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Nutritional Counseling Packet

Please read all the instructions carefully. Please complete all the forms as accurately as possible. I assure you that I read ALL of these forms, so take your time so I can make an accurate assessment and plan a proper diet and recommendations for you.

The following forms should be included herein:

- Food Preference List
- Daily Food Record (Make 4 copies)
- Basal Temperature Chart
- Metabolic Screening Questionnaire
- Protein-Carbohydrate Balance
- Symptom Survey Form (SSF)
- Hormone Balance Test (women)
- Menopausal Type Questionnaire (if appropriate)

If any of these forms are missing, illegible or incomplete please call the office and new forms will be sent, faxed or e-mailed. The completed forms must be received no later than 48 hours prior to your first Nutritional Counseling appointment.

Most of the forms are self-explanatory, but do not hesitate to call the office if you have questions.

The Daily Food Record is essential for proper evaluation of your diet.

- Please use **one side** for each day.
- Record the time that you put anything in your mouth.
- List all items a separate line, including condiments.
- Record the brand name, restaurant, home or friend's house in the "Brand" column. In the next column record the approximate quantity.
- The last column should be used for any physical or emotional reactions you may experience during the day.
- Carry one sheet with you and record everything as soon as possible after eating rather than relying on your memory later in the day.

If you have any questions don't hesitate to call the office.

Good Luck

Dr. Bill Rice

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FOOD PREFERENCE LIST

Please complete this form as completely as possible so that we can create a dietary program specifically for you. The column headings are self-explanatory.

FOOD I LIKE & EAT	QUANTITY	TIMES PER WEEK	FOOD I LIKE BUT DON'T EAT	FOOD I DO NOT LIKE OR EAT

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DAILY FOOD DIARY

DATE: ___________________ **DAY (circle one): MON TUE WED THU FRI SAT SUN**

TIME	FOOD – BEVERAGE ITEMS	BRAND	QUANTITY	REACTION

Physical Activity	Minutes	Intensity: Low ♦ Medium ♦ High

Check # 8 oz. glasses of water:

Notes: ____

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BASAL TEMPERATURE CHART

Please follow these instructions to test your basal metabolic rate:

1. Shake down the thermometer at night before bed.
2. FIRST THING upon arising place thermometer in your armpit for ten (10) minutes.
3. Record the results in the chart below by marking an "**X**" in the box corresponding to your temperature.
4. Female patients should make a note on the chart indicating the start & finish of your menstrual cycle.
5. Women who are menstruating should do this for thirty (30) days.
6. Men & non-menstruating women should do this for seven (7) days.

DATE→ TEMP↓																														
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Determining Your Protein-Carbohydrate Balance

Name ____ Date _______________

Please answer YES or NO for every question. Add your points for "YES" answers.

	YES	NO	
5	☐	☐	I have a tendency to higher blood pressure.
5	☐	☐	I gain weight easily, especially around my waist and have difficulty losing it.
5	☐	☐	I often experience mental confusion.
5	☐	☐	I often experience fatigue and generalized weakness.
10	☐	☐	I have diabetic tendencies.
4	☐	☐	I get tired and/ or hungry in the mid-afternoon.
5	☐	☐	About an hour or two after eating a full meal that includes dessert, I want more of the dessert.
3	☐	☐	It is harder for me to control my eating for the rest of the day if I have a breakfast containing sugars and starches, than it would if I had only coffee or nothing at all.
4	☐	☐	When I want to lose weight, I find it easier not to eat for most of the day rather than to try to east several small meals.
3	☐	☐	Once I start eating sweets, starches or snack foods, I often have a difficult time stopping.
3	☐	☐	I would rather have an ordinary meal that included dessert than a gourmet meal that did not include dessert.
5	☐	☐	After finishing a full meal, I sometimes feel as if I could back and eat the whole meal again.
3	☐	☐	A meal of only meat and vegetables leave me feeling unsatisfied.
3	☐	☐	If I'm feeling down, a snack of cake or cookies makes me feel better.
3	☐	☐	If potatoes, bread, pasta, or dessert are on the table, I will often skip eating vegetables or salad.
4	☐	☐	I get sleepy, almost "drugged" feeling after eating a large meal containing bread or pasta or potatoes and dessert. I feel more energetic after a meal of only meat or fish and salad.
3	☐	☐	I have hard time going to sleep at times without a bedtime snack.
3	☐	☐	At times I wake in the middle of the night and can't go back to sleep unless I eat something.
5	☐	☐	I get irritable if I miss a meal or mealtime is delayed.
2	☐	☐	At a restaurant, I almost always eat too much bread.

