Nutrition for Holistic Wellness

Comprehensive Health History Intake Form

Please fill out your comprehensive health history carefully and completely. Refrain from embellishing or omitting information, as doing so will negatively impact the success of your wellness journey. The information in this form is foundational to the practice of functional nutrition. Thank you for saying yes to yourself. It's the first step to knowing how powerful a role you play in your own wellness.

Office use only: Client ID #: Nourish Program: D E S

Demographics					
First Name		Middle Name		Last Name	
Date of Birth		Age		Gender	
Mailing Address					
City, State, Zip code					
Preferred phone	☐ Home ☐ Work ☐ Mobile				
Secondary phone	☐ Home ☐ Work ☐ Mobile				
Email address					
Referred by					

Concerns
What health and/or nutrition concerns would you like to focus on during your visit?
1.
2.
3.

Medical History

Please indicate the health conditions you have experienced in the past (P) or are experiencing now (N).

CONDITION	P or N	Date of Onset	CONDITION	P or N	Date of Onset
GASTROINTESTINAL			**INFLAMMATORY / AUTOIMMUNE**		
Irritable Bowel Syndrome	☐		Chronic Fatigue Syndrome	☐	
Inflammatory Bowel Disease	☐		Rheumatoid Arthritis	☐	
Crohn's Disease	☐		Lupus SLE	☐	
Ulcerative Colitis	☐		Frequent Infections	☐	
Celiac Disease	☐		Severe Infectious Disease	☐	
Gastric or Peptic Ulcer Disease	☐		Herpes	☐	
GERD, reflux / heartburn	☐		Gout	☐	
Hepatitis C or Liver Disease	☐		Other:	☐	
Food Intolerance	☐				
Other:	☐				
RESPIRATORY			**MUSCULOSKELETAL / PAIN**		
Asthma	☐		Osteoarthritis	☐	
Chronic Sinusitis	☐		Chronic pain	☐	
Sleep Apnea	☐		Fibromyalgia	☐	
Bronchitis or Emphysema	☐		Migraines	☐	
Tuberculosis	☐		Other:	☐	
Other:	☐				
CARDIOVASCULAR			**URINARY / REPRODUCTIVE**		
Heart Disease / Heart Attack	☐		Kidney Stones	☐	
Stroke	☐		Urinary Tract Infections	☐	
Elevated Cholesterol	☐		Yeast Infection	☐	
Irregular Heart Rate	☐		Prostate Problem	☐	
High Blood Pressure	☐		Other:	☐	
Other:	☐				
NEUROLOGICAL / BRAIN			**METABOLIC / ENDOCRINE**		
Depression	☐		Type 1 Diabetes	☐	
Anxiety	☐		Type 2 Diabetes	☐	
Bipolar disorder	☐		Metabolic syndrome	☐	
ADD/ADHD	☐		Hypoglycemia	☐	
Multiple Sclerosis	☐		Hypothyroidism	☐	
Seizures	☐		Hyperthyroidism	☐	
Anorexia Nervosa	☐		Polycystic Ovarian Syndrome	☐	
Bulimia	☐		Infertility	☐	
Unspecified Eating Disorder	☐		Other:	☐	
Parkinson's Disease	☐				
Other:	☐				
DERMATOLOGICAL			**CANCER: Please list type(s) and treatments.**		
Eczema	☐				
Psoriasis	☐				
Acne	☐				
Other:	☐				

Additional health conditions your doctor has diagnosed:

Please list any previous injuries, surgeries, and hospitalizations. Provide your age and date if known.

Your Birth History: ☐ Vaginal ☐ C-section	Were you breastfed as an infant? ☐ Yes ☐ No

Family History

Have any of your close relatives (parent, sibling, child grandparent) been diagnosed with the following? Please check, describe, and provide age of onset for those that apply.

Condition	Yes	Family Member(s)	Age of Onset	Description
Heart Disease	☐			
High Blood Pressure	☐			
Stroke	☐			
Diabetes	☐			
Cancer	☐			
Overweight	☐			
Food Intolerance	☐			
Autoimmune Disease	☐			

Oral History

Do you visit a dentist twice per year? ☐ Yes ☐ No

Do you have any silver/mercury amalgam fillings? ☐ Yes ☐ No If yes, how many?

