Medicatrix

Where Healthcare Is Individualized

Health Questionnaire

500 N. Fourth Street Albemarle, NC 28001

(704) 438-7396 www.medicatrix.doctorsoffice.net

Medicatrix

Where Healthcare Is Individualized

GENERAL INFORM	MATION			
Name	First	Middle	e Last	
Preferred Name				
Date of Birth				
Age				
Gender	O Male OF	emale		
Genetic Background	☐ African ☐ Asian	□ European □ Ashkenazi	☐ Native American ☐ Middle Eastern	☐ Mediterranean
Mother's Name			Occupation	
Father's Name			Occupation	
	Person comple	ting this questionnaire		
Primary Address	Number, Street			Apt. No.
	City		State	Zip
Alternate Address	Number, Street			Apt. No.
	City		State	Zip
Home Phone 1			*	
Home Phone 2				
Parent's Work Phone				
Parent's Cell Phone				
Fax				
Email				
Emergency Contact	Name		Phone Num	ber
	Address			Apt. No.
	City		State	Zip
Physician	Name		Phone Num	ber
	Fax			
Referred by		○ Website ○ Friend or Family Me	mber Other	

PHARMACY INFORMATION

Primary Pharmacy	Name	Phone Numbe	er
	Address		
	City'	State	Zip
	E-mail	Fax*	
		* It is extremely important that you	list the pharmacy's fax number
Compounding/ Supplement Pharmacy	Name	Phone Numbe	er .
	Address		
	City	State	Zip
	E-mail	Fax*	
		* It is extremely important that you	list the pharmacy's fax number
Patient DOB		Date	
Preferred Method of Paym	nent (please circle one): Cash	/ Check / Credit Card	
If paying by credit card, w	e accept VISA, MasterCard	d and Discover	
		other card (i.e., MasterCard or Visa) fo process. Some pharmacies do not accep	
PRIMARY CARD		SECONDARY CARD	
Name on Card	data.	Name on Card	
Card Type OVisa OMas	sterCard ODiscover	Card Type OVisa OMast	erCard ODiscover
Account Number		Account Number	
Expiration Date (mm/yy)		Expiration Date (mm/yy) _	
CVV#		CVV#	

Medical Questionnaire

ALLERGIES							
Medication/Supplement/Food				Reaction			
COMPLAINTS/CONCERN							
What do you hope to achieve in you	ır visit with u	s?					
If you had a magic wand and could 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 prob				ity:		Succe	ess
Describe Problem	Mild	Moderate	Severe	Prior Treatment/Approach	Excellent	Good	Fair
Example: Post Nasal Drip		X		Elimination Diet	X		
		L					L
		H				H	H
						T	
						-	-

MEDICAL HISTORY

☑ = Past Condition	Ø =	Ongoing	Condition
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DISEASES/DIAGNOSIS/CONDITIONS Check appropriate box and provide date of onset

