# FDN® Intake Form

The following questions will be used as valuable information to assess your current state of health. Please answer the questions to the best of your ability.

|  |  |  |
| --- | --- | --- |
| **Question** | **Yes** | **No** |
| **1. Intake Questions** |  |  |
| Do you experience problems falling asleep? |  |  |
|  |  |  |
| Do you experience problems staying asleep? |  |  |
|  |  |  |
| What time do you normally go to bed? |  |  |
|  |  |  |
| What time do you normally awaken? |  |  |
|  |  |  |
| Do you feel rested upon awakening? |  |  |
|  |  |  |
| Do you awaken regularly between 2-3 A.M.? |  |  |
|  |  |  |
| Do you recall your dreams? |  |  |
|  |  |  |
| Do you frequently have nightmares? |  |  |
|  |  |  |
| Is your energy good all day? |  |  |
| If No, what time of day is your energy best? | Time: | |
| What time is the lowest? | Time: | |
| Do you feel tired all the time? |  |  |
| If yes, how long have you felt this way? | | |
| Do you suffer from depression? |  |  |
| If yes, please describe: | | |
| Do you suffer from pain? |  |  |
| If yes, please explain: | | |
| Are you mentally and emotionally exceptionally stressed? |  |  |
| If yes, how long have you felt this way? | | |
| Do you suffer from low blood sugar? |  |  |
| If yes, please explain | | |
| How many meals (including snacks) do you eat a day?  © 2008 - 2015 Functional Diagnostic Nutrition® \_01022015 | Meals: | |
| **Question** | **Yes** | **No** |
| How much time between meals/snack? | Time: | |
|  |  | |
| Do you eat within 1 hour of awakening? |  |  |
| If yes, please describe a typical breakfast: | | |
| If no, how long after awakening until you eat your first meal of the day? | Time: | |
| Please describe the typical meal: | | |
| Do you have a bedtime snack? |  |  |
| If yes, please describe | | |
| If no, how many hours between dinner and bedtime? | Time: | |
| Please describe a typical day's meals and snacks from awakening until bedtime (ending your day) | | |
| Breakfast: (time) | | |
| Lunch: (time) | | |
| Dinner/supper: (time) | | |
| Snack: (time) | | |
| Snack: (time) | | |
| Snack: (time) | | |
| Do you frequently skip meals? |  |  |
|  |  |  |
| Do you need caffeine (Coffee, tea, etc.) to get going in the morning? |  |  |
|  |  |  |
| Do loud noises (sounds) bother you? |  |  |
|  |  |  |
| Are you startled easily? |  |  |
|  |  |  |
| Do you suffer from allergies? |  |  |
|  |  |  |
| Do you suffer from recurrent/chronic infections? |  |  |
| (Describe) | | |
| Do you take thyroid hormones? |  |  |
| If yes, please list type, dosage, and how long have you been taking them: | | |
| Do you suffer mental confusion? |  |  |
| Do you suffer from chronic headaches?  © 2008 - 2015 Functional Diagnostic Nutrition® \_01022015 |  |  |
| **Question** | **Yes** | **No** |
| Have you ever fainted? |  |  |
|  |  |  |
| Are you easily upset? |  |  |
|  |  |  |
| Are you taking any sleeping medication? |  |  |
| If yes, please list: | | |
| Are you taking any anti-depressants? |  |  |
| If yes, please list type and dosage: | | |
| Do you exercise? |  |  |
| If yes, what type, time of day, how long, how often? |  |  |
|  |  |  |
| If no, is there any reason you cannot exercise? |  |  |
| If yes, please explain: |  |  |
|  |  |  |
| Do you feel better or worse after exercise? | Better: | Worse: |
|  |  |  |
| Do you frequently experience a second wind (high energy) late at night? |  |  |
|  |  |  |
| What is your daytime light source? (i.e. indoor/outdoor, fluorescent, full spectrum, etc.) | Type: | |
|  |  |  |
| How much time do you get outdoor light (direct or indirect) daily? | Amount: | |
| Do you wear sunglasses when you are outdoors? |  |  |
| Does sunlight bother your eyes? |  |  |
|  |  |  |
| Do you have high blood pressure? |  |  |
| If yes, are you taking any medication? |  |  |
