COMPREHENSIVE HEALTH HISTORY

Thank you for choosing our office to assist you with your health care. Our ability to draw effective conclusions about your state of health and how to optimize its improvement depends largely on the accuracy of the information in which you provide, including symptoms that you may consider minor. Health issues may be influenced by many factors, therefore, it is important that you carefully consider the questions asked in this form as well as those posed by the doctor during your consultation. This will assist our goal to provide you with an optimal plan of health care, enhance our efficiency, and will provide effective use of your scheduled time.

Please Print Clearly and Legibly

Today's date: _____

Name: _____Date of Birth: ____/____/____
Age_____ Male _____ Female _____
Social Security #: _____ (Optional) Marital Status: S M D W
(Circle one)
Home Address: _____ _____ _____ _____
(City) (State) (Zip)
Home Phone #: _____Cell Phone #: _____
Email Address: _____
How did you hear about us? _____
Employer Business Name: _____
Occupation: _____
Name of Spouse: _____ Spouses Employer: _____
Spouses Employer Phone #: _____
Nearest Relative:_____ Relation: _____
What is your major complaint:

_____

_____

Is this condition related to: Employment _____ Auto Accident _____ Personal Injury _____
Are you being represented by an attorney for this condition: ____
Attorney's name: _____ Phone #: _____
Address: _____
Have you been treated for other health conditions by a physician in the last year: Yes___No___
Describe:

_____

_____

What operations have you had:_____

Have you ever had dental work with silver fillings (amalgams) or any other metals? Yes ____ No _____

Have you had the silver fillings (amalgams) removed from your mouth? Yes _____ No_____

Name of Dentist: _____

Have you ever had any metal in your body? Yes _____ No _____

Explain: _____

_____

Have you ever had root canals? Yes _____ No _____

Have you been treated by a chiropractic physician before: Yes___ No___ When: _____

By whom: _____ For what condition: _____

Do you suffer from any other disabling condition or physical impairment not due to this accident or illness Yes_____ No_____

Explain:

_____

_____

EMERGENCY CONTACT INFORMATION

Emergency Contact Person: _____

Phone: _____Relationship:_____

Are you prepared to pay for services today? Yes_____ No_____

I will be paying for this visit by: Check_____ Cash_____

CURRENT HEALTH STATUS/CONCERNS

Please provide us with current and ongoing problems

Problem	Date of Onset	Severity/Frequency	Treatment Approach	Success
Example: Headaches	May 2006	2 times per week	Acupuncture/Aspirin	Mild improvement

What diagnosis or explanation(s), if any, have been given to you for these concerns?

_____

_____

_____

When was the last time that you felt well?_____

What seems to trigger your symptoms?_____

What seems to worsen your symptoms?_____

What seems to make you feel better?_____

What physician or other health care provider (including alternative or complimentary practitioners) have you seen for these conditions?_____

_____

_____

How much time have you lost from work or school in the past year due to these conditions?_____

PAST MEDICAL AND SURGICAL HISTORY

If you have experienced reoccurrence of an illness, please indicate when or how often under comments.

ILLNESSES	WHEN /ONSET	COMMENTS
Anemia		
Arthritis		
Asthma		
Bronchitis		
Cancer		
Chicken Pox		
Chronic Fatigue Syndrome		
Crohn's Disease or Ulcerative Colitis		
Diabetes		

ILLNESS	WHEN/ONSET	COMMENTS
Emphysema		
Epilepsy, convulsions, or seizures		
Gallstones		
German Measles		
Gout		
Heart Attack, Angina		
Heart Failure		
Hepatitis		
Herpes Lesions/Shingles		
High blood fats (cholesterol, triglycerides)		
High blood pressure (hypertension)		
Irritable bowel (or chronic diarrhea)		
Kidney stones		
Measles		
Mononucleosis		
Mumps		
Pneumonia		
Rheumatic Fever		
Sinusitis		
Sleep Apnea		
Stroke		
Thyroid disease		
Whooping Cough		
Other (describe)		
Other (describe)		
INJURIES	**WHEN**	**COMMENTS**
Back injury		
Broken bones or fractures (describe)		
Head injury		
Neck injury		
Other (describe)		
Other (describe)		

DIAGNOSTIC STUDIES	WHEN	COMMENTS
Blood Tests		
Bone Density Test		
Bone Scan		
Carotid Artery Ultrasound		
CAT Scan (Please indicate type)		
Colonoscopy		
EKG		
Liver Scan		
Mammogram		
Neck X-Ray		
MRI		
X-Ray (Please indicate type)		
Other (describe)		
Other (describe)		
SURGERIES	**WHEN**	**COMMENTS**
Appendectomy		
Dental Surgery		
Gall Bladder		
Hernia		
Hysterectomy		
Tonsillectomy		
Tubes in Ears		
Other (describe)		
Other (describe)		