Allergies		Allergic Symptoms Experienced
Food		
Medication		
Supplement		
Environmental		

Medications and Supplements: Please list all prescription medications, nutritional supplements, and herbs/botanicals you are currently taking.

Medication Name	Brand	Dose	Frequency	Reason
Herb/Supplement				

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? ☐ Yes ☐ No

Have you had prolonged or regular use of acid-blocking drugs (Zantac, Pepcid, etc.)? ☐ Yes ☐ No

Have you taken antibiotics > 3 times per year? ☐ Yes ☐ No

Have you been on antibiotics long term (> 1 month continuously)? ☐ Yes ☐ No

Lifestyle Information

Do you engage in physical activity on a regular basis? ☐ Yes ☐ No If yes, complete the table below

Activity	Number of Days per Week	Duration (minutes) per Session

How many hours do you sleep on weeknights? ☐ < 6 ☐ 6-8 ☐ 8-10 ☐ 10 +

How many hours do you sleep on weekends? ☐ < 6 ☐ 6-8 ☐ 8-10 ☐ 10 +

Check which apply to you: ☐ Trouble falling asleep ☐ Wake up during the night ☐ Don't feel rested

How do you handle stress? What helps you relax?

Environmental Exposures

What is your occupation?

Are you regularly exposed to any of the following?

☐ Cigarette smoke ☐ Paint fumes ☐ Perfumes ☐ Nail Polish
☐ Auto exhaust / fumes ☐ Chemicals ☐ Dry-cleaned clothes ☐ Hair dyes

Do you feel dizzy or get a headache when exposed to strong chemical odors or fumes? ☐ Yes ☐ No
If yes, please explain.

Please describe any significant past or present exposure to substances such as recreational drugs, alcohol, or chemicals.

Nutrition History

Have you ever had an appointment with a dietitian or nutritionist? ☐ Yes ☐ No

Have you changed your eating habits for a health reason? ☐ Yes ☐ No Please describe.

Are you currently following a particular diet or nutrition plan? ☐ Yes ☐ No Please describe.

Do you avoid any particular foods? ☐ Yes ☐ No

Please explain.

Nutrition History (continued)

Do you have any adverse food reactions (intolerances or allergies)? ☐ Yes ☐ No Please explain.

Height:	Current Weight:	Usual Weight Range:	Desired Weight:

Have you recently lost or gained weight? ☐ Yes ☐ No If yes, please describe.

Do you have or have you had an eating disorder? ☐ Yes ☐ No If yes, please describe.

How many meals do you eat each day?	How many snacks do you eat each day?

How many meals do you buy from a restaurant or fast food **per week?** ☐ 0-1 ☐ 2-3 ☐ 4-6 ☐ > 6

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks **per week?**

Do you drink caffeinated beverages? ☐ Yes ☐ No If yes, how many cups **per day?**

Do you use any natural or artificial sweeteners? ☐ Yes ☐ No If yes, which ones?

What is your favorite meal?

Check all of the factors that apply to your eating habits and current lifestyle:

☐ Love to eat
☐ Love to cook
☐ Emotional eater
☐ Late night eater
☐ Struggle with eating issues
☐ Family members have different tastes
☐ Dislike cooking
☐ Fast eater
☐ Erratic eating patterns
☐ Eat too much
☐ Rely on convenience foods
☐ Eat fast food frequently
☐ Make poor snack choices
☐ Confused about food/nutrition
☐ Live alone or eat alone often
☐ Do not plan meals or menus
☐ Time constraints
☐ Travel frequently
☐ Eat only because I have to
☐ Negative relationship with food
☐ Dislike healthy food
☐ Don't know how to cook

Food Diary: Please record what you eat and drink during one typical day (24 hour period).
Please be sure to include all beverages, cream and sweetener added to beverages, and condiments added to foods.