| If yes, please list type and dosage: | | |
| Do you have low blood pressure? |  |  |
|  |  |  |
| Do you feel nauseous? |  |  |
|  |  |  |
| Do you have bloating? |  |  |
|  |  |  |
| Do you have heartburn? |  |  |
|  |  |  |
| Do you have constipation? |  |  |
| Do you have gas?  © 2008 - 2015 Functional Diagnostic Nutrition® \_01022015 |  |  |
| **Question** | **Yes** | **No** |
| Do you belch following meals? |  |  |
|  |  |  |
| Do your bowel movements alternate between constipation and diarrhea? |  |  |
|  |  |  |
| Do you have abdominal/intestinal pain? |  |  |
|  |  |  |
| Do you get bet bloated after meals? |  |  |
|  |  |  |
| Do you have diarrhea? |  |  |
|  |  |  |
| Do you travel outside of the U.S.? |  |  |
|  |  |  |
| Are your stools compact/hard to pass? |  |  |
|  |  |  |
| Do you have gurgles in your stomach? |  |  |
|  |  |  |
| Do you have any known food allergies? |  |  |
|  |  |  |
| What is your heritage? (e.g. Irish, German, Spanish, Asian, etc.) | | |
| Have you had any root canals? |  |  |
| If yes, how many and when? | | |
| Have you had any teeth extracted, including wisdom teeth? |  |  |
| If yes, when? | | |
| Do you have a dental bridge in your mouth? |  |  |
| If yes, what is the material used? | | |
| Do you have fillings? |  |  |
| If yes, how many and what materials were used? | | |
| Do you have braces? |  |  |
| If yes, what is the material used? | | |
| Do you have TMJ (jaw problems) |  |  |
| If yes, please describe: | | |
| Describe any believed exposure(s) to environmental and/or chemical toxins:  © 2008 - 2015 Functional Diagnostic Nutrition® \_01022015 | | |
| **Question** | **Yes** | **No** |
| Describe your hobbies and forms of recreation: | | |
| Are you currently taking nutritional supplements? |  |  |
| If yes, please list all products and daily dosages: | | |
| Have you ever had any head, neck, or back injuries? |  |  |
| If yes, please describe: | | |
| How long has it been since you have felt your best? | | |
| Please list your main health complaints, the one(s) you would most like to get rid of: | | |
|  | | |
|  | | |
|  | | |
|  | | |
|  | | |
| **Question** | **Yes** | **No** |
| **2. Patient Health Survey:** |  |  |
| **Estrogen Deficiency** |  |  |
| Hot flashes |  |  |
| Night Sweats |  |  |
| Vaginal Dryness |  |  |
| Foggy Thinking |  | ☐ |
| Memory Lapses |  |  |
| Incontinence |  |  |
| Tearful |  |  |
| Depressed |  |  |
| Sleep Disturbances |  |  |
|  |  |  |
| **Estrogen Excess** |  |  |
| Mood Swings (PMS) |  |  |
| Tender Breasts |  |  |
| Water Retention |  |  |
| Nervousness |  |  |
| Irritability |  |  |
| Anxiousness  © 2008 - 2015 Functional Diagnostic Nutrition® \_01022015 |  |  |
| **Question** | **Yes** | **No** |
| Fibrocystic Breasts |  |  |
| Uterine Fibroids |  |  |
| Weight gain in hips |  |  |
| Bleeding changes |  |  |
|  |  |  |
| **Progesterone Deficiency** |  |  |
| Hot Flashes |  |  |
| Night Sweats |  |  |
| Vaginal Dryness |  |  |
| Foggy Thinking |  |  |
| Memory Lapses |  |  |
| Bone Loss |  |  |
| Incontinence |  |  |
| Tearful |  |  |
| Depressed |  |  |
| Sleep Disturbances |  |  |
| Heart Palpitation |  |  |
|  |  |  |
| **Progesterone Excess** |  |  |
| Sleepiness |  |  |
| Breast swelling/tenderness |  |  |
| Decreased libido |  |  |
| Mild Depression |  |  |
| Candida infections |  |  |
|  |  |  |
| **Androgen Deficiency (Testosterone)** |  |  |
| Low libido |  |  |
| Vaginal Dryness |  |  |
| Foggy Thinking |  |  |
| Fatigue |  |  |
| Aches/pains |  |  |
| Memory lapses |  |  |
| Incontinence |  |  |
| Depressed |  |  |
| Sleep disturbances |  |  |
|  |  |  |
| **Androgen Excess (Testosterone)** |  |  |
| Excessive facial/body hair |  |  |
| Loss of scalp hair |  |  |
| Increased acne  © 2008 - 2015 Functional Diagnostic Nutrition® \_01022015 |  |  |