□ Irritable Bowel Syndrome □ Inflammatory Bowel Disease □ Crohn's □ Ulcerative Colitis □ Gastritis or Peptic Ulcer Disease □ Geliac Disease □ Other □ CARDIOVASCULAR □ Cardiac Disease □ Other □ CARDIOVASCULAR □ Heart Attack □ Other Heart Disease □ Stroke □ Elevated Cholesterol □ Arrythmia (irregular heart rate) □ Hypertension (high blood pressure) □ Rheumatic Fever □ Mitral Valve Prolapse □ Other □ Type 2 Diabetes □ Type 2 Diabetes □ Hypothyroidism (low thyroid) □ Metabolic Syndrome (Insulin Resistance or Pre-Diabetes) □ Hyperthyroidism (overactive thyroid) □ Hyperthyroidism (overactive thyroid) □ Endocrine Problems □ Polycystic Ovarian Syndrome □ Respiratory Disease □ Anorexia □ Binge Eating Disorder □ Night Lating Syndrome □ Chronic Sinusitis □ Bronchitis □ Disease □ Respiratory Diseases □ Respiratory Diseases □ Respiratory Diseases □ Chronic Sinusitis □ Bronchitis □ Disease □ Anorexia □ Disorder (non-specific) □ Other □ Carcili Visitis (requent infections) □ Cheronic Sinusitis □ Bronchitis □ Bronchitis □ Disease □ Chronic Sinusitis □ Bronchitis □ Disease □ Respiratory Disease □ Pheumonia □ Tuberculosis □ Step Apnea □ Other □ Chronic Sinusitis □ Bronchitis □ Disease □ Chronic Sinusitis □ Disposence □ Tybe Step Size Apnea □ Chronic Sinusitis □ Bronchitis □ Disease □ Pheumonia □ Tuberculosis	GASTROINTESTINAI			GENITAL AND URINARY SYSTEMS
Inflammatory Bowel Disease Gout Interstitial Cystitis Grothns Interstitial Cystitis Frequent Vinary Tract Infections Gastritis or Peptic Ulcer Disease Frequent Yeast Infections Frequent Yeast Infections GERD (reflux) GERD (reflux) Or Sexual Dysfunction Or Sexual Dysfunction Other				Kidney Stones
□ Crohn's □ Ulcerative Colitis □ Gastritis or Peptic Ulcer Disease □ GERD (reflux) □ Celiac Disease □ Other □ CARDIOVASCULAR □ Heart Attack □ Other Heart Disease □ Stroke □ Elevated Cholesterol □ Arrythmia (irregular heart rate) □ Hypertension (high blood pressure) □ Mitral Valve Prolapse □ Other □ Mitral Valve Prolapse □ Hype 1 Diabetes □ Hype 2 Diabetes □ Hypogycemia □ Metabolic Syndrome (Insulin Resistance or Pre-Diabetes) □ Hyperthyroidism (overactive thyroid) □ Hyperthyroidism (overactive thyroid) □ Endocrine Problems □ Polycystic Ovarian Syndrome (PCOS) □ Binge Eating Disorder □ Night Eating Syndrome □ Rating Syndrome □ Chronic Sinusitis □ Bulmia □ Binge Eating Disorder □ Tuber Coltes □ String Discrets □ Tuber Coltes □ String Discrets □ String Discrets □ Tuber Coltes □ String Discrets □ Chronic Sinusitis □ Pneumonia □ Tuber Coltes □ String Discrets □ Chronic Sinusitis □ Pneumonia □ Tuber Coltes □ Chronic Sinusitis □ String Discrets □ Tuber Coltes □ Chronic Sinusitis □ String Discrets □ Chronic Sinusitis □ String Discrets □ Tuber Coltes □ Chronic Sinusitis □ String Discrets □ Chronic Sinusitis □ String Discrets □ Chronic Sinusitis □ String Discrets □ Tuber Coltes □ Chronic Sinusitis □ String Discrets □ Chronic Sinusitis □ Tuber Colosis □ Step Apnea □ Other □ Colter □ Colte	☐ ☐ Inflammatory Bowel Di			
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Gastritis or Peptic Ulcer Disease Frequent Yeast Infections GERD (reflux) GERD (reflux) Other Other				
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□ Other				
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METABOLIC/ENDOCRINE	d duiei			Lupus SLE
□ Type 1 Diabetes □ Herpes-Genital □ Type 2 Diabetes □ Severe Infectious Disease □ Hypoglycemia □ Poor Immune Function □ Insulin Resistance or Pre-Diabetes □ Food Allergies □ Hypothyroidism (low thyroid) □ Environmental Allergies □ Hyperthyroidism (overactive thyroid) □ Multiple Chemical Sensitivities □ Endocrine Problems □ Latex Allergy □ Polycystic Ovarian Syndrome (PCOS) □ Other □ Infertility RESPIRATORY DISEASES □ Asthma □ Chronic Sinusitis □ Prequent Weight Fluctuations □ Bronchitis □ Bulimia □ Emphysema □ Respiratory Disease □ Pneumonia □ Emphysema □ Pneumonia □ Pneumonia □ Tuberculosis □ Sleep Apnea □ Other	METAROLIC/ENDOC			
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Hypoglycemia				
Metabolic Syndrome		and the second s		Poor Immune Function
Consulin Resistance or Pre-Diabetes				(frequent infections)
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☐ Eating Disorder (non-specific) ☐ ☐ Other ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Blige Eating Disorder			
☐ Other ☐ Other ☐ ☐ Other ☐	Night Eating Syndronic	enecific)		
CKINI DICEASES		specific)		
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CANCER	CANCER			
□ □ Lung Cancer □ □ Eczema_	(Williams) Charles of the Control of			
□ □ Breast Cancer □ □ Psoriasis	U-State -			
□ Colon Cancer □ Acne				
Ovarian Cancer	A STATE OF THE STA			
□ Prostate Cancer □ Skin Cancer □				Skin Cancer
☐ Skin Cancer ☐ ☐ Other ☐				Other
□ Other				

MEDICAL HISTORY (CONTINUED)

☑ = Past Condition ☑ = Ongoing Condition

NEUROLOGIC/MOOD	□ Autism
□ □ Depression	☐ ☐ Mild Cognitive Impairment
□ □ Anxiety	□ □ Memory Problems
□ □ Bipolar Disorder	□ □ Parkinson's Disease
□ Schizophrenia	□ □ Multiple Sclerosis
☐ ☐ Headaches	□ □ ALS
☐ ☐ Migraines	□ □ Seizures
□ □ ADD/ADHD	☐ ☐ Other Neurological Problems
- ADDIADNO	
PREVENTIVE TESTS AND	SURGERIES
DATE OF LAST TEST	Check box if yes and provide date of surgery
Check box if yes and provide date	□ Appendectomy
□ Full Physical Exam	☐ Hysterectomy +/- Ovaries
□ Bone Density	□ Gall Bladder
□ Colonoscopy	☐ Hernia
	☐ Tonsillectomy
☐ Cardiac Stress Test	□ Dental Surgery
□ EBT Heart Scan	☐ Joint Replacement–Knee/Hip
☐ EKG Hemoccult Test-stool test for blood	☐ Heart Surgery–Bypass Valve
□ MRI	☐ Angioplasty or Stent
CT Scan	□ Pacemaker
Upper Endoscopy	Other
□ Upper GI Series	□ None
□ Ultrasound	
INJURIES	
Check box if yes	BLOOD TYPE: OA OB OAB OO
☐ Back Injury ☐ Head Injury	ORh+ Ounknown
□ Neck Injury □ Broken Bones	
□ Other	
HOSPITALIZATIONS None	
Date Reason	
Date Reason	
COMMENTS	