Time woke up:		Bedtime:	
Time	Food / Beverage Items (include brands if possible)	Amount (e.g. cups, oz., tsp)	Location (Home/Away)

Food Frequency Questionnaire – How often do you eat the following?						
Food	**Never or <4x/year**	**Rarely or <4x/month**	**Once/wk**	**2x/wk**	**3x/wk**	**Daily**
Cheese	☐	☐	☐	☐	☐	☐
Yogurt, Kefir	☐	☐	☐	☐	☐	☐
Cow's Milk	☐	☐	☐	☐	☐	☐
Milk Substitute (soy, coconut, almond, rice, or hemp seed milk)	☐	☐	☐	☐	☐	☐
Red Meat	☐	☐	☐	☐	☐	☐
Pork (pork loin, pork roast, pork chops, barbecue)	☐	☐	☐	☐	☐	☐
Processed Meat (sausage, bacon, lunch meat)	☐	☐	☐	☐	☐	☐
Chicken	☐	☐	☐	☐	☐	☐
Eggs	☐	☐	☐	☐	☐	☐
Cold Water Fish (*striped bass, wild Alaskan salmon, herring, sardines, anchovies, mackerel, Alaskan halibut, Alaskan cod)*	☐	☐	☐	☐	☐	☐
Other fish or shellfish- Indicate type:	☐	☐	☐	☐	☐	☐
Beans, Legumes (black beans, kidney beans, white beans, lentils)	☐	☐	☐	☐	☐	☐
Whole Soy Foods (edamame, soy nuts)	☐	☐	☐	☐	☐	☐
Tofu, Tempeh	☐	☐	☐	☐	☐	☐
Soy "meat alternative" (ex. Tofurkey, soy "sausage", soy "bacon")	☐	☐	☐	☐	☐	☐
Berries	☐	☐	☐	☐	☐	☐
Other Fruits- Indicate type:	☐	☐	☐	☐	☐	☐
Cruciferous Vegetables (cabbage, broccoli, Brussels sprouts)	☐	☐	☐	☐	☐	☐
Green Leafy Vegetables (e.g. spinach, kale, collards, greens)	☐	☐	☐	☐	☐	☐
Yellow Fruits and Vegetables (e.g. yellow peppers, corn)	☐	☐	☐	☐	☐	☐
Other Green Fruits and Vegetables (e.g. peas, broccoli, avocado, cucumbers)	☐	☐	☐	☐	☐	☐
Blue/Purple Fruits and Vegetables (e.g. blueberries, prunes, beets, purple cabbage)	☐	☐	☐	☐	☐	☐
Red Fruits and Vegetables (e.g. cherries, apples, tomatoes, kidney beans)	☐	☐	☐	☐	☐	☐
Orange Fruits and Vegetables (e.g. orange, cantaloupe, carrots, sweet potato)	☐	☐	☐	☐	☐	☐
White/Tan Fruits and Vegetables (e.g. onions, garlic, ginger, nuts)	☐	☐	☐	☐	☐	☐
Turmeric, Cumin, Ginger, Rosemary, Oregano, Parsley	☐	☐	☐	☐	☐	☐
Nuts, Nut Butters- Indicate type:	☐	☐	☐	☐	☐	☐
Avocado, Extra Virgin Olive Oil , Canola Oil	☐	☐	☐	☐	☐	☐
Vegetable oil (corn, sunflower, safflower, etc. – NOT olive oil)	☐	☐	☐	☐	☐	☐
Butter, ghee	☐	☐	☐	☐	☐	☐
White Rice	☐	☐	☐	☐	☐	☐
White Pasta	☐	☐	☐	☐	☐	☐
White Bread	☐	☐	☐	☐	☐	☐
Bagels	☐	☐	☐	☐	☐	☐
English Muffins	☐	☐	☐	☐	☐	☐
Pancakes or Waffles	☐	☐	☐	☐	☐	☐