| **Question** | **Yes** | **No** |
| Voice change |  |  |
| Oily skin |  |  |
| Irritability |  |  |
|  |  |  |
| **Cortisol Deficiency (Adrenal)** |  |  |
| Fatigue |  |  |
| Sugar Craving |  |  |
| Allergies |  |  |
| Chemical sensitivity |  |  |
| Stress |  |  |
| Cold body temperature |  |  |
| Heart Palpitations |  |  |
|  |  |  |
| **Cortisol Excess (Adrenal)** |  |  |
| Sleep disturbances |  |  |
| Bone Loss |  |  |
| Fatigue |  |  |
| Weight gain in waist |  |  |
| Loss of muscle mass |  |  |
| Thinning skin |  |  |
|  |  |  |
| **3. Bivins-HormonalSymptoms1 List for Women and Men** |  |  |
| **A) Physical complaints** |  |  |
| headaches |  |  |
| low back pain |  |  |
| mid back pain |  |  |
| migraines |  |  |
| neck pain |  |  |
| neurological symptoms |  |  |
| wellness care |  |  |
| other pain: |  |  |
|  |  |  |
| **B) Rule Out Parasites:** *(401H, 410 stool)* |  |  |
| bloating |  |  |
| constipation |  |  |
| diarrhea |  |  |
| various GI symptoms |  |  |
| rectal itching |  |  |
| no symptoms  Adopted from the Patient and Significant Others Health Survey© with permission.  © 2008 - 2015 Functional Diagnostic Nutrition® \_01022015 |  |  |
| **Question** | **Yes** | **No** |
| **C) Rule Out H. Pylori:** *(401H & 418 stool)* |  |  |
| acid reflux |  |  |
| acne |  |  |
| bad breath |  |  |
| belching |  |  |
| burping |  |  |
| cancer |  |  |
| constipation |  |  |
| depression |  |  |
| fatigue |  |  |
| gastritis |  |  |
| headaches |  |  |
| heartburn |  |  |
| indigestion or nausea |  |  |
| intense hunger |  |  |
| malabsorption |  |  |
| migraines |  |  |
| morning, painful, or fowl smelling gas |  |  |
| overweight/cannot lose weight |  |  |
| poor sleep |  |  |
| rosacea |  |  |
| ulcers |  |  |
| upper abdominal pain |  |  |
|  |  |  |
| **D) Rule Out Gluten Intolerance:** *(Cyrex)* |  |  |
| ADD/ADHD |  |  |
| Addison's Disease |  |  |
| Alternating diarrhea/constipation |  |  |
| asthma |  |  |
| autism |  |  |
| autoimmune growth retardation |  |  |
| bone diseases |  |  |
| celiac disease |  |  |
| Crohn's Disease |  |  |
| colitis |  |  |
| dark circles under eyes |  |  |
| dental enamel lesions |  |  |
| depression  © 2008 - 2015 Functional Diagnostic Nutrition® \_01022015 |  |  |
| **Question** | **Yes** | **No** |
| Down's Syndrome |  |  |
| epilepsy |  |  |
| esophageal symptoms |  |  |
| failure to thrive |  |  |
| fatigue |  |  |
| fibromyalgia |  |  |
| food sensitivity (ex: soymilk, cow’s milk) |  |  |
| gynecological disorders |  |  |
| headaches |  |  |
| IBS |  |  |
| infertility |  |  |
| learning disabilities |  |  |
| liver disorders |  |  |
| malabsorption |  |  |
| nausea |  |  |
| otitis media |  |  |
| pernicious anemia |  |  |
| postpartum depression |  |  |
| psychiatric & brain disorders |  |  |
| RA |  |  |
| skin diseases |  |  |
| sleep & behavior disorders |  |  |
| suicidal thoughts (or attempts) |  |  |
| thyroid & eating disorders |  |  |
| undigested food in stool |  |  |
| vitamin & mineral deficiencies |  |  |
| vomiting |  |  |
| weight loss |  |  |
|  |  |  |
| **E) Low Adrenal Function:** *(201, 205 saliva)* |  |  |
| allergies |  |  |
| bacterial, fungus or mold infection |  |  |
| blood sugar imbalance |  |  |
| chronic illness |  |  |
| depression |  |  |
| digestive disorder |  |  |
| dizziness upon standing |  |  |
| dry or thin skin  © 2008 - 2015 Functional Diagnostic Nutrition® \_01022015 |  |  |
| **Question** | **Yes** | **No** |
| excessive hunger |  |  |
| hair loss |  |  |
| headaches |  |  |
| heart palpitations |  |  |
| immune deficiency |  |  |
| inflammation |  |  |
| liver disorders |  |  |
| low blood pressure |  |  |
| low body temperature |  |  |
| low sex drive |  |  |
| mood swings |  |  |
| parasite infection |  |  |
| PMS |  |  |
| poor concentration |  |  |
| poor memory |  |  |
| shoulder pain |  |  |