HOSPITALIZATIONS

WHERE HOSPITALIZED	WHEN	REASON

MEDICATIONS

How often have you taken antibiotics?	Less than 5 times	More than 5 times	Comments
Infancy/Childhood			
Teen			
Adulthood			

How often have you taken oral steroids? (e.g. Prednisone, Cortisone, etc)	Less than 5 times	More than 5 times	Comments
Infancy/Childhood			
Teen			
Adulthood			

List all medications. Include all over the counter non-prescription drugs.

Medication Name	Date started	Date stopped	Dosage

List all vitamins, minerals, and any nutritional supplements that you are taking now. If possible, indicate whether the dosage.

Type	Date Started	Date Stopped	Dosage

Are you allergic to any medication, vitamin, mineral, or other nutritional supplement? Yes___ No ___
If yes, please list:_____
_____

Divine Healing Ministries for Health, Inc.
3391 E Silver Springs Blvd, Suite B.
Ocala, Florida 34470
(325) 6222-1151 FAX (352) 622-8086

Authorization for Release of Medical Record Information

I hereby authorize Divine Healing Ministries for Health, Inc., Medical Record Department, to release the medical records and/or information including any HIV (aids) testing, alcohol, drugs sexually transmitted disease, psychiatric information. I further release Divine Healing Ministries for Health, Inc. from all legal responsibility and/or liability that may arise from the release of such records as specified above.

Please Print
Patient's legal name: _____DOB_____
Telephone: ( )_____SSN: _____
Mail to: Name_____
Address: _____City:_____State:_____ZiP:_____
This information is to be: _____Mailed _____picked-up Date: _____ Time:_____

The request is subject to the limitations as listed below:
Please furnish the following:

_____Discharge Summary _____Laboratory reports _____Billing Information

_____History/Physical _____ Diagnostic Reports _____All Information

_____Consultation _____Office Notes _____Other _____

This information is for the listed dates of treatment:
From: _____ To: _____

This information is needed for: _____
_____
_____

Patient Signature: _____Date: _____

(The fees are waived only if records are forwarded to a physician office and/or health care provider.)

Florida Statue 395.3025
The exclusive charge for copies of patient records may include sales tax and actual postage, and except for non paper records, which are subject to a charge not to exceed $2.00 per page as provided in S. 28.24 (9), may not exceed $1.00 per page, as provided in S.28.48 (8). A fee of up to $1.00 may be charged for each year of records requested. These charges shall not apply to all records furnished weather directly from the facility of from a copy service providing these services on behalf of the facility.
However, a patient whose medical records are copied and/or searched for the sole purpose of continuing medical care will not be required to pay any associated charges.
Written Authorization Required/Special Authorization: Confidential information may be released only with written Authorization from the patient. The signature of a parent or guardian is required when a Patient is under the age of 18, unless the minor is authorized by law to consent to his/her own treatment.
This includes:

A. Married minor
B. Unmarried pregnant minor females consenting to care during and related to pregnancy and for their children.
C. Minors over the age of 12 being treated for STD's
D. Minors receiving contraceptive advice and services
E. Minors receiving treatment for substance abuse

ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (please print) Date

_____

Parent, Guardian or Patient's Legal Representative

_____

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

General Consent Form:

The undersigned hereby consents to evaluation and treatment rendered according to the applicable standards of care. It is understood that options exist for treatment and all treatments are choices between risks and benefits. If the risks and benefits of proposed treatment are not clear to me, I understand that further information may be requested from Divine Healing Ministries for Health, Inc.

I understand that I have a responsibility to communicate honestly with Divine Healing Ministries for Health, Inc. and to notify them of any changes in my health status. All records in this office are the permanent property of this office; such as diagnostic records, daily notes, examination procedure forms, and x-rays. A patient is able, at any time to have copies of any of the aforementioned office property at a nominal charge for copying the particular said pieces of information.

I understand that if I am accepted as a patient by the doctor at Divine Healing Ministries for Health, Inc. I am authorizing them to proceed with any treatment that may deem necessary. Furthermore, any risks regarding Integrative/Functional Medicine Services will be explained to me upon my request. Integrative/Functional Medicine Services is a form of medicine to which there are and will be no guarantees of any success in this particular office. We will try our utmost to provide the best service and care rendered for the diminishment of the particular complaining problem.