Total score _______

Part XIII – Metabolic Clearing Assessment

Check the box that best describes the frequency AND severity of your symptoms over the last 30 days. If you have completed this questionnaire within the last 30 days, please fill it out based on your symptoms over the last 48 hours.

#	Symptom	Rarely / NO 1	Occasionally 2	Often 3	Frequently / YES 4
1	Nausea or vomiting				
2	Diarrhea				
3	Constipation				
4	Bloated feeling				
5	Belching, or passing gas				
6	Heartburn				
7	Watery or itchy eyes				
8	Swollen, reddened or sticky eyelids				
9	Bags or dark circles under eyes				
10	Blurred or tunnel vision (excluding near or far-sightedness).				
11	Headaches				
12	Faintness				
13	Dizziness				
14	Insomnia				
15	Itchy ears				
16	Earaches, ear infections				
17	Drainage from ear				
18	Ringing in ears, hearing loss				
19	Stuffy nose				
20	Sinus problems				
21	Hay fever				
22	Sneezing attacks				
23	Excessive mucus formation				
24	Chronic coughing				
25	Gagging, frequent need to clear throat				
26	Sore throat, hoarseness, loss of voice				
27	Swollen or discolored tongue, gums, lips				
28	Canker sores				
29	Irregular or skipped heartbeat				
30	Rapid or pounding heartbeat				
31	Chest pain				
32	Chest congestion				
33	Asthma, bronchitis				
34	Shortness of breath				
35	Difficulty breathing				

#	Symptom	Rarely / NO 1	Occasionally 2	Often 3	Frequently / YES 4
36	Pain or aches in joints				
37	Arthritis				
38	Stiffness or limitation of movement				
39	Pain or aches in muscles				
40	Feeling of weakness or tiredness				
41	Acne				
42	Hives, rashes, or dry skin				
43	Hair loss				
44	Flushing or hot flashes				
45	Excessive sweating				
46	Fatigue or sluggishness				
47	Apathy, lethargy				
48	Hyperactivity				
49	Restlessness				
50	Mood swings				
51	Anxiety, fear or nervousness				
52	Anger, irritability, or aggressiveness				
53	Depression				
54	Poor memory				
55	Confusion, poor comprehension				
56	Poor concentration				
57	Poor physical function				
58	Difficulty making decisions				
59	Stuttering or stammering				
60	Slurred speech				
61	Learning disabilities				
62	Binge eating/drinking				
63	Craving certain foods				
64	Excessive weight				
65	Compulsive eating				
66	Water retention				
67	Underweight				
68	Frequent illness				
69	Frequent or urgent urination				
70	Genital itch or discharge				
71	Intestinal and/or stomach pain				

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THE HORMONE BALANCE TEST

Check each symptom that applies to you

Group 1

- ☐ Insomnia
- ☐ Early Miscarriage
- ☐ Painful or lumpy breasts
- ☐ Unexplained weight gain
- ☐ Cyclical headaches
- ☐ Anxiety
- ☐ Infertility

Total Checked _____/ 8 % _____

Group 2

- ☐ Vaginal dryness
- ☐ Night sweats
- ☐ Painful intercourse
- ☐ Memory problems
- ☐ Bladder infections
- ☐ Lethargic depression
- ☐ Hot flashes

Total Checked _____/ 7 % _____

Group 3

- ☐ Puffiness and bloating
- ☐ Cervical dysplasia (abnormal pap test)
- ☐ Rapid weight gain
- ☐ Breast tenderness
- ☐ Mood swings
- ☐ Heavy bleeding
- ☐ Anxious depression
- ☐ Migraine headaches
- ☐ Insomnia
- ☐ Foggy thinking
- ☐ Red flush on face
- ☐ Gallbladder problems
- ☐ Weepiness

Total Checked _____/ 13 % _____

Group 4

This group is a combination of the symptoms in groups 1 and 3. If you've checked two or more in each of these two groups, you may belong to this group.