| sleep disorder |  |  |
| sweet craving |  |  |
| thyroid disorder |  |  |
| weakness |  |  |
| weight gain/loss |  |  |
|  |  |  |
| **F) High Estrogens:** *(205, 208 saliva)* |  |  |
| blood sugar imbalance |  |  |
| bone repair-interference |  |  |
| depression |  |  |
| endometriosis |  |  |
| excessive blood clotting |  |  |
| headaches |  |  |
| increased risk for breast cancer |  |  |
| increased body fat |  |  |
| infertility |  |  |
| interference with thyroid hormone |  |  |
| loss of zinc retention of copper |  |  |
| low sex drive |  |  |
| reduced vascular tone |  |  |
| reduced oxygen in all cells |  |  |
| risk for endometrial cancer  © 2008 - 2015 Functional Diagnostic Nutrition® \_01022015 |  |  |
| **Question** | **Yes** | **No** |
| salt & fluid retention |  |  |
| uterine cramping |  |  |
| **G) Low Estrogens:** *(205, 208 saliva)* |  |  |
| accelerated aging |  |  |
| depression |  |  |
| dry hair, skin, and nails |  |  |
| fear |  |  |
| headaches |  |  |
| heart palpitations |  |  |
| hot flashes |  |  |
| mental fogginess |  |  |
| migraines |  |  |
| poor sleep |  |  |
| vaginal dryness |  |  |
| worry |  |  |
| **H) Immunity** *(Genova, Cyrex)* |  |  |
| \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| **I) Toxic Liver** |  |  |
| abdominal pain |  |  |
| altered smell or taste |  |  |
| ascites (fluid that fills and distends the abdomen) |  |  |
| autoimmune disorders |  |  |
| aversion to certain foods |  |  |
| dark circles under eyes |  |  |
| fatigue |  |  |
| fever |  |  |
| hemochromatosis (too much iron) |  |  |
| infections (especially viral) |  |  |
| itching of the skin |  |  |
| jaundice (yellowness of skin and whites of eyes) |  |  |
| loss of appetite |  |  |
| muscles aches |  |  |
| nausea |  |  |
| progressive weight loss |  |  |
| weakness headache |  |  |
| Wilson' Disease  © 2008 - 2015 Functional Diagnostic Nutrition® \_01022015 |  |  |
| **Question** | **Yes** | **No** |
| **J) Low Progesterone:** *(205, 208 saliva)* |  |  |
| anxiety, can't shut down |  |  |
| endometriosis and uterine fibroids |  |  |
| heavy menstrual bleeding |  |  |
| irregular menstrual cycles |  |  |
| irritability and mood swings |  |  |
| poor sleep |  |  |
| tender breasts |  |  |
| unable to get pregnant |  |  |
| unable to maintain a pregnancy |  |  |
| **K) High Progesterone:** *(205, 208 saliva)* |  |  |
| bloating |  |  |
| breast tenderness |  |  |
| decreasing insulin sensitivity |  |  |
| depression |  |  |
| raising insulin levels |  |  |
| reducing libido |  |  |
| weight gain |  |  |
| **L) Hypothyroid:** *(Pharmasan serum)* |  |  |
| abnormal menstrual cycles |  |  |
| depression |  |  |
| dry & coarse skin and hair |  |  |
| fatigue |  |  |
| forgetfulness |  |  |
| high cholesterol |  |  |
| iodine deficiency |  |  |
| iodine increase |  |  |
| weight gain |  |  |
| **M) Hyperthyroid:** *(Pharmasan serum)* |  |  |
| breathlessness |  |  |
| budging eyes, "spacy gaze" |  |  |
| chest pain |  |  |
| diarrhea or GI upset |  |  |
| feeling of being too warm all the time |  |  |
| hair loss |  |  |
| heart palpitations/ accelerated heart rate |  |  |
| heightened anxiety, irritability, moodiness or depression |  |  |
| © 2008 - 2015 Functional Diagnostic Nutrition® \_01022015 |  |  |
| **Question** | **Yes** | **No** |
| increased appetite |  |  |
| light or absent menstrual periods, infertility |  |  |
| muscle deterioration |  |  |
| nervousness or trembling |  |  |
| poor sleep yet exhausted |  |  |
| vision problems or eye irritation |  |  |
| warm or moist skin |  |  |
| weight loss |  |  |
|  |  |  |
| **4. FACTOR Check Sheet** |  |  |
| **Predisposing Factors** |  |  |
| I have experienced long periods of stress that have affected my well-being. |  |  |
| I have had one or more severely stressful events that have affected my well-being. |  |  |
