**Intake Form**

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will also assist us to formulate a treatment plan.

**Please fill out all questions thoroughly. Please Circle or mark “X” next to the YES/NO questions. If a question does not apply, please fill in the space with “No” or “None.” Thank you.**

Date:

**PERSONAL INFORMATION**

Last Name: First Name: MI

DOB: Age: Ethnicity:

Address: City:

State: ZIP:

Primary Phone #: Alternate Phone #:

Email Address:

Occupation: SSN#

Marital Status: Spouse’s Name: Phone #:

Emergency Contact: Relation: Phone #:

How did you hear about this office?

Primary Physician Physician Phone #

|  |  |  |  |
| --- | --- | --- | --- |
| **Describe Problem** | **Mild/Moderate/Severe** | **Treatment Approach** | **Success?** |
| Ex: postnasal drip | Moderate | Elimination Diet | Moderate |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |
| 5. |  |  |  |
| 6. |  |  |  |

Take a minute to imagine what good health means to you. What would it look like if all the health concerns you currently have been successfully solved? What would you be able to do? How would you feel? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you believe is your greatest challenge in reaching your goals? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

And finally, what do you think you need to do in order for you vision of health to happen? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)

Example: Wendy, age 7, sister

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any pets or farm animals? If yes, do they live indoors or outdoors?

\_\_\_\_\_\_\_\_\_\_\_

Have you lived or travelled outside the United States?

Have you or your family experienced any major life changes? If yes, please comment.

Have you experienced any major losses in life? If yes, please comment.

How important is religion (or spirituality) for you and your family’s life?

a. \_\_\_\_\_ not at all important

b. \_\_\_\_\_ somewhat important

c. \_\_\_\_\_ extremely important

How much time have you lost from work or school in the past year?

a. \_\_\_\_\_ 0-2 days

b. \_\_\_\_\_ 3 –14 days

c. \_\_\_\_\_ > 15 days

Previous Jobs

Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to

chronic stress, illness, and immune system dysfunction; witnessing violence and abuse can also be very

traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your

life, it is very important that you feel safe telling us about it, so that we can support you and optimize your

treatment outcomes.

**Please do your best to answer the following questions:**

a. Did you feel safe growing up?

\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_No

b. Have you been involved in abusive relationships in your life?

\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_No

c. Was alcoholism or substance abuse present in your childhood home, or is it present now in your

relationships?

\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_No

d. Do you currently feel safe in your home?

\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_No

e. Do you feel safe, respected and valued in your current relationship?

\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_No

f. Have you had any violent or otherwise traumatic life experiences, or have you witnessed any violence

or abuse?

\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_No

g. Would you feel safer discussing any of these issues privately?

\_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_No

**Past Medical and Surgical History:**

|  |  |  |
| --- | --- | --- |
| **ILLNESSES** | **WHEN** | **COMMENTS** |
| a. Anemia |  |  |
| b. Arthritis |  |  |
| c. Asthma |  |  |
| d. Bronchitis |  |  |
| e. Cancer |  |  |
| f. Chronic Fatigue Syndrome |  |  |
| g. Crohn’s Disease or Ulcerative Colitis |  |  |
| h. Diabetes |  |  |
| i. Emphysema |  |  |
| j. Epilepsy, convulsions, or seizures |  |  |
| k. Gallstones |  |  |
| l. Gout |  |  |
| **ILLNESSES** | **WHEN** | **COMMENTS** |
| m. Heart attack/Angina |  |  |
| n. Heart failure |  |  |
| o. Hepatitis |  |  |
| p. High blood fats (cholesterol, triglycerides) |  |  |
| q. High blood pressure (hypertension) |  |  |
| r. Irritable bowel |  |  |
| s. Kidney stones |  |  |
| t. Mononucleosis |  |  |
| u. Pneumonia |  |  |
| v. Rheumatic fever |  |  |
| w. Sinusitis |  |  |
| x. Sleep apnea |  |  |
| y. Stroke |  |  |
| z. Thyroid disease |  |  |
| aa. | Other (describe) |  |  |
| **INJURIES** | **WHEN** | **COMMENTS** |
| ab. | Back injury |  |  |
| ac. | Broken (describe) |  |  |