Total Checked _____

Group 5

- ☐ Acne
- ☐ Polycystic ovary syndrome
- ☐ Excessive hair on the face and arms
- ☐ Hypoglycemia
- ☐ Thinning hair on the head
- ☐ Infertility
- ☐ Ovarian cysts
- ☐ Midcycle pain

Total Checked _____ / 8 % _____

Group 6

- ☐ Debilitating fatigue
- ☐ Unstable blood sugar
- ☐ Foggy thinking
- ☐ Low blood pressure
- ☐ Thin and/or dry skin
- ☐ Intolerance to exercise
- ☐ Brown spots on face

Total Checked _____ / 7 % _____

PATIENT SYMPTOM SURVEY

***DATE*_________________**

***PATIENT'S NAME*____ *DOB* ____/____/_____**

***WEIGHT*_________ *HEIGHT*_________ *BLOOD PRESSURE*___________ *PULSE*___________ O_2__________**

This is a confidential patient symptom survey. Please check each condition which is true for you. Take your time. If you are not sure the condition applies to you or do not understand a term, do not check the box. Use common sense. For example, Insomnia once last month probably isn't that important and would not be marked. However, Insomnia 1-2 times per week is notable and would be marked. Please take your time…

Primary Complaints

090 ☐ General Good Health
091 ☐ Desires Nutritional & Metabolic Analysis
001 ☐ Skin Disorder 692.9
002 ☐ Acne 706.1
003 ☐ Psoriasis 696.1
004 ☐ Urticaria (Hives) 708.9
005 ☐ ADD/ADHD 314.00/314.01
006 ☐ Allergies, Unspecified 477.9
007 ☐ Allergic Rhinitis from food 477.1
008 ☐ Sinusitis 461.9
009 ☐ Alzheimer's 331.0
010 ☐ Poor Concentration/Memory 310.1
011 ☐ Parkinson's Disease 332.0
012 ☐ Anemia 285.9
013 ☐ Arthritic Disorder 716.90
014 ☐ Osteoporosis 733.00
015 ☐ Asthma 493.90
016 ☐ Emphysema 492.8
017 ☐ Cancer
  018 ☐ Breast 174.9female 175.9male
  019 ☐ Prostate 185
  020 ☐ Lung 162.9
  021 ☐ Colon and Rectal 153.9
  022 ☐ Skin 173.9
  023 ☐ Leukemia w/o remission 208.90
      Leukemia w/ remission 208.91
  024 ☐ Lymphoma, malignant 202.8
  025 ☐ Brain Tumor, malignant 191.9
027 ☐ Anxiety Disorder 300.00
028 ☐ Autism 299.00
033 ☐ Edema 782.3
034 ☐ Eczema 692.9
035 ☐ Chronic Fatigue 780.71
036 ☐ Circulatory Disorder 459.9
037 ☐ Heart Disease 429.9
038 ☐ High Cholesterol 272.0

039 ☐ High Blood Pressure 401.9
040 ☐ Low Blood Pressure 458.9
041 ☐ Tachycardia (High Heart Rate) 785.00
042 ☐ Numbness 782.0
043 ☐ Constipation 564.0
044 ☐ Indigestion 536.8
045 ☐ Ulcerative Colitis 556.9
046 ☐ Depression 311
047 ☐ Diabetes Mellitus 250.0
030 ☐ Diabetes Type I 250.01
031 ☐ Diabetes Type II 250.02
029 ☐ Hyperglycemia [high blood sugar] 790.29
048 ☐ Hypoglycemia [low blood sugar] 251.2
049 ☐ Dizziness/Balance Problem 780.4
050 ☐ Ear Infection 381.4
051 ☐ Epstein Barr 075
052 ☐ Eye Problems 379.91
053 ☐ Cataracts 366.9
054 ☐ Glaucoma 365.9
055 ☐ Macular Degeneration 362.50
056 ☐ Fever 780.6
057 ☐ Fibromyalgia 729.1
058 ☐ Gallbladder Disorder 575.9
059 ☐ Gout 274.9
060 ☐ Headaches 784.0
061 ☐ Hearing Loss 389.9
062 ☐ Infertility, male 606.9
064 ☐ Liver Disease 571.9
  065 ☐ Hepatitis 573.3
  066 ☐ Hepatitis B 070.30
  067 ☐ Hepatitis C 070.51
068 ☐ Kidney Disorder 593.9 or Bladder Disorder 596.9