Patient Signature: _____ **Date:** _____

Financial Awareness and Consent:

I understand and agree that I am financially responsible, **WHETHER OR NOT MY INSURANCE COMPANY PAYS,** for all the charges incurred by me. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient Signature: _____ **Date:** _____

Release of Records:

I, _____, authorize to release all health records (including any electronic transmission) necessary for my treatment and/of evaluation to Divine Health Ministries for Health, Inc.

Patient Signature: _____ **Date:** _____

Medication History*

Please check any of the following medications you have been or are currently taking.

Acetylcholine Receptor Antagonist – Antimuscarinic Agents
☐ Atropine, ☐ Ipratopium, ☐ Scopolamine, ☐ Tiotropium

Acetylcholine Receptor Antagonist - Ganlionic Blockers
☐ Mecamylamine, ☐ Hexamethonium, ☐ Nicotine (high doses), ☐ Trimethaphan

Acetylcholinesterase Reactivators
☐ Pralidoxime

Acetylcholine Receptor Antagonist - Neuromuscular Blockers
☐ Atracurium, ☐ Cisatracurium, ☐ Doxacurium, ☐ Metocurine, ☐ Mivacurium, ☐ Pancuronium, ☐ Rocuronium, ☐ Succinylcholine, ☐ Tubocurarine, ☐ Vecuronium, ☐ Hemicholinium

Agonist Modulator of GABA Receptor (benzodiazepines)
☐ Xanax®, ☐ Lexotanil, ☐ Lexotan®, ☐ Librium, ☐ Klonopin®, ☐ Valium®, ☐ ProSom®, ☐ Rohypnol, ☐ Dalmane, ☐ Ativan, ☐ Loramet®, ☐ Sedoxil, ☐ Dormicum, ☐ Megalodon, ☐ Serax®, ☐ Restoril, ☐ Halcion

Agonist Modulator of GABA Receptors (nonbenzodiazepines)
☐ Ambien CR®, ☐ Sonata®, ☐ Lunesta®, ☐ Imovane

Cholinesterase Inhibitors (irreversible)
☐ Echodiophate, ☐ Isoflurophate, ☐ Organophosphate Insecticides, ☐ Organophosphate-containing nerve agents

Cholinesterase Inhibitors (reversible)
☐ Donepezil, ☐ Galatamine, ☐ Rivastigmine, ☐ Tacrine, ☐ THC, ☐ Edrophonium, ☐ Neostigmine, ☐ Physostigmine, ☐ Pyridostigmine, ☐ Carbamate Insecticides

Dopamine Reuptake Inhibitors
☐ Wellbutrin XL® (Bupropion)

Dopamine Receptor Agonists
☐ Mirapex®, ☐ Stifrol®, ☐ Requip®

D2 Dopamine Receptor Blockers (antipsychotics)
☐ Thorazine®, ☐ Prolixin®, ☐ Trilafon®, ☐ Compazine®, ☐ Mellaril®, ☐ Stelazine®, ☐ Vesprin®, ☐ Nozinan®, ☐ Depixol®, ☐ Navane®, ☐ Fluanxol®, ☐ Clopixol®, ☐ Acuphase®, ☐ Haldol®, ☐ Orap®, ☐ Clozaril®, ☐ Zyprexa®, ☐ Zydis®, ☐ Seroquel XR®, ☐ Geodon®, ☐ Solian®, ☐ Invega®, ☐ Abilify®

GABA Antagonist Competitive binder
☐ Flumazenil

Monoamine® Oxidase Inhibitors (MAOI)
☐ Marplan®, ☐ Aurorix®, ☐ Manerix®, ☐ Moclodura, ☐ Nardil, ☐ Adeline®, ☐ Eldepryl®, ☐ Azilect®, ☐ Marsilid®, ☐ Iprozid®, ☐ Ipronid®, ☐ Rivivol, ☐ Popilniazida®, ☐ Zyvox®, ☐ Zyvoxid®

Noradrenergic® and Specific Sertonergic® Antidepressants (NaSSas)
☐ Remeron®, ☐ Zispin®, ☐ Avanza®, ☐ Norset®, ☐ Remergil®, ☐ Axit®

Selective Serotonin Reuptake Inhibitors
☐ Paxil®, ☐ Zoloft®, ☐ Prozac®, ☐ Celexa®, ☐ Lexapro®, ☐ Luvox®, ☐ Cipramil®, ☐ Emocal®, ☐ Seropram®, ☐ Cipralex®, ☐ Esteria®, ☐ Fontex®, ☐ Dapoxetine® ☐ Seromex®, ☐ Seronil®, ☐ Sarafem®, ☐ Fluctin®, ☐ Faverin®, ☐ Seroxat, ☐ Aropax®, ☐ Deroxat®, ☐ Rexetin®, ☐ Paroxat®, ☐ Lustral®, ☐ Serlain®