| I have driven myself to exhaustion. |  |  |
| I overwork with little play or relaxation for extended periods. |  |  |
| I have had extended, severe or recurring respiratory infections. |  |  |
| I have taken long term or intense steroid therapy (corticosteroids). |  |  |
| I tend to gain weight, especially around the middle (spare tire). |  |  |
| I have a history or alcoholism and/or drug abuse. |  |  |
| I have environmental sensitivities. |  |  |
| I have diabetes (type II, adult onset, NIDDM). |  |  |
| I suffer from post-traumatic distress syndrome. |  |  |
| I suffer from anorexia. |  |  |
| I have one or more other chronic illnesses or diseases. |  |  |
|  |  |  |
| **Key Signs and Symptoms** |  |  |
| My ability to handle stress and pressure has decreased. |  |  |
| I am less productive at work. |  |  |
| I seem to have decreased in cognitive ability. I don't think as clearly as I used to. |  |  |
| My thinking is confused when hurried or under pressure. |  |  |
| I tend to avoid emotional situations. |  |  |
| I tend to shake or am nervous when under pressure. |  |  |
| I suffer from nervous stomach indigestions when tense. |  |  |
| I have many unexplained fears/anxieties. |  |  |
| My sex drive is noticeably less than it used to be. |  |  |
| I get lightheaded or dizzy when rising rapidly from a sitting or lying position. |  |  |
| I have feelings of graying out or blacking out/ |  |  |
| I am chronically fatigued; a tiredness that is not usually relieved by sleep.  © 2008 - 2015 Functional Diagnostic Nutrition® \_01022015 |  |  |
| **Question** | **Yes** | **No** |
| I feel unwell most of the time. |  |  |
| I notice that my ankles are sometimes swollen - the swelling worse in the evening. |  |  |
| I usually need to lie down or rest after sessions of psychological or emotional pressure/stress. |  |  |
| My muscles sometimes feel weaker than they should. |  |  |
| My hands and legs get restless - experience meaningless body movements. |  |  |
| I have become allergic or have increased frequency/severity of allergic reactions. |  |  |
| When I scratch my skin a white line remains for a minute or more. |  |  |
| Small irregular dark brown spots have appeared on my forehead, face, neck, and shoulders. |  |  |
| I sometimes feel weak all over. |  |  |
| I have unexplained and frequent headaches. |  |  |
| I am frequently cold. |  |  |
| I have decreased tolerance for cold. |  |  |
| I have low blood pressure. |  |  |
| I often become hungry, confused, shaky, or somewhat paralyzed under stress. |  |  |
| I have lost weight without reason while feeling very tired and listless. |  |  |
| I have feelings of hopelessness and despair. |  |  |
| I have decreased tolerance. People irritate me more. |  |  |
| The lymph nodes in my back are frequently swollen. (I get swollen glands on my neck). |  |  |
| I have times of nausea and vomiting for no apparent reason. |  |  |
|  |  |  |
|  |  |  |
| **Energy Patterns** | **Past** | **Now** |
| I often have to force myself in order to keep going. Everything seems like a chore. |  |  |
| I am easily fatigued. |  |  |
| I have difficulty getting up in the morning (don't really wake up until after 10:00 A.M.) |  |  |
| I suddenly run out of energy. |  |  |
| I usually feel much better and fully awake after the noon meal. |  |  |
| I often have an afternoon low between 3:00-5:00 P.M. |  |  |
| I get low energy, moody, foggy if I do not eat regularly. |  |  |
| I usually feel my best after 6:00 P.M. |  |  |
| I am often tired at 9:00-10:00 P.M., but resist going to bed. |  |  |
| I like to sleep late in the morning. |  |  |
| My best, most refreshing sleep often comes between 7:00-9:00 A.M. |  |  |
| I often do my best work late at night (early in the morning). |  |  |