Head injury

|  |  |  |
| --- | --- | --- |
| ae. Neck injury |  |  |
| af. Other (describe) |  |  |
| **DIAGNOSTIC STUDIES** | **WHEN** | **COMMENTS** |
| ag. Barium Enema |  |  |
| ah. Bone Scan |  |  |
| ai. CAT Scan of Abdomen |  |  |
| aj. CAT Scan of Brain |  |  |
| ak. CAT Scan of Spine |  |  |
| al. Chest X-ray |  |  |
| am. Colonoscopy |  |  |
| an. EKG |  |  |
| ao. Liver scan |  |  |
| ap. Neck X-ray |  |  |
| aq. NMR/MRI |  |  |
| ar. Sigmoidoscopy |  |  |
| as. Upper GI Series |  |  |
| at. Other (describe) |  |  |

|  |  |  |
| --- | --- | --- |
| **OPERATIONS** | **WHEN** | **COMMENTS** |
| au. Appendectomy |  |  |
| av. Dental Surgery |  |  |
| aw. Gall Bladder |  |  |
| ax. Hernia |  |  |
| ay. Hysterectomy |  |  |
| az. Tonsillectomy |  |  |
| ba. Other (describe) |  |  |
| bb. Other (describe) |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **HOSPITALIZATIONS** | **WHEN** | **FOR WHAT REASON** | **OUTCOME** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |  |  |
| --- | --- | --- |
| **HAVE YOU TAKEN ANTIBIOTICS?** | **<5 Times** | **>5 Times** |
| Infancy |  |  |
| Teen |  |  |
| Adulthood |  |  |

|  |  |  |
| --- | --- | --- |
| **ARE YOU TAKING ANY MEDICATIONS?** | **Date Started** | **Dosage** |
| 1. |  |  |
| 2. |  |  |
| 3.  |  |  |
| 4. |  |  |
| 5. |  |  |
| 6. |  |  |
| 7. |  |  |

Are you allergic to any medications? If yes, please list:

|  |  |  |
| --- | --- | --- |
| **ARE YOU TAKING ANY SUPPLEMENTS?** | **Date Started** | **Dosage** |
| 1. |  |  |
| 2. |  |  |
| 3.  |  |  |
| 4. |  |  |
| 5. |  |  |
| 6. |  |  |
| 7. |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Question | Yes | No | Unsure | Comment |
| Were you a full term baby? |  |  |  |  |
| Were you breast fed? |  |  |  |  |
| Were you bottle fed? |  |  |  |  |
| As a child, did you eat a lot of sugar/candy? |  |  |  |  |

As a child, were there any foods that gave you symptoms? (Ex: milk- diarrhea and gas):

**Please mark next to the food/drink that applies to your current eating habits.**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Usual Breakfast** | Yes |  | **Usual Lunch** | Yes |  | **Usual Dinner** | Yes |
| a. | None |  | a. | None |  | a. | None |  |
| b. | Bacon/Sausage |  | b. | Butter |  | b. | Beans (legumes) |  |
| c. | Bagel |  | c. | Coffee |  | c. | Brown rice |  |
| d. | Butter |  | d. | Eat in a cafeteria |  | d. | Butter |  |
| e. | Cereal |  | e. | Eat in restaurant |  | e. | Carrots |  |
| f. | Coffee |  | f. | Fish sandwich |  | f. | Coffee |  |
| g. | Donut |  | g. | Juice |  | g. | Fish |  |
| h. | Eggs |  | h. | Leftovers |  | h. | Green vegetables |  |
| i. | Fruit |  | i. | Lettuce |  | i. | Juice |  |
| j. | Juice |  | j. | Margarine |  | j. | Margarine |  |
| k. | Margarine |  | k. | Mayo |  | k. | Milk |  |
| l. | Milk |  | l. | Meat sandwich |  | l. | Pasta |  |
| m. | Oat bran |  | m. | Milk |  | m. | Potato |  |
| n. | Sugar |  | n. | Salad |  | n. | Poultry |  |
| o. | Sweet roll |  | o. | Salad dressing |  | o. | Red meat |  |
| p. | Sweetener |  | p. | Soda |  | p. | Rice |  |
| q. | Tea |  | q. | Soup |  | q. | Salad |  |
| r. | Toast |  | r. | Sugar |  | r. | Salad dressing |  |
| s. | Water |  | s. | Sweetener |  | s. | Soda |  |
| t. | Wheat bran |  | t. | Tea |  | t. | Sugar |  |
| u. | Yogurt |  | u. | Tomato |  | u. | Sweetener |  |
| v. | Other: (List below) |  | v. | Water |  | v. | Tea |  |
|  |  |  | w. | Yogurt |  | w. | Water |  |
|  |  |  | x. | Other: (List below) |  | x. | Yellow vegetables |  |
|  |  |  |  |  |  | y. | Other: (List below) |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |

**How much of the following do you consume each week?**

|  |  |
| --- | --- |
| Candy |  |
| Cheese |  |
| Chocolate |  |
| Cups of coffee (caffeinated) |  |
| Decaf coffee or tea |  |
| Cups of hot chocolate |  |
| Caffeinated teas |  |
| Diet sodas |  |
| Ice cream |  |
| Salty foods |  |
| Takeout/ dining out |  |
| White bread, rolls, or bagels |  |
| Caffeinated sodas (energy drinks) |  |
| Non-caffeinated sodas |  |

Are you on a special diet? \_\_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_\_No

 \_\_ ovo-lacto \_\_\_\_\_\_\_\_\_\_vegetarian \_\_\_\_\_\_\_\_\_other (describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_ diabetic \_\_\_\_\_\_\_\_\_\_vegan

 \_\_ dairy restricted \_\_\_\_\_\_\_\_\_\_\_\_blood type diet

Is there anything special about your diet that we should know? \_\_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_No

Do you have symptoms *immediately after* eating (bloating, belching, sneezing, hives, etc)? \_\_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_No

If yes, are they associated with a specific symptom associated with the food/supplement, and explain further:

Do you feel you have delayed symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? \_\_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_\_ No

Do you feel worse when you eat a lot of:

 \_\_\_\_\_\_\_\_\_ High fat foods \_\_\_\_\_\_\_\_\_\_ High protein foods \_\_\_\_\_\_\_\_\_ High carbohydrate foods (bread, pasta, etc)

\_\_\_\_\_\_\_\_\_ Refined sugars \_\_\_\_\_\_\_\_\_\_ Fried foods \_\_\_\_\_\_\_\_\_1-2 alcoholic drinks

\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does skipping a meal greatly affect your symptoms \_\_\_\_\_\_\_\_Yes \_\_\_\_\_\_\_\_No

If yes, please explain:

­

Have you ever had a food that you craved or really "binged" on over a period of time? \_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_ No

***Food craving may be an indicator that you may be allergic to that food.***

If yes, what food(s)?

Do you have an aversion to certain foods? \_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_ No

If yes, what foods?

Please fill in the chart below with information about your bowel movements:

|  |  |  |  |
| --- | --- | --- | --- |
| **a. Frequency** | **Yes** | **b. Color** | **Yes** |
| More than 3x/day |  | Medium brown consistently |  |
| 1-3x/day |  | Very dark or black |  |
| 4-6x/week |  | Greenish color |  |
| 2-3x/week |  | Blood is visible. |  |
| 1 or fewer x/week |  | Varies a lot. |  |
|  |  | Dark brown consistently |  |
| **b. Consistency** |  | Yellow, light brown |  |
| Soft and well formed |  | Greasy, shiny appearance |  |
| Often float |  |  |  |
| Difficult to pass |  |  |  |
| Thin, long, and narrow |  |  |  |
| Small and hard |  |  |  |
| Alternating between hard and loose or watery |  |  |  |