GYNECOLOGIC HISTORY (for women only)

OBSTETRIC HISTORY	Check box if yes and pro	vide number of		
☐ Pregnancies	□ Caesarean	□ Vaginal d	eliveries	
☐ Miscarriage	☐ Abortion	Living Ch	ildren	
☐ Post Partum Depression	☐ Toxemia ☐ Go	estational Diabetes	☐ Baby Over 8 Pound	s
☐ Breast Feeding For how	w long?			
MENSTRUAL HISTORY			D	
Age at First Period:			Pain: O Yes O No	Clotting: O Yes O No
Has your period ever skipp		long?		
Last Menstrual Period:				
Use of hormonal contracer				
Do you use contraception?	O Yes O No Co	ondom 🛮 Diaphra	gm 🛘 IUD 🗘 Partne	er Vasectomy
WOMEN'S DISORDERS	HORMONAL IMBA	ALANCES		
☐ Fibrocystic Breasts ☐ H	Indometriosis Fibr	roids Infertility		
□ Painful Periods □ Hear	vy periods □ PMS			
Last Mammogram:	□ Breast Biop	osy/Date:		
Last PAP Test:	ONormal O Abnor	mal		
Last Bone Density:	Results: OHig	gh OLow OWithin	Normal Range	
Are you in menopause? O				
Age at Menopause				
☐ Hot Flashes ☐ Mood S	wings Concentrati	ion/Memory Proble	ms Daginal Dryness	☐ Decreased Libido
☐ Heavy Bleeding ☐ Join	t Pains	□ Weight Gain □	Loss of Control of Uri	ne 🗖 Palpitations
☐ Use of hormone replace	ment therapy. How los	ng?		
MEN'S HISTORY (f	or men only)			
	or men only)			
Have you had a PSA done?	OYes ONo			
PSA Level: □ 0-2 □ 2-4	□ 4-10 □ > 10			
☐ Prostate Enlargement 【	☐ Prostate infection	□ Change in Libido	□Impotence	
☐ Difficulty Obtaining an	Erection Difficulty	y Maintaining an Ero	ection	
□ Nocturia (urination at n	ight). How many time	es at night?		
☐ Urgency/Hesitancy/Cha	nge in Urinary Strean	n □ Loss of Contro	ol of Urine	

GI HISTORY	
Foreign Travel? O Yes O No Where?	
Wilderness Camping? O Yes O No Where?	
Have you ever had severe: ☐ Gastroenteritis ☐ Diarrhea	
Do you feel like you digest your food well? O Yes O No	
Do you feel bloated after meals? O Yes O 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	
DENTAL SURGERY	
□ Silver Mercury Fillings How many?	
□ Gold Fillings □ Root Canals □ Implants □ Tooth Pain □ Bleeding Gums	
☐ Gingivitis ☐ Problems with Chewing	
Do you floss regularly? O Ves O No	

CURRENT MEDICATIONS

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use
DELIGOUS MESSA	TIONIC I			
PREVIOUS MEDICA				
Medication	Dose	Frequency	Start Date (month/year)	Reason For Use
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NUTRITIONAL SUP	PLEMENT	'S (VITAMINS	/MINERALS/HERBS/HOM	ЕОРАТНҮ)
			/MINERALS/HERBS/HOM	Control of the Contro
NUTRITIONAL SUP	PLEMENT Dose	S (VITAMINS	/MINERALS/HERBS/HOM Start Date (month/year)	EOPATHY) Reason For Use
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Have your medications 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 or regular use of Tylenol? O Yes O No
Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.) ◆ Yes ◆ No
Frequent antibiotics > 3 times/year O Yes O No
Long term antibiotics • Yes • No
Use of steroids (prednisone, nasal allergy inhalers) in the past O Yes O No
Use of oral contraceptives O Yes O 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	7.3											
Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Sondylitis)												
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? OYes O	No
Have you made any changes in your eating habits beca	use of your health? OYes ONo Describe:
Do you currently follow a special diet or nutritional procheck all that apply:	
□ Low Fat □ Low Carbohydrate □ High Protein □	Low Sodium □ Diabetic □ No Dairy □ No Wheat
□ Gluten Restricted □ Vegetarian □ Vegan □ Ultr	rametabolism
	e: Other
Height (feet/inches)	Current Weight
Usual Weight Range +/- 5 lbs	Desired Weight Range +/- 5 lbs
Highest adult weight	Lowest adult weight
Weight Fluctuations (> 10 lbs.) • Yes • No	Body Fat %
How often do you weigh yourself? O Daily O Weekly	OMonthly ORarely ONever
Have you ever had your metabolism (resting metaboli	c rate) checked? • Yes • No If yes, what was it?
	types and reason
20 your old any paradount 200 as C 200 C 210 11 yes,	7,700
If you could only eat a few foods a week, what would t	hey be?
Do you grocery shop? OYes ONo If no, who does to	he shopping?
Do you read food labels? O Yes ONo	
	ing?
How many meals do you eat out per week? □0-1 □1-	
Check all the factors that apply to your current lifestyl	
□ Fast eater	☐ Significant other or family members have special
☐ Erratic eating pattern	☐ dietary needs or food preferences
□ Eat too much	□ Love to eat
☐ Late night eating	☐ Eat because I have to
☐ Dislike healthy food	☐ Have a negative relationship to food
☐ Time constraints	☐ Struggle with eating issues
☐ Eat more than 50% meals away from home	☐ Emotional eater (eat when sad, lonely,
☐ Travel frequently	depressed, bored)
□ Non-availability of healthy foods	☐ Eat too much under stress
□ Do not plan meals or menus	☐ Eat too little under stress
Reliance on convenience items	□ Don't care to cook
□ Poor snack choices	☐ Eating in the middle of the night
☐ Significant other or family members don't like	Confused about nutrition advice
healthy foods	