Selective Serotonin Reuptake Enhancers
☐ Stablon®, ☐ Coaxil, ☐ Tatinol®

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)
☐ Effexor®, ☐ Pristiq®, ☐ Meridia, ☐ Serzone®, ☐ Dalcipran®, ☐ Despiramin, ☐ Duloxetine

Tricyclic Antidepressants (TCAs)
☐ Elavil®, ☐ Endep®, ☐ Tryptanol, ☐ Trepiline®, ☐ Asendin®, ☐ Asendis®, ☐ Defanyl®, ☐ Demolox®, ☐ Moxadil®, ☐ Anafranil®, ☐ Norpramin®, ☐ Pertofrane®, ☐ Prothiaden®, ☐ Adapin®, ☐ Sinequan®, ☐ Tofranil®, ☐ Janamine®, ☐ Gamanil®, ☐ Aventyl®, ☐ Pamelor®, ☐ Opipramol®, ☐ Vivactil®, ☐ Rhotrimine®, ☐ Surmontil®

*Please refer to prescribing physician for nutritional interactions with any medications you may be taking.

Health Questionnaire (NTAF)

Name: _____ Age: _____ Sex: _____ Date: _____

* Please circle the appropriate number "0 - 3" on all questions below. 0 as the least/never to 3 as the most/always.

SECTION A

- Is your memory noticeably declining? 0 1 2 3
- Are you having a hard time remembering names and phone numbers? 0 1 2 3
- Is your ability to focus noticeably declining? 0 1 2 3
- Has it become harder for you to learn things? 0 1 2 3
- How often do you have a hard time remembering your appointments? 0 1 2 3
- Is your temperament getting worse in general? 0 1 2 3
- Are you losing your attention span endurance? 0 1 2 3
- How often do you find yourself down or sad? 0 1 2 3
- How often do you fatigue when driving compared to the past? 0 1 2 3
- How often do you fatigue when reading compared to the past? 0 1 2 3
- How often do you walk into rooms and forget why? 0 1 2 3
- How often do you pick up your cell phone and forget why? 0 1 2 3

SECTION B

- How high is your stress level? 0 1 2 3
- How often do you feel that you have something that must be done? 0 1 2 3
- Do you feel you never have time for yourself? 0 1 2 3
- How often do you feel you are not getting enough sleep or rest? 0 1 2 3
- Do you find it difficult to get regular exercise? 0 1 2 3
- Do you feel uncared for by the people in your life? 0 1 2 3
- Do you feel you are not accomplishing your life's purpose? 0 1 2 3
- Is sharing your problems with someone difficult for you? 0 1 2 3

SECTION C

SECTION C1

- How often do you get irritable, shaky, or have lightheadedness between meals? 0 1 2 3
- How often do you feel energized after eating? 0 1 2 3
- How often do you have difficulty eating large meals in the morning? 0 1 2 3
- How often does your energy level drop in the afternoon? 0 1 2 3
- How often do you crave sugar and sweets in the afternoon? 0 1 2 3
- How often do you wake up in the middle of the night? 0 1 2 3
- How often do you have difficulty concentrating before eating? 0 1 2 3
- How often do you depend on coffee to keep yourself going? 0 1 2 3
- How often do you feel agitated, easily upset, and nervous between meals? 0 1 2 3

SECTION C2

- Do you get fatigued after meals? 0 1 2 3
- Do you crave sugar and sweets after meals? 0 1 2 3
- Do you feel you need stimulants such as coffee after meals? 0 1 2 3
- Do you have difficulty losing weight? 0 1 2 3
- How much larger is your waist girth compared to your hip girth? 0 1 2 3
- How often do you urinate? 0 1 2 3
- Have your thirst and appetite been increased? 0 1 2 3
- Do you have weight gain when under stress? 0 1 2 3
- Do you have difficulty falling asleep? 0 1 2 3

SECTION 1 - S

- Are you losing your pleasure in hobbies and interests? 0 1 2 3
- How often do you feel overwhelmed with ideas to manage? 0 1 2 3
- How often do you have feelings of inner rage (anger)? 0 1 2 3
- How often do you have feelings of paranoia? 0 1 2 3
- How often do you feel sad or down for no reason? 0 1 2 3
- How often do you feel like you are not enjoying life? 0 1 2 3
- How often do you feel you lack artistic appreciation? 0 1 2 3
- How often do you feel depressed in overcast weather? 0 1 2 3
- How much are you losing your enthusiasm for your favorite activities? 0 1 2 3
- How much are you losing enjoyment for your favorite foods? 0 1 2 3
- How much are you losing your enjoyment of friendships and relationships? 0 1 2 3
- How often do you have difficulty falling into deep restful sleep? 0 1 2 3
- How often do you have feelings of dependency on others? 0 1 2 3
- How often do you feel more susceptible to pain? 0 1 2 3
- How often do you have feelings of unprovoked anger? 0 1 2 3
- How much are you losing interest in life? 0 1 2 3