Do you have intestinal gas? \_\_\_\_\_\_\_\_ Daily \_\_\_\_\_\_\_\_ Occasionally \_\_\_\_\_\_\_\_\_\_ Excessively

Does it… \_\_\_\_\_\_\_\_ Present with pain \_\_\_\_\_\_\_\_\_ Smell foul \_\_\_\_\_\_\_\_\_ Has little or no odor

|  |  |
| --- | --- |
| **Do you drink alcohol?**  | **Check the box that applies** |
| Never used alcohol |  |
| No longer drink alcohol |  |
| Average 1-3 drinks per week |  |
| Average 4-6 drinks per week |  |
| Average 7-10 drinks per week |  |
| >10 drinks per week |  |

Have you ever had a problem with alcohol? \_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_ No

If yes, please indicate the time period:

Have you ever used recreational drugs? \_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_ No

Have you ever used tobacco? \_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_ No

If yes, how many years have you been a nicotine user? Amount per day?

Have you quit? If yes, what year did you quit?

What type of nicotine have you used (cigarette, cigar, pipe, smokeless, vaping)?

Are you regularly exposed to second-hand smoke?

Do you have any mercury amalgam fillings? If yes, how many?

Do you have any artificial joints or implants (Ex: screws, plates, etc)? If yes, please elaborate:

Are you sensitive to certain odors? If yes, please explain:

Do you feel worse at certain times of the year (Spring, Summer, Fall, Winter)?

To your knowledge, are you exposed to any toxic metals at work or at home (lead, mercury, cadmium, aluminum, arsenic)?

Overall how well have things been going for you?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Very Well** | **Fairly** | **Poorly** | **Very Poorly** | **N/A** |
| At school |  |  |  |  |  |
| At work |  |  |  |  |  |
| In your social life |  |  |  |  |  |
| With sex |  |  |  |  |  |
| With your attitude |  |  |  |  |  |
| With your boyfriend/ girlfriend/ spouse |  |  |  |  |  |
| With your children |  |  |  |  |  |
| With your parents |  |  |  |  |  |

Have you ever had psychotherapy? If yes, please explain (include time, what kind, and if this treatment is ongoing):

Are you married?

Have you ever been married?

Are you divorced/separated? If yes, when:

Did you remarry?

Comments:

Please explain any hobbies or leisure activities you enjoy:

How many days per week do you exercise?

How long are your exercise sessions?

What type of exercise do you enjoy?

**FAMILY MEDICAL HISTORY**

To the best of your knowledge, has your mother, father, siblings, or grandparents ever had any of the following conditions? If so, list who and the age of onset.

High cholesterol Anxiety/Panic Attacks

Arthritis Ulcerative Colitis

Alcoholism Obesity

Thyroid Disease Asthma

Heart Disease Crohn’s Disease

Kidney Disease Hypertension

Osteoporosis Eczema

Stroke Autoimmune Disease

Cancer Mental Illness

Allergies Depression

Alzheimer’s Diabetes

Other:

**Comprehensive Health Questionnaire**

***(Adapted from Campbell Care)***

Please circle the appropriate number on all questions below.

0 = never. 1 = 1x/month or less. 2 = few times/month. 3 = few times/week. 4 = most days. 5 = always/every day