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

SMOKING			
Currently Smoking? O Yes O No How	many years?	Packs per day:	
Attempts to quit:			
Previous Smoking: How many years?	Packs p	er day?	
Second Hand Smoke Exposure?			
ALCOHOL INTAKE			
How many drinks currently per week? 1	drink = 5 ounces wi	ne, 12 ounces beer, 1.5 ounces sp	pirits
□None □1-3 □4-6 □7-10 □>	10 If "None," skip	to Other Substances	
Previous alcohol intake? • Yes (• Mild	O Moderate O Hi	gh) O None	
Have you ever been told you should cut			
Do you get annoyed when people ask yo	u about your drin	king? OYes ONo	
Do you ever feel guilty about your alcoh-	ol consumption?	OYes ONo	
Do you ever take an eye-opener? • Yes	ONo		
Do you notice a tolerance to alcohol (car	n you "hold" more	than others)? OYes ONo	
Have you ever been unable to remember	what you did dur	ring a drinking episode? O	Yes O No
Do you get into arguments or physical fi	ghts when you have	ve been drinking? O Yes C	No
Have you ever been arrested or hospitali	zed because of dri	nking? O Yes O No	
Have you ever thought about getting hel	p to control or sto	p your drinking? • Yes	No
OTHER SUBSTANCES			
Caffeine Intake: O Yes O No Coffee c	ups/day: 🗖 1 🗖 :	2-4 □>4 Tea cups/day:	□1 □2-4 □>4
Caffeinated Sodas or Diet Sodas Intake:	OYes ONo		
12-ounce can/bottle ■1 ■2-4	□> 4 per day		
List favorite type (Ex. Diet Coke, Pe	epsi, etc.):		
Are you currently using any recreational	drugs? O Yes	No Type	
Have you ever used IV or inhaled recrea	tional drugs? OY	es ONo	
EXERCISE			
Current Exercise Program: (List type of a	ctivity, number of se		
Activity	Туре	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 includi	ng exercise in you	r life? O Low O Medium) High
List problems that limit activity:			
Do you feel unusually fatigued after exer	rcise? OYes ONo		
If yes, please describe:			

PSYCHOSOCIAL		
Do you feel significantly less vital than you did a ye	ear ago? • Yes • No	
Are you happy? • Yes • No		
Do you feel your life has meaning and purpose? O	Yes O No	
Do you believe stress is presently reducing the qua	lity of your life? O Yes O	No
Do you like the work you do? O Yes O No		
Have you ever experienced major losses in your life	e? O Yes O No	
Do you spend the majority of your time and mone		and obligations? O Yes O No
Would you describe your experience as a child in y		
STRESS/COPING		
Have you ever sought counseling? O Yes O No		
Are you currently in therapy? O Yes O No Describ		
Do you feel you have an excessive amount of stress		
Do you feel you can easily handle the stress in you	r life? O Yes O No	
Daily Stressors: Rate on scale of 1-10		
Work Family Social Finance		
Do you practice meditation or relaxation technique		
Check all that apply: ☐ Yoga ☐ Meditation ☐ Imag		
Have you ever been abused, a victim of a crime, or	experienced a significant	trauma? O Yes O No
SLEEP/REST Average number of hours you sleep per night: □>	10 08 10 06 8 0	6
	10 10-10 10-6 1	0
Do you have trouble falling asleep? O Yes O No		
Do you feel rested upon awakening? O Yes O No		
Do you have problems with insomnia? OYes ONo		
Do you snore? OYes ONo		
Do you use sleeping aids? • Yes • No Explain:		
ROLES/RELATIONSHIP		
Marital status □ Single □ Married □ Divorced □ O	Gay/Lesbian □ Long Tern	n Partnership 🗆 Widow
List Children:		
Child's Name	Age	Gender
Who is Living in Household? Number: N	ames:	
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? O Yes O No