063 ☐ Prostate Disorder 602.9
069 ☐ Hyperthyroidism 242.90
070 ☐ Hypothyroidism 244.9
071 ☐ Systemic Lupus 710.0
072 ☐ Infertility, female 628.9
073 ☐ Interstitial Cystitis 595.1
074 ☐ Irregular Menstrual Cycle 626.4
075 ☐ Menopausal Symptoms 627.2
076 ☐ Hot Flashes 627.2
077 ☐ Mental Disorder 300.9
078 ☐ Insomnia 780.52
079 ☐ Mouth/Throat/Tongue
080 ☐ Canker Sores 528.2
081 ☐ Overweight 278.02
082 ☐ Underweight 783.22
083 ☐ Sexual Disorder 302.89
084 ☐ Spinal Problems 724.9
085 ☐ Obesity 278.00
086 ☐ GERD 530.81
087 ☐ HIV 042
088 ☐ Crohn's Disease 555.9
089 ☐ Irritable Bowel Syndrome 564.1
092 ☐ Normal Pregnancy v22.2
  **only applicable if *currently* pregnant
093 ☐ Shingles 053.9
140 ☐ Migraines 346.90
141 ☐ Rheumatoid Arthritis 714.0
142 ☐ Non-Systemic Lupus 695.4
143 ☐ Multiple Sclerosis 340
144 ☐ ALS (Lou Gerigs) 335.20
145 ☐ Polymyalgia Rheumatica 725
146 ☐ Scleroderma 710.1
171 ☐ Goiter 240.9
178 ☐ Raynaud's Syndrome 443.8
179 ☐ Hemochromatosis 275.0
180 ☐ Thalassemia 282.49
181 ☐ Brain aneurysm 431

If necessary, please state your most significant concern…

General Health

100 ☐ Fingernail base is pink
101 ☐ Fingernail base is purple
102 ☐ Fingernails have ridges or white spots
103 ☐ Fingernails are soft
104 ☐ Fingernails are splitting
105 ☐ Fingernails peel
106 ☐ Pale fingernail beds
107 ☐ Blacks out easily
108 ☐ Balance problems
109 ☐ Difficulty walking
110 ☐ Has tattoos
111 ☐ Brittle hair
112 ☐ Dry hair
113 ☐ Thin hair
114 ☐ Hair loss
115 ☐ Drinks alcoholic beverages daily
116 ☐ Drinks less than 8 glasses of water per day
117 ☐ Currently on Chemotherapy
118 ☐ Currently on radiation treatment
119 ☐ Had chemotherapy in the past
120 ☐ Has had radiation treatments in the past
121 ☐ Gained over 20 lbs in the last 12 months
122 ☐ Somewhat Overweight
123 ☐ Somewhat Underweight

124 ☐ Unexplained loss of >20lbs in last 4 months
125 ☐ Energy level is worse than it was 5 years ago
127 ☐ Sleeps less than 6 hours per night
128 ☐ Unable to recall dreams the next day
129 ☐ Sensitive to chemicals, paint, fumes, cologne
130 ☐ Had blood transfusion in the past
131 ☐ Had transplant in the past
138 ☐ Takes anti-rejection drugs
132 ☐ Had a major accident or injury
137 ☐ Sleep Apnea
139 ☐ Toxic chemical exposure
175 ☐ Has been out of the country recently
176 ☐ Had childhood vaccines
177 ☐ Had a vaccine in the last 12 months
147 ☐ Had a flu shot last year
182 ☐ Had a pneumonia vaccine last year
183 ☐ Had a Hepatitis B vaccine in the last 2 years.

Has a family history of:

184 ☐ Cancer
185 ☐ Heart Disease
186 ☐ Diabetes
187 ☐ Alcoholism
188 ☐ Depression
189 ☐ Obesity

Lifestyle & Environment

Do you use? ☐ Well Water ☐ City Water Filtered? ☐ Yes ☐ No Filter Type? ________________________

What kind of pipes are in your home? ☐ Steel ☐ CPVC ☐ Copper ☐ Pex ☐ Other ______________

What year was your home built? ___________ Any renovations in the past year? ___________________________

Do you use chlorine bleach or other heavy duty cleaners in your home/work? ☐ Yes ☐ No

Have you ever worked around heavy machinery, plumbing, automotive or the metallurgic industry? ☐ Yes ☐ No

