
 - Peeling-Hands
 - 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 fingernails
- Thickening of 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

MENSTRUAL

- Snoring
- Wheezing
- Winter stuffiness

- Heart Murmur
- Irregular Pulse

- Palpitations
 - Phlebitis
 - Swollen ankles/feet
 - Varicose veins

URINARY

- Bed wetting
- Hesitancy
- Infection
- Kidney disease
- Leaking/incontinence
- Pain/burning
- Prostate infection
- Urgency

MALE REPRODUCTIVE

- Discharge from penis
- Ejaculation problem
- Genital pain
- Impotence
 - Prostate infection or UTI
 - Lumps in testicles
 - Poor libido (sex drive)

FEMALE REPRODUCTIVE

- Breast cysts
- Breast lumps
- Indigestion
- 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
 - Throat

- Cramps
- Heavy periods
- Irregular periods
- No periods
- Scanty periods
- Spotting between

3-DAY DIET INSTRUCTIONS

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

- 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 and 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 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 - DAY 1

Name: _____ Date: _____

Daily Exercise (Type of Activity / Time of day / Duration): _____

Daily Bowel Movements: _____

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

DIET DIARY - DAY 2 _____

Name: _____ Date: _____

Daily Exercise (Type of Activity / Time of day / Duration): _____

Daily Bowel Movements: _____

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

DIET DIARY - DAY 3 _____

Name: _____ Date: _____

Daily Exercise (Type of Activity / Time of day / Duration): _____

Daily Bowel Movements: _____

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

OTHER COMMENTS / QUESTIONS / CONCERNS: _____

Medical Symptoms Questionnaire

Name _____ Date _____

Rate each of the following symptoms based upon your typical health profile for the *past 30 days*

- Point Scale**
- 0 - Never or almost never have the symptom
 - 1 - Occasionally have it, effect is not severe
 - 2 - Occasionally have it, effect is severe
 - 3 - Frequently have it, effect is not severe
 - 4 - Frequently have it, effect is severe

HEAD

	_____	Headaches	
	_____	Faintness	
	_____	Dizziness	
	_____	Insomnia	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: _____

EARS

	_____	Itchy ears	
	_____	Earaches, ear infections	
	_____	Drainage from ear	
	_____	Ringling in ears, hearing loss	Total: _____

NOSE

	_____	Stuffy nose	
	_____	Sinus problems	
	_____	Hay fever	
	_____	Sneezing attacks	
	_____	Excessive mucus formation	Total: _____

MOUTH/THROAT

	_____	Chronic coughing	
	_____	Gagging, frequent need to clear throat	
	_____	Sore throat, hoarseness, loss of voice	
	_____	Swollen or discolored tongue, gums, lips	
	_____	Canker sores	Total: _____

SKIN

	_____	Acne	
	_____	Hives, rashes, dry skin	
	_____	Hair loss	
	_____	Flushing, hot flashes	
	_____	Excessive sweating	Total: _____

HEART

	_____	Irregular or skipped heartbeat	
	_____	Rapid or pounding heartbeat	
	_____	Chest pain	Total: _____

LUNGS

_____	Chest congestion	
_____	Asthma, bronchitis	
_____	Shortness of breath	
_____	Difficulty breathing	Total: _____

DIGESTIVE TRACT

_____	Nausea, vomiting	
_____	Diarrhea	
_____	Constipation	
_____	Bloated feeling	
_____	Belching, passing gas	
_____	Heartburn	
_____	Intestinal/Stomach pain	Total: _____

JOINTS/MUSCLE

_____	Pain or aches in joints	
_____	Arthritis	
_____	Stiffness or limitation of movement	
_____	Feeling weakness or tiredness	Total: _____

WEIGHT

_____	Binge eating/drinking	
_____	Craving certain foods	
_____	Excessive weight	
_____	Compulsive eating	
_____	Water retention	
_____	Underweight	Total: _____

ENERGY/ACTIVITY

_____	Fatigue, sluggishness	
_____	Apathy, lethargy	
_____	Hyperactivity	
_____	Restlessness	Total: _____

MIND

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

EMOTIONS

_____	Mood swings	
_____	Anxiety, fear, nervousness	
_____	Anger, irritability, aggressiveness	
_____	Depression	Total: _____

OTHER

_____	Frequent illness	
_____	Frequent or urgent urination	
_____	Genital itch or discharge	Total: _____

GRAND TOTAL

TOTAL: _____