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | 0 | 1 | 2 | 3 | 4 | 5 |
| ***Digestive Problems*** |  |  |  |  |  |  |
| Bad breath  |  |  |  |  |  |  |
| Coated tongue  |  |  |  |  |  |  |
| Constipation/Incomplete emptying feeling  |  |  |  |  |  |  |
| Bloating  |  |  |  |  |  |  |
| Diarrhea/watery/loose stool  |  |  |  |  |  |  |
| Loss of appetite for meat/high-protein foods  |  |  |  |  |  |  |
| Eating relieves an acid stomach  |  |  |  |  |  |  |
| Gas after eating  |  |  |  |  |  |  |
| Indigestion 30min-1 hour after eating  |  |  |  |  |  |  |
| Difficulty digesting fruits & vegetables; undigested food in stool |  |  |  |  |  |  |
| Acid or spicy foods upset stomach  |  |  |  |  |  |  |
| Burning stomach sensation, eating helps |  |  |  |  |  |  |
| Knee pain on the front of the knee/Jumper’s Knee/Patellar tendon syndrome/Osgood-Schlatter’s Disease |  |  |  |  |  |  |
| ***Total score:*** |  |  |  |  |  |  |
| Key: 0-13=not likely an issue. 14-26=minor issue. 27-39=moderate issue. 40-65=major issue. |  |  |  |  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ***Liver/Gallbladder*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| Lower bowel gas and/or bloating several hours after eating  |  |  |  |  |  |  |
| Feet or hands burning  |  |  |  |  |  |  |
| Whites of eyes (sclera) yellow  |  |  |  |  |  |  |
| Dry skin; itchy skin; skin peels on feet/heels  |  |  |  |  |  |  |
| Brown spots or bronzing of skin |  |  |  |  |  |  |
| Bitter or metallic taste in mouth  |  |  |  |  |  |  |
| Dizziness |  |  |  |  |  |  |
| Blurred vision |  |  |  |  |  |  |
| Poor Memory |  |  |  |  |  |  |
| Headache in the eyes or temples |  |  |  |  |  |  |
| Feel nauseous, get queasy and/or gag easily |  |  |  |  |  |  |
| Color of stools light brown or yellow |  |  |  |  |  |  |
| Greasy or high-fat foods cause distress/upset |  |  |  |  |  |  |
| Pain/discomfort between shoulder blades |  |  |  |  |  |  |
| Dark circles under eyes |  |  |  |  |  |  |
| Nightmares/bad dreams |  |  |  |  |  |  |
| Bad/Acid breath (Halitosis) |  |  |  |  |  |  |
| Milk products cause upset |  |  |  |  |  |  |
| Sensitive to hot weather |  |  |  |  |  |  |
| Burning or itching anus |  |  |  |  |  |  |
| Crave Sweets |  |  |  |  |  |  |
| History of gallbladder attacks or gallbladder removed |  |  |  |  |  |  |
| Appetite reduced |  |  |  |  |  |  |
| Tendonitis, shoulder/rotator cuff issues, bursitis, arthritis |  |  |  |  |  |  |
| Aches/Pains |  |  |  |  |  |  |
| Ringing in ears (tinnitus) |  |  |  |  |  |  |
| Vertigo |  |  |  |  |  |  |
| Knee pain on the outside of the knee |  |  |  |  |  |  |
| Varicose Veins |  |  |  |  |  |  |
| Hemorrhoids |  |  |  |  |  |  |
| ***Total score:***  |  |  |  |  |  |  |
| Key: 0-30=not likely an issue. 31-60=minor issue. 61-90=moderate issue. 90-150=major issue |  |  |  |  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Large Intestine** | **0** | 1 | 2 | 3 | 4 | 5 |
| Coated tongue or fuzzy debris on tongue |  |  |  |  |  |  |
| Pass large amounts of foul-smelling gas |  |  |  |  |  |  |
| Diagnosis of Irritable bowel syndrome/Diverticulitis/Colitis/ Ulcerative Colitis/Crohn’s/Celiac |  |  |  |  |  |  |
| Alternating constipation and diarrhea |  |  |  |  |  |  |
| Bowel movements painful or difficult; constipation |  |  |  |  |  |  |
| Burning or itching anus |  |  |  |  |  |  |
| Allergies |  |  |  |  |  |  |
| Head congestion/sinus fullness |  |  |  |  |  |  |
| Sneezing attacks |  |  |  |  |  |  |
| Nightmares and bad dreams |  |  |  |  |  |  |
| Milk products and/or wheat products cause distress |  |  |  |  |  |  |
| Eyes and nose watery |  |  |  |  |  |  |
| Eyes swollen and puffy |  |  |  |  |  |  |
| Pulse speeds after meals and/or heart pounds after retiring |  |  |  |  |  |  |
| ***Total score:***  |  |  |  |  |  |  |
| Key: 0-14=not likely an issue. 15-28=minor issue. 29-42=moderate issue. 43-70=major issue. |  |  |  |  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ***Immune System*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| Chronic or recurrent infections |  |  |  |  |  |  |
| Constant lung congestion |  |  |  |  |  |  |
| Heal slowly from infections |  |  |  |  |  |  |
| Allergies since birth |  |  |  |  |  |  |
| Autoimmune disease (rheumatoid arthritis, MS, etc.) |  |  |  |  |  |  |
| Chronic fatigue syndrome and/or fibromyalgia syndrome |  |  |  |  |  |  |
| Not breastfed for over 6 months |  |  |  |  |  |  |
| ***Total score:***  |  |  |  |  |  |  |
| Key: 0-7=not likely an issue. 8-14=minor issue. 9-21=moderate issue. 22-35=major issue. |  |  |  |  |  |  |