011	Very Well	Fine	Poorly	Does Not Apply
Overall		0	0	0
At school	0	0	0	0
In your job	0	0	0	0
In your social life	O	0	0	0
With close friends		0	0	0
With sex	0	0	0	0
With your attitude		0	0	0
With your boyfriend/girlfriend		0	0	
With your children		0	0	0
With your parents	0	0	0	0
With your spouse	Ö	0	0	0
Do you have any food allergies or sensitivities? On Do you have an adverse reaction to caffeine? O Yes	⊙ No	Daine		ON
Do you have an adverse reaction to caffeine? •Yes When you drink caffeine do you feel: •Irritable of Do you adversely react to (Check all that apply):	⊙No r Wired ⊙Aches & l		Pananas 🗖	
Do you have an adverse reaction to caffeine? •Yes When you drink caffeine do you feel: • Irritable of Do you adversely react to (Check all that apply): Monosodium glutamate (MSG) Aspartame	o No r Wired O Aches & I (Nutrasweet) □ Ca		Bananas 🗖 (
Do you have an adverse reaction to caffeine? ● Yes When you drink caffeine do you feel: ● Irritable of Do you adversely react to (<i>Check all that apply</i>): □ Monosodium glutamate (MSG) □ Aspartame □ Cheese □ Citrus Foods □ Chocolate □ Alco	o No r Wired O Aches & I (Nutrasweet) □ Ca thol □ Red Wine	ıffeine □ l		Garlic □ Onion
Do you have an adverse reaction to caffeine? •Yes When you drink caffeine do you feel: • Irritable of Do you adversely react to (Check all that apply): Monosodium glutamate (MSG) Aspartame Cheese Citrus Foods Chocolate Alco	o No r Wired O Aches & I (Nutrasweet) □ Ca thol □ Red Wine	ıffeine □ l		Garlic □ Onion
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Do you have an adverse reaction to caffeine? •Yes When you drink caffeine do you feel: • Irritable of Do you adversely react to (Check all that apply): Monosodium glutamate (MSG) Aspartame Cheese Citrus Foods Chocolate Alcolors Sulfite Containing Foods (wine, dried fruit, sala Other: Which of these significantly affect you? Check all the	o No r Wired O Aches & I (Nutrasweet) □ Ca chol □ Red Wine d bars) □ Preserva at apply:	offeine □ l	odium benzo	Garlic □ Onion oate)
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Do you have an adverse reaction to caffeine? •Yes When you drink caffeine do you feel: • Irritable of Do you adversely react to (Check all that apply): Monosodium glutamate (MSG) Aspartame Cheese Citrus Foods Chocolate Alcolor Sulfite Containing Foods (wine, dried fruit, sala Other: Which of these significantly affect you? Check all the Cigarette Smoke Perfumes/Colognes Au In your work or home environment, are you expose Have you ever turned yellow (jaundiced)? •Yes • Have you ever been told you have Gilbert's syndrone.	More Wired O Aches & I (Nutrasweet) □ Ca chol □ Red Wine d bars) □ Preserva at apply: to Exhaust Fumes sed to: □ Chemicals No me or a liver disorde	offeine □ l tives (ex. se □ Other: _ □ Electro	odium benzo omagnetic Ra	Garlic □ Onion oate)
Do you have an adverse reaction to caffeine? •Yes When you drink caffeine do you feel: • Irritable of Do you adversely react to (Check all that apply): Monosodium glutamate (MSG) Aspartame Cheese Citrus Foods Chocolate Alco Sulfite Containing Foods (wine, dried fruit, sala Other: Which of these significantly affect you? Check all the Cigarette Smoke Perfumes/Colognes Au In your work or home environment, are you expose Have you ever turned yellow (jaundiced)? •Yes • Have you ever been told you have Gilbert's syndro Explain:	© No r Wired ○ Aches & I (Nutrasweet) □ Ca thol □ Red Wine d bars) □ Preserva at apply: to Exhaust Fumes sed to: □ Chemicals No me or a liver disorde	tives (ex. so Other: _ Electro	odium benzo omagnetic Ra	Garlic
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Do you have an adverse reaction to caffeine? •Yes When you drink caffeine do you feel: • Irritable of Do you adversely react to (Check all that apply): Monosodium glutamate (MSG) Aspartame Cheese Citrus Foods Chocolate Alcolors Sulfite Containing Foods (wine, dried fruit, sala Other: Which of these significantly affect you? Check all the Cigarette Smoke Perfumes/Colognes Au In your work or home environment, are you expose Have you ever turned yellow (jaundiced)? •Yes • Have you ever been told you have Gilbert's syndrostyplain: Do you have a known history of significant exposured.	More Wired O Aches & I (Nutrasweet) □ Ca (Nutrasweet) □ Ca (hol □ Red Wine d bars) □ Preserva at apply: to Exhaust Fumes sed to: □ Chemicals No me or a liver disorder ure to any harmful chemicals terminator) □ Pes	tives (ex. so Other: Electro Yes hemicals su	odium benzo	Garlic Onion Date) Adiation Mold Blowing:
Do you have an adverse reaction to caffeine? •Yes When you drink caffeine do you feel: • Irritable of Do you adversely react to (Check all that apply): Monosodium glutamate (MSG) Aspartame Cheese Citrus Foods Chocolate Alcolors Sulfite Containing Foods (wine, dried fruit, sala Other: Which of these significantly affect you? Check all the Cigarette Smoke Perfumes/Colognes Au In your work or home environment, are you expose Have you ever turned yellow (jaundiced)? •Yes •Have you ever been told you have Gilbert's syndromatical Explain: Do you have a known history of significant exposed Herbicides Insecticides (frequent visits of explains).	More of North of Nor	tives (ex. seconds) Other: _ Electroner? O Yes Contemicals subticides	odium benzo	Garlic Onion Date) Adiation Mold Clowing:
Do you have an adverse reaction to caffeine? •Yes When you drink caffeine do you feel: • Irritable of Do you adversely react to (Check all that apply): Monosodium glutamate (MSG) Aspartame Cheese Citrus Foods Chocolate Alcolors Sulfite Containing Foods (wine, dried fruit, sala Other: Which of these significantly affect you? Check all the Cigarette Smoke Perfumes/Colognes Au In your work or home environment, are you exposed Have you ever turned yellow (jaundiced)? •Yes •Have you ever been told you have Gilbert's syndromatical Explain: Do you have a known history of significant exposurable Herbicides Insecticides (frequent visits of explain)	(Nutrasweet)	tives (ex. seconds) Other: _ Electroner? O Yes Contemicals subticides	odium benzo	Garlic Onion Date) Adiation Mold Clowing:

Do you have any pets or farm animals? • Yes • No

SYMPTOM REVIEW

☐ Around Eyes ☐ Arms or Legs

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

GENERAL	☐ Muscle Weakness	DIGESTION
☐ Cold Hands & Feet	☐ Neck Muscle Spasm	☐ Anal Spasms
☐ Cold Intolerance	☐ Tendonitis	□ Bad Teeth
☐ Low Body Temperature	☐ Tension Headache	☐ Bleeding Gums
☐ Low Blood Pressure	☐ TMJ Problems	Bloating of:
☐ Daytime Sleepiness		☐ Lower Abdomen
☐ Difficulty Falling Asleep	MOOD/NERVES	☐ Whole Abdomen
☐ Early Waking	☐ Agoraphobia	☐ Bloating After Meals
☐ Fatigue	☐ Anxiety	☐ Blood in Stools
☐ Fever	☐ Auditory Hallucinations	☐ Burping
☐ Flushing	☐ Black-out	☐ Canker Sores
☐ Heat Intolerance	□ Depression	□ Cold Sores
☐ Night Waking	Difficulty:	☐ Constipation
□ Nightmares	☐ Concentrating	☐ Cracking at Corner of Lips
□ No Dream Recall	☐ With Balance	☐ Cramps
- No Dicum Noom	☐ With Thinking	☐ Dentures w/Poor Chewing
HEAD, EYES & EARS	☐ With Judgment	☐ Diarrhea
□ Conjunctivitis	☐ With Speech	☐ Alternating Diarrhea and Constipation
☐ Distorted Sense of Smell	☐ With Memory	☐ Difficulty Swallowing
☐ Distorted Taste	☐ Dizziness (Spinning)	☐ Dry Mouth
☐ Ear Fullness	☐ Fainting	☐ Excess Flatulence/Gas
☐ Ear Pain	☐ Fearfulness	☐ Fissures
☐ Ear Ringing/Buzzing	☐ Irritability	☐ Foods "Repeat" (Reflux)
☐ Lid Margin Redness	☐ Light-headedness	□ Gas
☐ Eye Crusting	□ Numbness	☐ Heartburn
☐ Eye Pain	☐ Other Phobias	☐ Hemorrhoids
☐ Hearing Loss	☐ Panic Attacks	□ Indigestion
☐ Hearing Problems	☐ Paranoia	□ Nausea
☐ Headache	☐ Seizures	☐ Upper Abdominal Pain
☐ Migraine	☐ Suicidal Thoughts	□ Vomiting
☐ Sensitivity to Loud Noises	☐ Tingling	Intolerance to:
☐ Vision problems (other than glasses)	☐ Tremor/Trembling	☐ Lactose
☐ Macular Degeneration	☐ Visual Hallucinations	☐ All Dairy Products
☐ Vitreous Detachment		☐ Wheat
☐ Retinal Detachment	EATING	☐ Gluten (Wheat, Rye, Barley)
	☐ Binge Eating	□ Corn
MUSCULOSKELETAL	☐ Bulimia	□ Eggs
☐ Back Muscle Spasm	☐ Can't Gain Weight	☐ Fatty Foods
☐ Calf Cramps	☐ Can't Lose Weight	☐ Yeast
☐ Chest Tightness	☐ Can't Maintain Healthy Weight	☐ Liver Disease/Jaundice
☐ Foot Cramps	☐ Frequent Dieting	(Yellow Eyes or Skin)
☐ Joint Deformity	☐ Poor Appetite	☐ Abnormal Liver Function Tests
☐ Joint Pain	☐ Salt Cravings	☐ Lower Abdominal Pain
☐ Joint Redness	☐ Carbohydrate Craving (breads, pastas)	☐ Mucus in Stools
☐ Joint Stiffness	☐ Sweet Cravings (candy, cookies, cakes)	☐ Periodontal Disease
☐ Muscle Pain	☐ Chocolate Cravings	□ Sore Tongue
☐ Muscle Spasms	☐ Caffeine Dependency	☐ Strong Stool Odor
Muscle Stiffness		☐ Undigested Food in Stools
Aduccia I witches:		

