

What have you tried to do to improve your state of health (ex: other doctors, treatments, etc)?

Please list the five most significant stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? If so, please indicate these clearly.

1. _____
2. _____
3. _____
4. _____
5. _____

Please list any other health concerns/conditions, even if you think they may not be important.

Why did you choose my clinic?

For our time together to be a true win for you, what do you want to take place over the course of your care here?

How long do you feel this will take?

Do you think the pain and/or symptoms that you are experiencing could be purposeful? That is, could they be your body's wisdom saying, "I need some help...let's change some things here!" Please explain:

Do you feel your pain and/or illness is a reflection of short-term superficial circumstances or longer-term potentially deeper-seated challenges?

What areas of your life are likely involved with your condition and you would like to improve: (prioritize #1, 2, 3, etc.)

- | | |
|--|--|
| <input type="checkbox"/> My diet and nutrition program | <input type="checkbox"/> My level of anxiety |
| <input type="checkbox"/> Not enough quiet time and rest | <input type="checkbox"/> My pace of living |
| <input type="checkbox"/> Not enough time spent in nature | <input type="checkbox"/> My exercise program |
| <input type="checkbox"/> My creative expression | <input type="checkbox"/> My feelings around career |
| <input type="checkbox"/> My social and family life | <input type="checkbox"/> My communication skills |

Please list any self-destructive lifestyle habits (ex: smoking, lack of exercise, addictions, etc.)

How might it affect you if you don't significantly improve your lifestyle and any underlying contributors to compromised health? (For example: vitality, longevity, joy, happiness, peace of mind, future physical independence, current and/or future relationships, career effectiveness, etc.)

What is your present level of commitment to change the underlying causes of problem(s) which relate to your lifestyle? (Rate from 1 to 10, with 10 being 100% committed).

List your three highest priorities in life which come to mind and speak to your heart. Where does your health and vitality factor in?

1. _____
2. _____

3. _____

What obstacles could prevent you from changing those lifestyle factors that are undermining your health?

What might stop you from following the therapeutic protocols that I may prescribe for you?

Who would be willing to support you in your health goals?

Please list your special interests and passions:

Please circle the appropriate number “0 – 3” on all questions below.
0 as the least/never to 3 as the most/always

Feel that bowels do not empty completely	0 1 2 3	Greasy or high fat foods cause distress	0 1 2 3
Lower abdominal pain relief by passing stool or gas	0 1 2 3	Lower bowel gas and/or bloating several hours after eating	0 1 2 3
Alternating constipation and diarrhea	0 1 2 3	Bitter metallic taste in mouth, especially in the morning	0 1 2 3
Diarrhea	0 1 2 3	Unexplained itchy skin	0 1 2 3
Constipation	0 1 2 3	Yellowish cast to eyes	0 1 2 3
Hard, dry or small stool	0 1 2 3	Stool color alternated from clay colored to normal brown	0 1 2 3
Coated tongue or “fuzzy” debris on tongue	0 1 2 3	Reddened skin, especially palms	0 1 2 3
Pass large amounts of foul smelling gas	0 1 2 3	Dry or flaky skin and/or hair	0 1 2 3
More than 3 bowel movements daily	0 1 2 3	History of gallbladder attacks or stones	0 1 2 3
Do you use laxatives frequently	0 1 2 3	Have you had your gallbladder removed?	Yes No
Excessive belching, burping or bloating	0 1 2 3		