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| ***Sinuses*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| Chest congestion |  |  |  |  |  |  |
| Shortness of breath |  |  |  |  |  |  |
| Difficulty breathing |  |  |  |  |  |  |
| Acne |  |  |  |  |  |  |
| Neck or head rashes, hives, or dry skin |  |  |  |  |  |  |
| Watery, itchy eyes |  |  |  |  |  |  |
| Sinus congestion/mucus |  |  |  |  |  |  |
| Drippy sinuses/Post Nasal Drip |  |  |  |  |  |  |
| Sore throat |  |  |  |  |  |  |
| Dizziness/vertigo |  |  |  |  |  |  |
| Sinus pain |  |  |  |  |  |  |
| Sinus infections |  |  |  |  |  |  |
| Swollen/red eyes |  |  |  |  |  |  |
| Bags or dark circles under eyes |  |  |  |  |  |  |
| Frequent need to clear throat |  |  |  |  |  |  |
| Lump/pit/sensation/feeling in throat |  |  |  |  |  |  |
| Seasonal allergies/hay fever |  |  |  |  |  |  |
| Excessive nasal, throat, or lung mucus |  |  |  |  |  |  |
| Ear aches or infections |  |  |  |  |  |  |
| Ear drainage/wetness |  |  |  |  |  |  |
| Ringing in the ears (tinnitus) |  |  |  |  |  |  |
| Toothaches/pain |  |  |  |  |  |  |
| Red or burning ears |  |  |  |  |  |  |
| ***Total score:***  |  |  |  |  |  |  |
| Key: 0-23=not likely an issue. 24-46=minor issue. 47-69=moderate issue. 70-115=major issue. |  |  |  |  |  |  |

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| ***Blood Sugar/Candida*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| Crave sugar, sodas, coffee, or caffeine in mid-morning/ early afternoon |  |  |  |  |  |  |
|  Hungry between meals |  |  |  |  |  |  |
| Irritable if not eating/irritable before meals |  |  |  |  |  |  |
| Large/Excessive appetite |  |  |  |  |  |  |
| Eating sweets upsets/calms |  |  |  |  |  |  |
| Eat compulsively when nervous, anxious, or stressed |  |  |  |  |  |  |
| Irritable before meals (“Hangry”) |  |  |  |  |  |  |
| Shaky, weak, irritable, or light-headed between meals |  |  |  |  |  |  |
| Fatigue; eating relieves |  |  |  |  |  |  |
| Anus/butt/thighs itch |  |  |  |  |  |  |
| Coated tongue |  |  |  |  |  |  |
| ***Total score:***  |  |  |  |  |  |  |
| Key: 0-11=not likely an issue. 12-22=minor issue. 23-33=moderate issue. 34-55=major issue |  |  |  |  |  |  |