Explain: ____

Have you ever worked around industrial solvents, chemicals or pesticides? ☐ Yes ☐ No

Explain: ____

380 ☐ Drinks beverages from a can
370 ☐ Drinks alcohol
371 ☐ Drinks caffeinated coffee
372 ☐ Drinks caffeinated pop/soda
373 ☐ Drinks caffeinated tea
374 ☐ Drinks decaffeinated coffee
375 ☐ Drinks decaffeinated pop/soda
376 ☐ Drinks decaffeinated tea
377 ☐ Drinks >3 cups of coffee daily
378 ☐ Drinks >3 cups of tea per day
388 ☐ Drinks diet pop/soda

379 ☐ Drinks >1 pop/sodas per day

I had 4 alcoholic drinks in one day:

172 ☐ never
173 ☐ more than 3 months ago
174 ☐ less than 3 months ago

381 ☐ Has >5 alcoholic drinks/week
391 ☐ Craves sugar / starches
382 ☐ Currently smokes
383 ☐ Quit smoking in last 5 years
384 ☐ Smoked for >5 years
385 ☐ Smokes >1 pack per day

126 ☐ Rarely exercises
133 ☐ Regularly exercises
386 ☐ Takes Vitamins
134 ☐ Vegetarian
135 ☐ Eats no red meat
136 ☐ Eats no meat, no dairy
387 ☐ Frequent use of artificial sweeteners
389 ☐ Anorexia
390 ☐ Bulimic

Surgeries

700 ☐ Tonsillectomy and/or Adenoids
701 ☐ Appendix
702 ☐ Gallbladder
703 ☐ Thyroid
704 ☐ Hysterectomy, complete
705 ☐ Hysterectomy, partial
706 ☐ Tubal ligation
707 ☐ Breast implants
708 ☐ Cancer
709 ☐ Coronary by-pass
710 ☐ Spinal surgery
711 ☐ Extremity surgery
712 ☐ Hip replacement
713 ☐ Knee replacement
714 ☐ Splenectomy
715 ☐ Radiated thyroid
716 ☐ Cataract surgery
717 ☐ Hemorroidectomy
718 ☐ Bariatric/Weight loss
Type: ________________

Gastrointestinal

265 ☐ 4-5 bowel movements per week
266 ☐ 3 or less bowel movements per week
267 ☐ 6 or more bowel movements per week
268 ☐ Black tarry stools
269 ☐ Pale or yellow colored stool
270 ☐ Blood stools
271 ☐ Constipation
272 ☐ Hemorrhoids
273 ☐ Loose bowel movements
274 ☐ Frequent diarrhea
275 ☐ Frequent nausea
276 ☐ Frequent vomiting
277 ☐ Abdominal gas
278 ☐ Belching and burping after eating
279 ☐ Bloated after eating
280 ☐ Severe abdominal pains
281 ☐ Stomach ulcers
282 ☐ Uses digestive aids
283 ☐ Uses laxatives
284 ☐ Immediate indigestion upon eating
285 ☐ Indigestion in 2 hours or more after meals
286 ☐ Indigestion within 1 hour after meals
287 ☐ Difficulty swallowing
288 ☐ Eating relieves fatigue
289 ☐ Eats when nervous
290 ☐ Excessive hunger
291 ☐ Poor appetite
292 ☐ Experiences fainting spells when hungry
293 ☐ Feels shaky when hungry
294 ☐ Frequently drowsy after eating a meal
295 ☐ Gall bladder disease
296 ☐ Has had intestinal worms
297 ☐ Reflux/Hiatal hernia
298 ☐ Liver disease
299 ☐ Irritable Bowel Syndrome
300 ☐ Diverticulitis
301 ☐ Diverticulosis

Respiratory

485 ☐ Catches severe colds
486 ☐ Chronic chest condition
487 ☐ Chronic cough
488 ☐ Constant runny nose
489 ☐ COPD
490 ☐ Difficulty breathing
491 ☐ Frequent colds
492 ☐ Frequent nose bleeds
493 ☐ Frequent sinus infections
494 ☐ Frequent stuffy nose
495 ☐ Hay fever
496 ☐ Nasal polyps
497 ☐ Night sweats
498 ☐ Post nasal drip
499 ☐ Sneezing spells
500 ☐ Spits up blood
501 ☐ Spits up phlegm
502 ☐ Wheezes

