Name: ____ Phone: ___________________________________

Address: ____ City, State, Zip: _____________________________

Circle Gender: Male or Female Birth date: _______________ Height: ______________ Weight: ____________

Blood Type (O, A, B, or AB): ______________ If you do not know your blood type, please let us know. We will need to determine your type for nutritional recommendations. Blood type testing is available at our location for a small fee

Early Nutritional History

Instructions: Check each statement that is true.

_____ I was born prematurely at _____ months of age.

_____ I was hospitalized after birth due to pre-maturity, jaundice or other medical condition.

Please complete this statement: I was the _______________ child in the family.

First born Second born Third born Fourth born Other

Please list any diseases/ailments that are on your maternal and paternal sides of the family:

Maternal: ____________________________ Paternal: ________________________________

Your mother's ancestry? _________________ Your father's ancestry? _____________________

_____ I was not breastfed as an infant.

_____ I drank the following type of infant formula

_____cow's milk ____ goat milk ____ grain/rice milk

_____ soy milk ____ condensed milk ____________ other

At approximately what age were solid foods introduced to you? ________________________________

What type(s) of food did you eat most often when you were young?

_____ fresh _____ canned _____ fast food _____ fried

_____ frozen __________________________ other

_____ I suffered from allergies as an infant/child/teenager. List allergies: _________________________

Check the word that best describes your nutritional status:

During Infancy:	_____ excellent	_____ satisfactory	_____ poor	_____ malnourished
During Childhood:	_____ excellent	_____ satisfactory	_____ poor	_____ malnourished
During Adolescence:	_____ excellent	_____ satisfactory	_____ poor	_____ malnourished
During Adulthood:	_____ excellent	_____ satisfactory	_____ poor	_____ malnourished

Dietary Habits

What type(s) of food do you eat most often?

_____ fresh _____ canned _____ fast food _____ frozen

_____ fried _____ fine dining _____ other

Do you adhere to any particular diet program, i.e. macrobiotic, vegetarianism? _____ Yes _____ No

If you answered "yes," please list your specific nutritional program: ________________________________

Do you take any nutritional supplementation, i.e. digestive enzymes, vitamins, minerals, glandulars, etc.?

_____ Yes _____ No

If you answered "yes," please list the products and dosages that you regularly take:

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

How many meals do you eat daily? _____ one _____ two _____ three _____other

Check the following word (s) that best describe your typical eating experiences:

_____ I chew my food slowly & thoroughly. _____ I rarely finish my meals because I am so busy.

_____ I relax & enjoy my meals. _____ I eat quickly and often do not chew my food thoroughly.

Check the following word (s) that best describe (s) your manner of eating meals:

_____ I enjoy long, leisurely and relaxing meals. _____ I eat on the run.

_____ I eat most meals while standing, driving or attending to other matters. _____ other

Choose the word (s) that best describe (s) your experiences 30-60 minutes after eating:

_____ filled & satisfied _____ bloated _____ gas/flatus

_____ burning sensation _____ diarrhea _____ cramping

_____ cramping _____ itching _____ weak/tired

_____ hives _____ congestion _____ wheezing

_____ headache _____ nausea/vomiting _____ other

_____ pain (describe location) ________________________________

Complete this sentence with one or more words: Most foods that I eat cause me to feel

_____ energized _____ drained _____ guilty

_____ sick _____ tired _____ uncomfortable

_____ healthy _____other

_____ I rarely think about how I feel after eating.

Do you have any frequent food cravings? _____ Yes _____ No

If you answered "yes," indicate which type of food (s) that you crave:

_____ salty foods _____ sweet foods _____ protein

_____ chocolate _____ caffeine _____ fried foods

_____ alcohol _____ other

When do you most often experience food cravings? _____ between meals _____ after meals

______ before bedtime _____ when I'm bored

_____ when I'm under stress

Please complete this statement: "No meal is complete without ____________________________________."

Have you ever dieted? _____ Yes _____No

Check the phrases (s) that best describe your dieting experiences:

_____ I have dieted off and on my entire life. _____ I began dieting as a teenager.

_____ My diet programs have been successful. _____ I lose a few pounds only to gain them back.

_____ I have never dieted. _____ I enjoy dieting.

When you gain weight, in what area (s) do you generally notice it?

_____ waist ("love handles") _____ below the waist _____ all over

_____ upper body _____ stomach _____ other

Describe the type of water that you drink most frequently:

_____ fluoridated water _____ well water _____ cistern water

_____ bottled water _____distilled water _____ reverse-osmosis water

_____ other

Check the word (s) that best describe(s) your drinking water habits:

_____ I always drink the same water.

_____ I drink water throughout the day.

_____ I rarely drink water because I am rarely thirsty.

_____ I rotate the type of water (s) that I drink.

_____ I drink water infrequently.

_____ I drink water frequently because I am always thirsty.

Approximately how much water do you drink on a daily basis?