Food	Never or <4x/year	Rarely or <4x/month	Once/wk	2x/wk	3x/wk	Daily
Buttermilk Biscuits	☐	☐	☐	☐	☐	☐
Chips	☐	☐	☐	☐	☐	☐
Pretzels	☐	☐	☐	☐	☐	☐
Popcorn	☐	☐	☐	☐	☐	☐
Other Snack Food (crackers, Goldfish)	☐	☐	☐	☐	☐	☐
100% Whole Wheat, Rye, Barley (whole wheat bread and pasta)	☐	☐	☐	☐	☐	☐
Other Whole Grains (millet, quinoa, amaranth, flax, oats, brown rice)	☐	☐	☐	☐	☐	☐
Ice Cream	☐	☐	☐	☐	☐	☐
Pastries, cookies, cakes	☐	☐	☐	☐	☐	☐
Juice- Indicate type:	☐	☐	☐	☐	☐	☐
Punch, Lemonade, or Sweet Tea	☐	☐	☐	☐	☐	☐
Diet Soda	☐	☐	☐	☐	☐	☐
Soda (not diet)	☐	☐	☐	☐	☐	☐
Red Wine	☐	☐	☐	☐	☐	☐
Tea (white, green, black)	☐	☐	☐	☐	☐	☐

Daily Intake Summary

What type(s) of protein do you consume most days of the week? (Check all that apply.)

☐ Animal meat ☐ Beans ☐ Eggs ☐ Soy-based ☐ Dairy ☐ Nuts and seeds

How many servings of fruit do you have in a day?	
How many servings of vegetables do you have in a day?	

Provide an estimate of the amount of each beverage that you consume on an average day.
Circle the label that is most appropriate based on how you consume the beverage.

Water: _____ ounces, cup(s) Diet soda: _____ cup(s), can(s), liter(s) Tea: _____ cup(s)

Coffee: _____ ounces, cup(s) Non-diet soda: _____ cup(s), can(s), liter(s) Other: _____

SYMPTOM SURVEY

Patient Name:_____Date:_____

Completing this form is particularly helpful if you have experienced persistent and bothersome symptoms from more than one category below. Score <u>every</u> symptom based on your experience over the last 30 days. Start with the first symptom and ask yourself, "Lately, have I experienced this symptom?" If you answer no or almost not at all, then write a "0" in the corresponding field. If the answer is yes, then ask yourself if you experience the symptom occasionally (less than 2 times in a week) or frequently (2 or more times in a week). After you have decided on the frequency, then ask yourself if the symptom is "Severe" or "Not Severe". Using the SCALE OF SYMPTOM POINTS listed below, write the appropriate score in the corresponding field for EVERY symptom listed. Total the points for each category, and add all category totals to come up with the Grand Total.

SCALE OF SYMPTOM POINTS: 0 = Do Not Suffer From This Ever or Almost Ever 1 = Suffer OCCASSIONALLY (less than 2 times per week), is not severe 2 = Suffer FREQUENTLY (2 or more times per week), is not severe 3 = Suffer OCCASSIONALLY and is severe 4 = Suffer FREQUENTLY and is severe	Grand Total:

CONSTITUTIONAL

_____ Fatigue (sluggish, tired)
_____ Hyperactive (nervous energy)
_____ Restless (can't relax/sit still)
_____ Sleepiness During Day
_____ Insomnia at Night
_____ Malaise
_____ TOTAL (0-20)

EMOTIONAL/MENTAL

_____ Depression (feelings of hopelessness)
_____ Anxiety (vague fears, uneasiness)
_____ Mood Swings (rapid distinct changes)
_____ Irritability
_____ Forgetfulness
_____ Lack of concentration/focus
_____ TOTAL (0-24)

HEAD/EARS

_____ Headache (any kind)
_____ Migraine (diagnosed)
_____ Earache
_____ Ear Infection
_____ Ringing in Ear
_____ Itchy Ears
_____TOTAL (0-24)

SKIN

_____ Blemishes, Acne
_____ Rashes, Hives
_____ Eczema
_____ "Rosy" Cheeks
_____ TOTAL (0-16)

NASAL/SINUS

_____ Post Nasal Drip
_____ Sinus Pain
_____ Runny Nose
_____ Stuffy Nose
_____ Sneezing
_____ TOTAL (0-20)

MOUTH/THROAT

_____ Sore Throat
_____ Swollen Throat
_____ Swelling of Lips/Tongue
_____ Gagging/Throat Clearing
_____ Lesions ("Canker Sores")
_____ TOTAL (0-20)