Mouth and Throat

400 ☐ Bad breath
401 ☐ Bitter taste in the mouth in the morning
402 ☐ Dry mouth
403 ☐ Excessive saliva
404 ☐ Sores or cracks in the corners of the mouth
405 ☐ Glands often swell
406 ☐ Frequent canker sores
407 ☐ Frequent fever blisters
408 ☐ Frequent sore throats
409 ☐ Frequently has a sore tongue
410 ☐ Sore gums
411 ☐ Swollen gums
412 ☐ Swollen tongue
413 ☐ Tongue burns
414 ☐ Tongue has grooves or fissures
415 ☐ Tongue is coated
416 ☐ Gums bleed when brushing teeth
417 ☐ Toothaches
418 ☐ Amalgam dental fillings
420 ☐ Other dental fillings (gold, composite, etc)
419 ☐ Has had root canal(s)

Endocrine

245 ☐ Coarse hair
246 ☐ Coarse skin
247 ☐ Diabetic
248 ☐ Excessive thirst
249 ☐ Frequently feels cold
250 ☐ Frequently feels hot
251 ☐ Gets lightheaded when standing quickly
252 ☐ Heals slowly
253 ☐ Unusually jumpy or nervous
254 ☐ Unusually tired most of the time

Cardiovascular

190 ☐ Cold feet
191 ☐ Cold hands
192 ☐ Experiences shortness of breath while sitting still
193 ☐ Heart skips beats
194 ☐ Tendency of High blood pressure
195 ☐ Leg cramps during bedtime
196 ☐ Leg cramps during daytime
197 ☐ Low blood pressure at times
198 ☐ Pain in leg/hips when walking
199 ☐ Frequent swollen ankles
200 ☐ Pains in the heart or chest
201 ☐ Spells of rapid heart rate
202 ☐ Troubled with blood clots
203 ☐ Unusually slow pulse rate
204 ☐ Varicose veins
205 ☐ Heart palpitations

Skin

520 ☐ Bruises easily
521 ☐ Excessive perspiration
522 ☐ Frequent goose bumps
523 ☐ Has acne
524 ☐ Has Psoriasis
525 ☐ Hives
526 ☐ Itchy skin
527 ☐ Problems with Eczema
528 ☐ Has moles which are changing in size and/or color
530 ☐ Skin is rough, especially on the back of the arms
529 ☐ Skin eruptions
531 ☐ Skin is tender
532 ☐ Sores that heal slowly
533 ☐ Troubled with boils
534 ☐ Dry skin

Ears

220 ☐ Discharge from ears
221 ☐ Hard of hearing
222 ☐ Punctured ear drum
223 ☐ Recurrent ear infection
224 ☐ Ringing or noises in the ears
225 ☐ Tinnitus

Eyes

320 ☐ Bloodshot eyes
321 ☐ Blurred vision
322 ☐ Cross eyes
323 ☐ Eye pain
324 ☐ Eyes feel gritty
325 ☐ Eyes watery
326 ☐ Mild Glaucoma
327 ☐ Far sighted
328 ☐ Developing cataracts
329 ☐ Mild Macular degeneration
330 ☐ Itchy eyes
331 ☐ Near sighted
332 ☐ Dry Eyes

Feet

350 ☐ Corns
351 ☐ Frequent foot cramps
352 ☐ Heel spurs
353 ☐ Painful feet
354 ☐ Plantar warts
355 ☐ Swelling in the feet and/or ankles
356 ☐ Plantar fasciitis
357 ☐ Fungal Infection

Neuromuscular

440 ☐ Bites nails
441 ☐ Frequent muscle soreness
442 ☐ Muscle spasms
443 ☐ Muscle weakness
444 ☐ Tremors
445 ☐ Frequent headaches
446 ☐ Often dizzy
447 ☐ Frequently feels faint
448 ☐ Has Epilepsy
449 ☐ Has motion sickness
450 ☐ Has Osteoarthritis
451 ☐ Has Rheumatism
452 ☐ Rheumatoid Arthritis
453 ☐ Joint stiffness in the morning
454 ☐ Swollen joints
455 ☐ Leg pain at rest
456 ☐ Spinal curvature
457 ☐ Low back pain
458 ☐ Neck pain
459 ☐ Pain between the shoulders
460 ☐ Shoulder/arm pain
461 ☐ Numbness/tingling in the body
462 ☐ Sleep walks
463 ☐ Stutters or stammers
464 ☐ Nerve pain