Gas immediately following a meal	0 1 2 3		
Offensive breath	0 1 2 3	Crave sweets during the day	0 1 2 3
Difficult bowel movements	0 1 2 3	Irritable if meals are missed	0 1 2 3
Sense of fullness during and after meals	0 1 2 3	Depend on coffee to keep yourself going or started	0 1 2 3
Difficulty digesting fruits and vegetables; undigested foods found in stools	0 1 2 3	Get lightheaded if meals are missed	0 1 2 3
		Eating relieves fatigue	0 1 2 3
		Feel shaky, jittery, tremors	0 1 2 3
Stomach pain, burning or aching 1-4 hours after eating	0 1 2 3	Agitated, easily upset, nervous	0 1 2 3
Do you frequently use antacids?	0 1 2 3	Poor memory, forgetful	0 1 2 3
Feeling hungry an hour or two after eating?	0 1 2 3	Blurred vision	0 1 2 3
Heartburn when lying down or bending forward	0 1 2 3	Fatigue after meals	0 1 2 3
Temporary relief from antacids, food, milk, carbonated beverages	0 1 2 3	Crave sweets during the day	0 1 2 3
Digestive problems subside with rest and relaxation	0 1 2 3	Eating sweets does not relieve cravings for sugar	0 1 2 3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine	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
Roughage and fiber cause constipation	0 1 2 3		
Indigestion and fullness lasts 2-4 hours after eating	0 1 2 3	Cannot stay asleep	0 1 2 3
Pain, tenderness, soreness on left side under rib cage bloated	0 1 2 3	Crave salt	0 1 2 3
Excessive passage of gas	0 1 2 3	Slow starter in the morning	0 1 2 3
Nausea and/or vomiting	0 1 2 3	Afternoon fatigue	0 1 2 3
Stool undigested, foul smelling, mucous-like, greasy or poorly formed	0 1 2 3	Dizziness when standing up quickly	0 1 2 3
Frequent urination	0 1 2 3	Afternoon headaches	0 1 2 3
Increased thirst and appetite	0 1 2 3	Headaches with exertion or stress	0 1 2 3
Difficulty losing weight	0 1 2 3	Weak nails	0 1 2 3

Please circle the appropriate number “0 – 3” on all questions below.
0 as the least/never to 3 as the most/always

Cannot fall asleep	0 1 2 3	Males Only	
Perspire easily	0 1 2 3	Decrease in libido	0 1 2 3
Under high amounts of stress	0 1 2 3	Decrease in spontaneous morning erections	0 1 2 3
Weight gain when under stress	0 1 2 3	Decrease in fullness of erections	0 1 2 3
Wake up tired even after 6 or more hours of sleep	0 1 2 3	Difficulty in maintaining morning erections	0 1 2 3
Excessive perspiration or perspiration with little or no activity	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
Tired, sluggish	0 1 2 3	Decrease in physical stamina	0 1 2 3
Feel cold – hands, feet, all over	0 1 2 3	Unexplained weight gain	0 1 2 3
Require excessive amounts of sleep to function properly	0 1 2 3	Increase in fat distribution around chest and hips	0 1 2 3
Increase in weight gain even with low calorie diet	0 1 2 3	Sweating attacks	0 1 2 3
Gain weight easily	0 1 2 3	More emotional than in the past	0 1 2 3

Difficult, infrequent bowel movements	0 1 2 3	Menstruating Females Only		
Depression, lack of motivation	0 1 2 3	Are you menopausal?	Yes	No
Morning headaches that wear off as the day progresses	0 1 2 3	Alternating menstrual cycle lengths?	Yes	No
Outer third of eyebrow thins	0 1 2 3	Extended menstrual cycle, greater than 32 days	Yes	No
Thinning of hair on scalp, face or genitals or excessive falling hair	0 1 2 3	Shortened menses, less than every 24 days	Yes	No
Dryness of skin and/or scalp	0 1 2 3	Pain and cramping during periods	0 1 2 3	
Mental sluggishness	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	
Heart palpitations	0 1 2 3	Acne break outs	0 1 2 3	
Inward trembling	0 1 2 3	Facial hair growth	0 1 2 3	
Increased pulse even at rest	0 1 2 3	Hair loss/thinning	0 1 2 3	
Nervous and emotional	0 1 2 3			
Insomnia	0 1 2 3			
Night sweats	0 1 2 3	Menopausal Females Only		
Difficulty gaining weight	0 1 2 3	How many years have you been menopausal?		
		Do you ever have uterine bleeding since menopause?	Yes	No
Diminished sex drive	0 1 2 3	Hot flashes	0 1 2 3	
Menstrual disorders or lack of menstruation	0 1 2 3	Mental fogginess	0 1 2 3	
Increased ability to eat sugars without symptoms	0 1 2 3	Disinterest in sex	0 1 2 3	
		Mood swings	0 1 2 3	
Increased sex drive	0 1 2 3	Depression	0 1 2 3	
Tolerance to sugars reduced	0 1 2 3	Painful intercourse	0 1 2 3	
"Splitting" type headaches	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	
Males Only				
Urination difficulty or dribbling	0 1 2 3			
Urination frequent	0 1 2 3			
Pain inside of legs or heels	0 1 2 3			
Feeling of incomplete bowel evacuation	0 1 2 3			
Leg nervousness at night	0 1 2 3			