LUNGS

_____ Wheezing" (Asthma or Asthma-like Symptoms)
_____ Chest Congestion
_____ Non-Productive Coughing
_____ Productive Coughing
_____ TOTAL (0-20)

EYES

_____ Red or Swollen Eyes
_____ Watery Eyes
_____ Itchy Eyes
_____ Dark Circles" or "Baggy"
_____ TOTAL (0-16)

GENITOURINARY

_____ Increased Urinary Frequency
_____ Painful Urination
_____ TOTAL (0-8)

MUSCULOSKELETAL

_____ Joint Pains/Aching
_____ Stiff Joints
_____ Muscle Aches
_____ Stiff Muscles
_____ TOTAL (0-20)

CARDIOVASCULAR

_____ Irregular Heartbeat
_____ High Blood Pressure _____ TOTAL (0-8)

DIGESTIVE

_____ Heartburn/Esoph.Reflux
_____ Stomach Pains/Cramps
_____ Intestinal Pains/Cramps
_____ Constipation
_____ Diarrhea
_____ Bloating Sensation
_____ Gas (of Any Kind)
_____ Nausea, Vomiting
_____ Painful Elimination
_____ TOTAL (0-36)

WEIGHT MANAGEMENT

_____ **Record Actual Weight**
_____ **Approximate Height**
_____ Fluctuating Weight
_____ Food Cravings
_____ Water Retention
_____ Binge Eating or Drinking
_____ Purging (all methods)
_____ TOTAL (0-20)

Comments:

Life Events

1. Have you lived or traveled outside of the United States? If so, when and where?:

2. Have you or your family recently experienced any major life changes? If so, please comment:

3. Have you experienced any major losses in life? If so, please comment:

4. How much time have you had to take off from work or school in the last year?

   - ☐ 0 to 2 days
   - ☐ 3 to 14 days
   - ☐ more than 15 days

5. What other health practitioners are you currently seeing? List name, specialty and phone # below.

Nutritional Status

1. Are there any foods that you avoid because of the way they make you feel?
   If yes, please name the food and the symptom:

2. Do you have symptoms immediately after eating like bloating, gas, sneezing or hives?
   If so, please explain:

3. Are you aware of any delayed symptoms after eating certain foods such as fatigue, muscle aches, sinus congestion, etc? If so, please explain:

4. Are there foods that you crave? If so, please explain:

5. Describe your diet at the onset of your health concerns:

6. Is there anything else we should know about your current diet, history or relationship to food?

Intestinal Status

1. Bowel Movement Frequency

- ☐ 1–3 times per day
- ☐ more than 3 times per day
- ☐ not regularly every

2. Bowel Movement Consistency

- ☐ soft & well formed
- ☐ often float
- ☐ difficult to pass
- ☐ diarrhea
- ☐ thin, long or narrow
- ☐ small and hard
- ☐ loose but not watery
- ☐ alternating between hard and loose

3. Bowel Movement Color

- ☐ medium brown
- ☐ very dark or black
- ☐ greenish
- ☐ blood is visible
- ☐ variable
- ☐ yellow, light brown
- ☐ chalky colored
- ☐ greasy, shiny

4. Do you experience intestinal gas? If so, please explain if it is excessive, occasional, odorous, etc:

5. Have you ever had food poisoning? If yes, please describe in detail, including 1) Where were you 2) What did you treat it with and 3) If you feel like you fully recovered from it

Health Hazards

1. Have you been exposed to any chemicals or toxic metals (lead, mercury, arsenic, aluminum)?

2. Do odors affect you?

3. Are you or have you been exposed to second-hand smoke?

Oral Health History

1. How long since you last visited the dentist? What was the reason for that visit?

2. In the past 12 months has a dentist or hygienist talked to you about your oral health, blood sugar or other health concerns? (Explain.)

3. What is your current oral and dental regimen? (Please note whether this regimen is once or twice daily or occasionally and what kind of toothpaste you use.)

