# 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 symptomsAdopted 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 | [ ]  | [ ]  |
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| **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:  |  |  |
|       |  |  |

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