_____ 1-2 glasses _____ 3-4 glasses _____ 5-7 glasses

_____ 8-10 glasses _____ other

Check the type of beverages that you drink daily in addition to water:

_____ soda _____ coffee _____ juice _____ diet drinks

_____ tea (hot/cold) _____ milk _____ sports drinks _____ alcohol

_____ soy/rice milk _____ weight building drinks _____ other

Please complete this statement: My alcohol intake involves drinking

_____ 1-2 drinks/week _____ 3-5 drinks/week _____ 6 or more drinks/week

_____ only on rare occasions _____ never _____ other

Main Health Concerns

What health challenges do you currently have or have been diagnosed with by a licensed medical doctor? (optional)

____

What are some of your main concerns with your health? ____________________________________

____

Sometimes, your body gives you early signals of health concerns all the time. Some of them are in the form of pain, soreness, tenderness, mood swings, rashes, etc… What are some ways your body is communicating with you?

____

____

Elimination History/Habits

How many bowel movements do you have daily?

_____ one   _____ two   _____ three   _____ four or more

_____ none   _____ 1-2x week   _____ other

Do you have a history of diarrhea?   _____ Yes   _____ No

Do you have a history of constipation?   _____ Yes   _____ No

Which word (s) best describe your typical bowel movements?

_____ loose & easy to pass   _____ hard & difficult to pass   _____ bloody stools

_____ stools float   _____ stools frequently green   _____ stools often black

_____ stools contain mucous   _____ stools frequently diarrhea   _____ other

_____ stools often preceded or followed by cramping or pain

Do you frequently have gas (flatus)?   _____ Yes   _____ No

If you answered “yes,” choose the phrase that best describes your experiences:

_____ I never have gas.   _____ I have gas all of the time

_____ Gas creates pain, bloating & discomfort for me.   _____ I have gas occasionally

Do you frequently have hemorrhoids?   _____ Yes   _____ No

Have you ever received a colonic?   _____ Yes   _____ No

Approximately how many times do you urinate daily?   _____ 1-2   _____ 3-4

_____ 5-7   _____ other

Choose the word (s) that best describe your urination process:

_____ easy & complete flow of urine   _____ cramping   _____ urgency

_____ flank pain before/during/after   _____ burning/pain   _____urine contains blood

_____ unable to empty bladder fully   _____ urine looks clear like water

_____ Urine often contains particles or sediment   _____ urine contains blood

_____ urinate frequently during the night   _____ incontinence   _____ urine has a strong odor

Do you have a history of frequent urinary tract infections?   _____ Yes   _____ No

Sweating is one of your body's methods of removing waste products. Choose the phrase (s) that best describe (s) how Your body sweats:

_____ I sweat all of the time. _____ I sweat occasionally.

_____ I sweat only when I exercise rigorously. _____ I sweat when I am nervous or tense.

_____ My sweat has an unpleasant odor. _____ Even when the temperature is hot, I rarely sweat.

Please complete this statement: I regularly use an _____ antiperspirant _____ deodorant _____ none

Do you ever have any unusual or unexplained swelling, inflammation or fluid retention in your body?

_____ Yes _____ No _____ occasionally _____ premenstrual

If you answered "yes," list area (s) of swelling/inflammation/fluid retention: ___________________________________

Environmental Toxins

If you have amalgam (silver) fillings, please list the total number that you presently have in your mouth: ____________

If you have root canals in your mouth, please list the total number that you have in your mouth: _________________

Have you been exposed to radiation? _____ Yes _____ No

Have you ever been diagnosed or treated for parasites? _____ Yes _____ No

Have you visited a foreign country in the past five years? _____ Yes _____ No

Have you ever lived on a tropical island? _____ Yes _____ No

Have you ever been bitten by a deer tick? _____ Yes _____ No

Have you ever been bitten by a poisonous spider or snake? _____ Yes _____ No

Do you have a history of drug addiction? _____ Yes _____ No

Do you now or have you ever smoked? _____ Yes _____ No

Are you frequently exposed to second-hand smoke? _____ Yes _____ No

Did your mother have a history of alcohol or drug abuse during her pregnancy with you?. _____ Yes _____ No

Was your mother frequently exposed to toxic materials before and/or during her pregnancy with you, i.e. _____ Yes _____ No

Was your father frequently exposed to toxic materials prior to your conception/birth. _____ Yes _____ No

Are you frequently exposed to toxic or poisonous materials? _____ Yes _____ No

Are you frequently exposed to pesticides or herbicides? _____ Yes _____ No

Does your toothpaste contain fluoride? _____ Yes _____ No

Do you now or have you recently moved into a newly constructed home or workplace?