Acne on Back	SKIN PROBLEMS	☐ Hands	□ Breathlessness
Acne on Face	☐ Acne on Back	□ Any Cracking?	☐ Heart Murmur
Acne on Shoulders	☐ Acne on Chest	☐ Any Peeling?	☐ Irregular Pulse
Athlete's Foot	☐ Acne on Face	☐ Mouth/Throat	
Blumps on Back of Upper Arms	☐ Acne on Shoulders	☐ Scalp	□ Phlebitis
Cellulire Dark Circles Under Eyes Earls Get Red Ealarged/neck Bed Wetting Earls Get Red Earls Ge	☐ Athlete's Foot	☐ Any Dandruff?	☐ Swollen Ankles/Feet
Cellulite	☐ Bumps on Back of Upper Arms	☐ Skin In General	☐ Varicose Veins
Dark Circles Under Eyes			
Ears Get Red		LYMPH NODES	
Cack of Sweating		☐ Enlarged/neck	☐ Bed Wetting
Cack Of Sweating	☐ Easy Bruising	☐ Tender/neck	☐ Hesitancy (trouble getting started)
Eczema		Other Enlarged/Tender	☐ Infection
Jock Itch Bitten Prostate Infection Bitten Prostate Infection Drostate Infection	The state of the s	☐ Lymph Nodes	
Dick Rith Bitten	□ Hives		
Lackluster Skin	□ Jock Itch		
Moles w/Color/Size Change □ Brittle □ Urgency Oily Skin □ Prayed MALE REPRODUCTIVE Pate Skin □ Frayed □ Discharge From Penis Patchy Dullness □ Fungus-Toes □ Discharge From Penis Rash □ Protest □ Discharge From Penis Rash □ Protest □ Discharge From Penis Rash □ Protest □ Discharge From Penis Ejaculation Problem Genital Pain □ Genital Pain Genital Pain □ Frostate or Urinary Infection Importance □ Frostate or Urinary Infection Davor Libido (Sex Drive) Female Reproductive □ Poor Libido (Sex Drive) Davor Libido (Sex Drive		☐ Bitten	☐ Prostate Infection
Oily Skin	☐ Moles w/Color/Size Change	☐ Brittle	☐ Urgency
Pale Skin			
□ Patchy Dullness □ Fungus-Fingers □ Discharge From Penis □ Rad Face □ Pitting □ Genital Pain □ Sensitivity to Bites □ Radged Cuticles □ Impotence □ Sensitivity to Poison Ivy/Oak □ Ridges □ Prostate or Urinary Infection □ Shingles □ Thickening of: □ Poor Libido (Sex Drive) □ Skin Darkening □ Thickening of: □ Poor Libido (Sex Drive) □ Strong Body Odor □ Fingernails □ Femata ErproDUCTIVE □ Hair Loss □ Breast Cysts □ Breast Cysts □ Vitiligo □ White Spots/Lines □ Breast Lumps ITCHING SKIN RESPIRATORY □ Breast Tenderness □ Skin in General □ Bad Breath □ Ovarian Cyst □ Anus □ Bad Breath □ Ovarian Cyst □ Arms □ Cough-Pry □ Vaginal Discharge □ Exes □ Hoarseness □ Vaginal Discharge □ Exes □ Googh-Productive □ Vaginal Discharge □ Eyes □ Hoarseness □ Vaginal Pain with Sex □ Eyes □ Sore Throat □ Vaginal Pain with Sex □ Feet Hay Fever: □ Remenstrual: □ Lags □ Spring □ Bloating Breast Tenderness □ Nose □ Eyes □ Change Of Season □ Carbohydrate Cravings			
□ Rash □ Fungus-Toes □ Ejaculation Problem □ Red Face □ Pitting □ Genital Pain □ Sensitivity to Bites □ Ragged Cuticles □ Impotence □ Sensitivity to Poison Ivy/Oak □ Ridges □ Prostate or Urinary Infection □ Shingles □ Thickening of: □ Lumps In Testicles □ Strong Body Odor □ Fingernails □ FEMALE REPRODUCTIVE □ Hair Loss □ Toenails FEMALE REPRODUCTIVE □ Hair Loss □ White Spots/Lines □ Breast Cysts □ Strong Body Odor □ Fingernails □ FEMALE REPRODUCTIVE □ Hair Loss □ Breast Cysts □ Breast Cysts □ Strong Body Odor □ Femantial Pain □ Poor Libido (Sex Drive) □ White Spots/Lines □ Breast Tenderness □ Skin in General □ Bad Breath □ Ovarian Cyst □ Anus □ Bad Breath □ Ovarian Cyst □ Anus □ Dough-Dry □ Vaginal Discharge □ Ear Canals □ Cough-Dry □ Vaginal Discharge □ Ear Canals □ Hoarseness □ Vaginal Discharge □ Eyes □ Spring □ Bloating Breast Tenderness □ Lumps			
Red Face			
Sensitivity to Poison Ivy/Oak Ridges Prostate or Urinary Infection Shingles Thickening of: Proprocession Lumps In Testicles Proprocession Lumps In Testicles Lumps In Testicles Proprocession Proproce			
□ Sensitivity to Poison Ivy/Oak □ Ridges □ Prostate or Urinary Infection □ Shingles □ Nickening of: □ Poor Libido (Sex Drive) □ Strong Body Odor □ Fingernails FEMALE REPRODUCTIVE □ Hair Loss □ White Spots/Lines □ Breast Cysts □ White Spots/Lines □ Breast Lumps ITCHING SKIN RESPIRATORY □ Breast Tenderness □ Skin in General □ Bad Breath □ Ovarian Cyst □ Anus □ Bad Odor in Nose □ Poor Libido (Sex Drive) □ Arms □ Cough-Dry □ Vaginal Discharge □ Ear Canals □ Hoarseness □ Vaginal Odor □ Ear Canals □ Hoarseness □ Vaginal Odor □ Eyes □ Hoarseness □ Vaginal Pain with Sex □ Feet □ Hay Fever: Premenstrual: □ Legs □ Sorn Throat □ Vaginal Pain with Sex □ Legs □ Summer □ Carbohydrate Cravings □ Nose □ Summer □ Carbohydrate Cravings □ Penis □ Change Of Season □ Cough-Dry □ Roof of Mouth □ Nasal Stuffiness □ Decreased Sleep □ Scalp □ Roof of Mouth □ R	☐ Sensitivity to Bites		
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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	05	04	O 3	02 (01	
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Have periodic lab tests to assess your progress............. 05 04 03 02 01