SECTION 2 - D

- How often do you have feelings of hopelessness? 0 1 2 3
- How often do you have self-destructive thoughts? 0 1 2 3
- How often do you have an inability to handle stress? 0 1 2 3
- How often do you have anger and aggression while under stress? 0 1 2 3
- How often do you feel you are not rested even after long hours of sleep? 0 1 2 3
- How often do you prefer to isolate yourself from others? 0 1 2 3
- How often do you have unexplained lack of concern for family and friends? 0 1 2 3
- How easily are you distracted from your tasks? 0 1 2 3
- How often do you have an inability to finish tasks? 0 1 2 3
- How often do you feel the need to consume caffeine to stay alert? 0 1 2 3
- How often do you feel your libido has been decreased? 0 1 2 3
- How often do you lose your temper for minor reasons? 0 1 2 3
- How often do you have feelings of worthlessness? 0 1 2 3

SECTION 3 - G

- How often do you feel anxious or panic for no reason? 0 1 2 3
- How often do you have feelings of dread or impending doom? 0 1 2 3
- How often do you feel knots in your stomach? 0 1 2 3
- How often do you have feelings of being overwhelmed for no reason? 0 1 2 3
- How often do you have feelings of guilt about everyday decisions? 0 1 2 3
- How often does your mind feel restless? 0 1 2 3
- How difficult is it to turn your mind off when you want to relax? 0 1 2 3
- How often do you have disorganized attention? 0 1 2 3
- How often do you worry about things you were not worried about before? 0 1 2 3
- How often do you have feelings of inner tension and inner excitability? 0 1 2 3

SECTION 4 - ACH

- Do you feel your visual memory (shapes & images) is decreased? 0 1 2 3
- Do you feel your verbal memory is decreased? 0 1 2 3
- Do you have memory lapses? 0 1 2 3
- Has your creativity been decreased? 0 1 2 3
- Has your comprehension been diminished? 0 1 2 3
- Do you have difficulty calculating numbers? 0 1 2 3
- Do you have difficulty recognizing objects & faces? 0 1 2 3
- Do you feel like your opinion about yourself has changed? 0 1 2 3
- Are you experiencing excessive urination? 0 1 2 3
- Are you experiencing slower mental response? 0 1 2 3

Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition.
For nutritional purposes only.

Metabolic Assessment Form

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

PART I

Please list the 5 major health concerns in your order of importance:

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

PART II

Please circle the appropriate number "0 - 3" on all questions below.
0 as the least/never to 3 as the most/always.

Category I				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relief by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3
Category II				
Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested foods found in stools	0	1	2	3
Category III				
Stomach pain, burning, or aching 1- 4 hours after eating	0	1	2	3
Use antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief from antacids, food, milk, carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3
Category IV				
Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness lasts 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucous-like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Category V				
Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed		**Yes**	**No**	
Category VI				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep yourself going or started	0	1	2	3
Get lightheaded if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory/forgetful	0	1	2	3
Blurred vision	0	1	2	3
Category VII				
Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3
Category VIII				
Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

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Category IX				
Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category X				
Tired, sluggish	0	1	2	3
Feel cold – hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly.	0	1	2	3
Increase in weight gain even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression, lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals or excessive falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XI				
Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XII				
Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XIII				
Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting" type headaches	0	1	2	3

Category XIV (Males only)				
Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

Category XV (Males only)				
Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decrease in physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XVI (Menstruating Females Only)				
Are you perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle, greater than 32 days	Yes	No		
Shortened menses, less than every 24 days	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne breakouts	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XVII (Menopausal Females Only)				
How many years have you been menopausal?	_____			
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness or itching	0	1	2	3

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times a week do you eat raw nuts or seeds? _____

How many times a week do you eat fish? _____

How many times a week do you work out? _____

List the three worst foods you eat during the average week: _____, _____, _____

List the three healthiest foods you eat during the average week: _____, _____, _____

Do you smoke?_____ If yes, how many times a day: _____

Rate your stress levels on a scale of 1-10 during the average week: _____

Please list any medications you currently take and for what conditions:

_____

Please list any natural supplements you currently take and for what conditions:

_____