4. Do you have any mercury amalgams? (If no, were they removed? If so, how?)

5. Do you have any concerns about your oral or dental health?

6. Is there anything else about your current oral or dental health or health history that you'd like us to know?

Lifestyle History

1. Have you had periods of eating junk food, binge eating or dieting? List any known diet that you have been on for a significant amount of time.

2. Have you used or abused alcohol, drugs, meds, tobacco or caffeine? Do you still?

3. How do you handle stress?

Sleep History

1. Are you satisfied with your sleep?

2. Do you stay awake all day without dozing?

3. Are you asleep (or trying to sleep) between 2:00 a.m. and 4:00 a.m.?

4. Do you fall asleep in less than 30 minutes?

5. Do you sleep between 6 and 8 hours per night?

For Women Only

1. How old were you when you first got your period?

2. How are/were your menses? Do/did you have PMS? Painful periods? If so, explain.

3. In the second half of your cycle do you experience any symptoms of breast tenderness, water retention or irritability?

4. Have you experienced any yeast infections or urinary tract infections? Are they regular?

5. Have you/do you still take birth control pills: If so, please list length of time and type.

6. Have you had any problems with conception or pregnancy?

7. Are you taking any hormone replacement therapy or hormonal supportive herbs? If so, please list again here.

Sexual History

1. Do you have any concerns or issues with your sexual functioning that you'd like to share with us (pain with intercourse, dryness, libido issues, erectile dysfunction)?

2. In the past year, have your sexual partners been men, women, or both? And how many partners have you had in the past year?

Mental Health Status

1. How are your moods in general? Do you experience more anxiety, depression or anger than you would like?

2. On a scale of 1-10, one being the worst and 10 being the best, describe your usual level of energy.

3. At what point in your life did you feel best? Why?

Other

1. Do you think family and friends will be supportive of you making health and lifestyle changes to improve your quality of life? Explain, if no.

2. Who in you family or on your health care team will be most supportive of you making dietary change?

3. Please describe any other information you think would be useful in helping to address your health concern(s):

Nutrition Focused Current Symptom Questionnaire

Section 1	Y/N/Some
Indigestion, burping, bloating or sleepy immediately after meals	
Heartburn or acid reflux symptoms	
Tendency to allergies, eczema, asthma	
Nausea in evenings	
Proteins hard to digest, complex meals hard to digest (combination of proteins and carbs)	
Loss of taste for meat	
Sense of excess fullness after meals	
Feel like skipping breakfast, overall low appetite	
Undigested food in stool	
Anemia, unresponsive to iron	

Section 2	
Heartburn or acid reflux symptoms	
Nausea in mornings	
Strong appetite, demanding hunger, excess salivation	
Aggravated by spice or sour, sour burps, sour smell	

Section 3	
Pain between shoulder blades	
Stomach upset by fatty or fried foods	
Loose stools with fatty foods, irregular stools, fat in stools (shiny, floating), smelly stools	
Nausea	
Light, clay colored or greenish/yellow stools	
Dry skin, itchy feet or skin peels on feet	
Gallbladder attacks	
Gallbladder removed	
Bitter taste in mouth, especially after meals	
Easily intoxicated or hung over if you were to drink wine	
Pain under right side of rib cage	
Hemorrhoids or varicose veins	
Sensitive to chemicals (perfume, cleaning agents, etc.), diesel fumes or tobacco smoke	

Section 4	
Food allergies or sensitivities (wheat or grain, or dairy or other)	
Frequent intake of allergenic food (s), strong attachment to allergenic foods	
Craving, addiction or binging of allergenic foods (s)	
Abdominal bloating 1-2 hours after eating	
Pulse speeds up after eating	
Crohn's disease, frequent sinus infection, migraines, asthma	
Airborne allergies	
Experience hives	

Section 5	
Catch colds at the beginning of winter	
Mucous producing cough	
Frequent colds, flu or other infections (sinus, ear, bladder, skin, etc.)	
Never get sick	
History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue Syndrome, Hepatitis, or other chronic viral conditions	
Do you have food allergies or sensitivities?	