Behavior Patterns

150 ☐ Afraid to eat anywhere except home
151 ☐ Always needs someone to advise
152 ☐ Cries often
153 ☐ Difficulty concentrating
154 ☐ Difficulty falling asleep
155 ☐ Difficulty staying asleep
156 ☐ Easily angered
157 ☐ Feelings are easily hurt
158 ☐ Frequently becomes scared for no reason
159 ☐ Frequently miserable or blue
160 ☐ Has to be on guard even with friends
161 ☐ Often annoyed by people
162 ☐ Recurrent bad dreams
163 ☐ Sometimes wishes to be dead or away from it all
164 ☐ Upset by criticism
165 ☐ Poor memory
166 ☐ Scared to be alone
167 ☐ Strange people or places cause fear
168 ☐ Under considerable emotional stress
169 ☐ Unhappy when other are happy
170 ☐ Brain fog

Urinary

555 ☐ Urinates more than 2 times per night
556 ☐ Bed wetting
557 ☐ Blood in the urine
558 ☐ Difficulty starting urination
559 ☐ Painful urination
560 ☐ Frequent urination
561 ☐ Troubled by urgent urination
562 ☐ Incontinence when sneezing or laughing
563 ☐ Loses bladder control
564 ☐ Frequent bladder infections
565 ☐ Frequent kidney infections
566 ☐ Kidney stones

Men Only

585 ☐ Difficulty completing intercourse
586 ☐ Difficulty getting or keeping an erection
587 ☐ Discharge from the urethra
588 ☐ Had a vasectomy
589 ☐ Had difficulty fathering children
590 ☐ Lumps in the testicles
591 ☐ Painful genitals
592 ☐ Prostate troubles
593 ☐ Sores on external genitalia
594 ☐ Herpes
595 ☐ Sexual diseases

Women Only

610 ☐ Heavy hair growth on face or body
611 ☐ Cycles are every 27-29 days
612 ☐ Abnormal cycle >29 days and/or <26 days
613 ☐ PMS
614 ☐ Menstrual cramps
615 ☐ Painful periods
616 ☐ Acne worse at menstruation
617 ☐ Excessive menstrual flow
618 ☐ Retains fluid during periods
619 ☐ Pre-menstrual depression
620 ☐ Currently taking birth control medication
621 ☐ Has taken birth control medication more than 1 year
622 ☐ Has taken birth control medication within the last year
623 ☐ Has had miscarriage
624 ☐ Hot flashes
625 ☐ Takes hormone replacement medication
627 ☐ Diminished sexual desire
628 ☐ Painful intercourse
629 ☐ Poor or infrequent orgasm
630 ☐ Lumps in the breasts
631 ☐ Tender breasts
633 ☐ Vaginal discharge
634 ☐ Bloody spotting discharge
635 ☐ Yeast infections
636 ☐ Sores on external genitalia
637 ☐ Herpes
638 ☐ Sexual diseases
639 ☐ Endometriosis
640 ☐ Breast reduction
641 ☐ Breast augmentation
642 ☐ Abortion
643 ☐ D&C
644 ☐ Tubal pregnancy
645 ☐ Uterine fibroids
646 ☐ Ovarian fibroids
647 ☐ Breast fibroids
648 ☐ Currently Breastfeeding

Medications

Please list all drugs you are <u>currently</u> taking on a <u>daily basis</u>.

DRUG	PRESCRIBED FOR:	HOW LONG

Please list all drugs taken <u>within the last year and/or you take as needed</u> including over the counter drugs, antibiotics, aspirin, inhalers, etc.

DRUG	PRESCRIBED FOR:	HOW LONG

Allergies

Please list any known allergies (ex. foods, medications, spices, environmental, etc.)

☐ Dairy	☐ Gluten	☐ Ragweed	☐ Sulfa drugs
☐ Eggs	☐ Mold	☐ Shellfish	☐ Tree nuts
☐ Garlic	☐ Peanut	☐ Soy	☐ Wheat

☐ Other ____________________

Supplements

Please list all vitamins/herbs/supplements you are currently taking and dosages.

VITAMIN	BRAND	DOSAGE