| If I don't go to bed by 11:00 P.M. I get a second burst of energy, often lasting until 1:00-2:00 A.M.  © 2008 - 2015 Functional Diagnostic Nutrition® \_01022015 |  |  |
|  |  |  |
| **Question** | **Yes** | **No** |
|  |  |  |
| **Frequently Observed Events** |  |  |
| I get coughs/colds that stay around for several weeks. |  |  |
| I have frequent or recurring bronchitis, pneumonia or other respiratory infections. |  |  |
| I get asthma, colds and other respiratory involvements two or more times per year. |  |  |
| I frequently get rashes, dermatitis or other skin conditions. |  |  |
| I have rheumatoid arthritis. |  |  |
| I have allergies to several things in the environment. |  |  |
| I have multiple chemical sensitivities. |  |  |
| I have chronic fatigue syndrome. |  |  |
| I get pain in the muscles of my upper back and lower neck for no apparent reason. |  |  |
| I get pain in the muscles on the sides of my neck. |  |  |
| I have insomnia or difficulty sleeping. |  |  |
| I have fibromyalgia. |  |  |
| I suffer from asthma. |  |  |
| I suffer from hay fever. |  |  |
| I suffer from nervous breakdowns. |  |  |
| My allergies are becoming worse (more severe/frequent/diverse) |  |  |
| The fat pads on my palms of my hands and/or tips of my fingers are often red. |  |  |
| I bruise more easily than I used to. |  |  |
| I have tenderness in my back near my spine at the bottom of my rib cage when pressed. |  |  |
| I have a swelling under my eyes upon rising that goes away after I have been up for a couple of hours |  |  |
|  |  |  |
| **The next two questions are for women only** |  |  |
| I have increasing symptoms of PMS such as cramps, bloating, moodiness, irritability, emotional instability, |  |  |
| headaches, tiredness and/or intolerance before my period (only some of these need be present) |  |  |
| My periods are generally heavy but they often stop, or almost stop, on the fourth day, only to start up profusely on the 5th or 6th day |  |  |
|  |  |  |
|  |  |  |
| **Food Patterns** |  |  |
| I need coffee or some other stimulant to get going in the morning. |  |  |
| I often crave food high in fat and feel better with high fat foods. |  |  |
| I use high fat foods to drive myself. |  |  |
| I often use high fat foods and caffeine containing drinks (coffees, colas, chocolate) to drive myself. |  |  |
| I often crave salt and/or foods high in salt. I like salty foods.  © 2008 - 2015 Functional Diagnostic Nutrition® \_01022015 |  |  |
|  |  |  |
| **Question** | **Yes** | **No** |
| I feel worse if I eat high potassium foods (like bananas, figs, raw potatoes), especially if I eat them in the morning |  |  |
| I crave high protein foods (meats, cheeses). |  |  |
| I crave sweet foods (pies, cakes, pastries, doughnuts, dried fruits, candies or desserts). |  |  |
| I feel worse if I miss or skip a meal. |  |  |
|  |  |  |
| **Aggravating Factors** |  |  |
| I have constant stress in my life or work. |  |  |
| My dietary habits tend to be sporadic and unplanned. |  |  |
| My relationships at work and/or home are unhappy. |  |  |
| I do not exercise regularly. |  |  |
| I eat lots of fruit. |  |  |
| My life contains insufficient enjoyable activities. |  |  |
| I have little control over how I spend my time/ |  |  |
| I restrict my salt intake. |  |  |
| I have gum and/or tooth infections and abscesses. |  |  |
| I have meals at irregular times |  |  |
|  |  |  |
| **Relieving Factors** |  |  |
| I feel better almost right away once a stressful situation is resolved. |  |  |
| Regular meals decrease the severity of my symptoms. |  |  |
| I often feel better after spending a night out with my friends. |  |  |
| I often feel better if I lie down. |  |  |
| Other relieving factors: |  |  |
|  |  |  |
| Additional comments and/or questions: |  |  |
|  |  |  |

© 2008 - 2015 Functional Diagnostic Nutrition® \_01022015