Section 6	Y/N/Some
Coating on tongue	
Anus itches	
Fungus or yeast infections	
Yeast symptoms increase with sugar, starch or alcohol consumption	
Less than one bowel movement a day	
Constipation, stools hard or difficult to pass	
Excessive foul smelling lower bowel gas	
Irritable bowel or mucous colitis	
Bad breath or strong body odor	
Cramping in lower abdominal region	
Stools are difficult to pass	
History of parasites	
Stools have corners or edges, are flat and ribbon shaped	

Section 7	
Do you eat less than five to nine servings (one-half cup cooked, 1 cup raw) of colored vegetables or fruits a day?	
Do you crave sweets, breads, rolls, cookies, pasta, pizza or chips?	
Crave coffee or sugar in the afternoon?	
Sleepy in the afternoon?	
Fatigue is relieved by eating	
Binging or uncontrolled eating	
Excessive appetite	
When you eat snacks/sweets, do you eat them, get a temporary boost of energy and mood, and later crash?	
Headache, irritability or shakiness if meals are skipped or delayed	
Do you get symptoms such as heart palpitations after eating sweets?	
Frequent thirst?	
Frequent urination?	
Once you start eating sweets or carbohydrates, do you feel you can't stop?	
Do you tend to gain weight in the belly?	
Do you have pre-diabetes, diabetes, PCOS, hypoglycemia or alcoholism or a family history of any one of these?	
Do you have elevated triglycerides or cholesterol?	
Do you have high blood pressure?	

Section 8	
Do you have high or low blood pressure?	
Do you have a low libido?	
Do you have trouble falling asleep?	
Do you get less than 8 hours a sleep a night?	
Do you go to bed frequently after midnight?	
Do you get less than 1 hour a day of sunlight?	
Do you work the night shift?	
Are you an emotional eater?	
Do you feel anxious or have panic attacks?	
Are you a shallow breather?	
Do you experience heart palpitations?	
Do you have cravings for salt or sweets?	
Do you experience chronic or prolonged fatigue?	
Does fatigue prevent you from doing things you would like to do? Interfere with you work, family or social life?	
Do you feel you can't get started in the morning without coffee or caffeinated drinks?	

Section 9	
Are you cold when everyone else is warm or warm when everyone else is cold?	
Do you have course or brittle hair?	

Do you experience constipation?	
Do you have thinning hair or hair loss?	
Have you experienced a loss of sex drive?	
Have you lost the outside of your eyebrow?	
Do you experience depression?	
Do you have trouble losing weight?	
Do you have a low blood pressure or heart rate?	
Do you have elevated cholesterol?	
Do you have a horse voice?	
Do you have dry, scaly skin?	
Do you have cold hands and feet?	
Do you experience fatigue?	
Do you experience fluid retention?	

Section 10	
Aware of irregular or heavy breathing	
Discomfort at high altitudes	
Sigh frequently or “air hunger”	
Shortness of breath with moderate exertion	
Ankles swell, especially at end of day	
Blush or face turns red for no reason	
Dull pain or tightness in chest and/or radiate into left arm, worse on exertion	
Muscle cramps on exertion	

Section 11	
Do you rarely break out into a sweat?	
Do you use aluminum cooking equipment?	
Do you have mercury amalgams?	
Do you have your clothes dry-cleaned?	
Do you eat “fast-food” > 2 times a week	
Do you drink tap, well or bottled water?	
Do you have strong body odor?	
Do you have acne on face or buttocks?	
Do you drink < 4 cups water a day (approximately 30 oz)	
Do you live in a large urban or industrial area?	
Do you use lawn or garden chemicals?	
Do you have less < 1 bowel movement per day?	
Do you react to small amounts of alcohol?	
Do you sit on your computer 3+ hours a day?	
Do you exercise < 3 times a week?	
Do you use tobacco products?	
Do you eat large fish (sword fish, tuna, shark, tilefish) more than once a week?	
Do you urinate small amounts of dark urine only a few times a day?	
Are you frequently exposed to solvents and chemicals at work or at home?	
When you drink coffee or other substances containing caffeine, do you feel any of the following: wired, increased aches in muscles and joints, anxiety, palpitations, sweating, dizziness?	
Do you have a negative reaction when you consume foods containing MSG, sulfites or other preservatives?	