_____ Yes _____ No

Has new carpeting recently been installed in your home or workplace?

_____ Yes _____ No

Has your home or workplace recently been painted? _____ Yes _____ No

Has new furniture or cabinetry recently been installed into your home or workplace?

_____ Yes _____ No

What type of cooling system is used in your home environment?

_____ air conditioning _____ swamp cooler _____fans _____ other

What type of heating system is used in your home environment?

_____ electric _____ propane gas _____ natural gas _____fireplace

Is your home or work place located in close proximity to excessive air, water or environmental pollution?

_____ Yes _____ No

Are pesticides frequently sprayed or applied in your home or work environment?

_____ Yes _____ No

Do you reside in a home, attend school or work in a building that is located in close proximity to high-intensity power lines?

_____ Yes _____ No

Do you reside in a home, attend school or work in a building that is located in close proximity to a cellular phone or radio tower?

_____ Yes _____ No

Does your occupation involve frequent exposure to devices or equipment that emits electromagnetic frequencies (EMF's), i.e. radar, electrical devices?

_____ Yes _____ No

Does your work involve using a desktop computer daily? _____ Yes _____ No

If you answered "yes," how many hours do you use a computer daily?

_____ 0-1 hour _____ 2-4 hours _____ 5-8 hours _____> 8 hours

Do you frequently use a cellular phone? _____ Yes _____ No

Are you frequently exposed to florescent lighting in your home, school or workplace? _____ Yes _____ No

Does your work/personal life involve frequent airline travel? _____ Yes _____ No

Are you frequently exposed to ill people, i.e. teacher, day care worker, health care worker?

_____ Yes _____ No

What is your occupation? ____

Yeast/Fungal

Check any of the following that you are presently experiencing:

_____ indigestion after eating fruits & sweets

_____ chronic sinus problems

_____ frequent antibiotic usage

_____ feeling of being in a mental fog

_____ constipation/chronic diarrhea

_____ vaginal discharge

_____ recurrent urinary tract infections

_____ bloating after meals

_____ itchy skin/scalp

_____ craving for sweets

_____ history of eczema/psoriasis/dandruff

_____ consume large amounts of “natural sugars”

_____ rectal/vaginal burning or itching

_____ allergy/sensitivity to fermented & moldy foods

Heavy Metals

Check any of the following that you are presently experiencing:

_____ metallic taste in mouth

_____ chronic headaches

_____ bad breath/halitosis

_____ swollen tongue

_____ behavioral changes (anxiety, depression)

_____ frequent ingestion of seafood

_____ digestive problems

_____ Multiple Sclerosis

_____ loose teeth

_____ pain in joints/arthritis

_____ mouth ulcers

_____ unexplained skin rashes

_____ frequent exposure to fertilizers

_____ neurological changes (tremors, twitching)

_____ bone loss around teeth

_____ autoimmune disease

_____ frequent exposure to lead-based paints, solvents & chemicals

Viral

Check any of the following that you are presently experiencing:

_____ frequent viral infections

_____ recurrent warts

_____ history of mononucleosis

_____ history of infectious hepatitis

_____ frequent muscular aching/chills

_____ history of shingles (Herpes Zoster)

_____ recurrent canker sores

_____ history of polio

_____ Herpes Simplex I or Genital Herpes

_____ frequent colds/flu's

_____ frequent exposure to ill individuals

_____ history of tonsillitis/croup

Bacterial

Check any of the following that you are presently experiencing:

_____ frequent bacterial infections

_____ dental abscess

_____ history of staph or strep infections

_____ sinus discomfort or facial bone pain

_____ frequent ear infections

_____ chronic sinusitis

_____ frequent exposure to ill individuals

_____ frequent discolored mucous/nasal secretions

_____ unusual skin rash/eczema

_____ history of tuberculosis

Thyroid

Check any of the following that you are presently experiencing:

_____ cold hands and feet

_____ fatigue

_____ slow or slurred speech

_____ frequently constipated

_____ low libido

_____ low body temperature

_____ swelling of hands/face

_____ dry/brittle hair

_____ tired in AM & energetic in PM

_____ bloating/indigestion after eating

_____ muscle cramps, especially at night

_____ hair loss

_____ PMS or menstrual difficulties

_____ cracks in the bottom of your heels

Adrenal

Check any of the following that you are presently experiencing:

_____ craving for salt/sweets

_____ headaches/migraines

_____ frequent hives/rashes

_____ panic attacks

_____ intolerance to hot, humid weather

_____ stress-filled lifestyle

_____ clench/grind teeth at night

_____ tendency to gain weight in waist ("love handles")

_____ constant or chronic fatigue

_____ low blood pressure

_____ chronic back pain

_____ nervousness

_____ muscular weakness

_____ extreme sensitivity to odors/noise

_____ blood sugar disturbances