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? - **Q5 Q4 Q3 Q2 Q1**

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? - O5 O4 O3 O2 O1

Comments

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

3-DAY DIET DIARY INSTRUCTIONS

DIET DIARY

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.)

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

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MSQ - MEDICAL SYMPTOM/TOXICITY QUESTIONNAIRE DATE: NAME: 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 2 = Occasionally have, effect is severe 0 = Never or almost never have the symptom 3 = Frequently have it, effect is not severe 1 = Occasionally have it, effect is not severe 4 = Frequently have it, effect is severe DIGESTIVE TRACT **HEAD** MOUTH/THROAT Headaches Nausea or vomiting Chronic coughing Diarrhea **Faintness** Gagging, frequent need to clear throat Constipation Dizziness Sore throat, hoarseness, loss of voice Bloated feeling Insomnia Swollen/discolored tongue, gum, lips Belching or passing gas Canker sores Total 0 Heartburn Total 0 Intestinal/Stomach pain HEART Total 0 Irregular or skipped heartbeat NOSE Rapid or pounding heartbeat Stuffy nose EARS Chest pain Sinus problems Itchy ears Total o Hay fever Earaches, ear infections Sneezing attacks JOINTS/MUSCLES Drainage from ear Excessive mucus formation Ringing in ears, hearing loss Pain or aches in joints Total 0 Total 0 Arthritis Stiffness or limitation of movement SKIN **EMOTIONS** Pain or aches in muscles Acne Feeling of weakness or tiredness Hives, rashes or dry skin Mood swings Hair loss Total 0 Anxiety, fear or nervousness Flushing or hot flushes Anger, irritability or aggressiveness **Excessive** sweating LUNGS Depression Total 0 Total o Chest congestion Asthma, bronchitis WEIGHT **ENERGY/ACTIVITY** Shortness of breath Difficult breathing Binge eating/drinking Fatigue, sluggishness Craving certain foods Apathy, lethargy Total o Excessive weight Hyperactivity Compulsive eating Restlessness MIND Water retention Total o Poor memory Underweight Confusion, poor comprehension Total 0 **EYES** Poor concentration

KEY TO QUESTIONNAIRE

Watery or itchy eyes

Total 0

Swollen, reddened or sticky eyelids

Blurred or tunnel vision (does not

Bags or dark circles under eyes

include near or far-sightedness)

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

Total 0

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

Slurred speech

Learning disabilities

Poor physical coordination

Stuttering or stammering

Difficulty in making decisions

OTHER

Total 0

Frequent illness

GRAND TOTAL 0

Frequent or urgent urination

Genital itch or discharge