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| ***Fungus/Yeast Infections*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| Mucus in stool |  |  |  |  |  |  |
| Foul smelling bowel movements |  |  |  |  |  |  |
| Lower abdominal cramping |  |  |  |  |  |  |
| Dark Circles under eyes |  |  |  |  |  |  |
| Painful to press along outside of thighs (Iliotibial band) |  |  |  |  |  |  |
| Ringworm skin infection/Jock itch/athlete’s foot/nail fungus |  |  |  |  |  |  |
| History of parasites |  |  |  |  |  |  |
| Feel worse in moldy/musty places |  |  |  |  |  |  |
| Heart palpitates if meals are missed/delayed |  |  |  |  |  |  |
| Wake at night; hard to get back to sleep |  |  |  |  |  |  |
| Frequent unrealistic fears or worries |  |  |  |  |  |  |
| Often have to eat in the middle of the night |  |  |  |  |  |  |
| Often hard to concentrate or have trouble remembering things |  |  |  |  |  |  |
| Become anxious without reason |  |  |  |  |  |  |
| Excessively weak for no apparent reason |  |  |  |  |  |  |
| Often moody or depressed |  |  |  |  |  |  |
| Frequently feel drowsy |  |  |  |  |  |  |
| Difficulty making decisions |  |  |  |  |  |  |
| Often have blurred vision |  |  |  |  |  |  |
| Feel you lack sex drive |  |  |  |  |  |  |
| Often have muscle twitching or jerking |  |  |  |  |  |  |
| Feel better after eating |  |  |  |  |  |  |
| Get sleepy/drowsy after lunch |  |  |  |  |  |  |
| Taken an antibiotic for 0-6 or more times |  |  |  |  |  |  |
| ***Total score:***  |  |  |  |  |  |  |
| Key: 0-24=not likely an issue. 25-48=minor issue. 49-72=moderate issue. 73-120=major issue. |  |  |  |  |  |  |

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| ***B Vitamin Deficiency*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| Enlarged heart and/or heart failure |  |  |  |  |  |  |
| Pulse slow (below 65) or irregular pulse |  |  |  |  |  |  |
| Low blood pressure |  |  |  |  |  |  |
| Varicose veins (spider veins) and/or hemorrhoids |  |  |  |  |  |  |
| Slow reflexes |  |  |  |  |  |  |
| Irregular heart beat |  |  |  |  |  |  |
| Worry, anxiety, insecurity, or highly emotional state |  |  |  |  |  |  |
| Sensitive to noises and/or smells |  |  |  |  |  |  |
| Have trouble with concentration (foggy-headed) |  |  |  |  |  |  |
| Weak digestion (gas, bloating, indigestion) |  |  |  |  |  |  |
| Feel drowsy after eating |  |  |  |  |  |  |
| Sore and achy muscles after little exercise |  |  |  |  |  |  |
| Constantly fatigued |  |  |  |  |  |  |
| Wake up at night to urinate |  |  |  |  |  |  |
| Wake up at night and can’t get back to sleep |  |  |  |  |  |  |
| Back pain when in one position (i.e., in bed at night) |  |  |  |  |  |  |
| Headband-like headache (like a tight band around head) |  |  |  |  |  |  |
| Itchy skin |  |  |  |  |  |  |
| Sensitive to insect bites |  |  |  |  |  |  |
| Shortness of breath (can’t hold breath very long) |  |  |  |  |  |  |
| No stamina (get winded easily) |  |  |  |  |  |  |
| Frequently yawn |  |  |  |  |  |  |
| Low body temperature |  |  |  |  |  |  |
| Muscles feel weak (body feels heavy) |  |  |  |  |  |  |
| ***Total score:***  |  |  |  |  |  |  |
| Key: 0-24=not likely an issue. 25-48=minor issue. 49-72=moderate issue. 73-120=major issue. |  |  |  |  |  |  |

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| ***Riboflavin Deficiency*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| High blood pressure |  |  |  |  |  |  |
| Fast heart rate (pulse) |  |  |  |  |  |  |
| Muscles feel tense & tight |  |  |  |  |  |  |
| Worry excessively (mind races) |  |  |  |  |  |  |
| Always tense can’t relax |  |  |  |  |  |  |
| Tend to be suspicious by nature |  |  |  |  |  |  |
| Moody |  |  |  |  |  |  |
| Depressed |  |  |  |  |  |  |
| Tend to have cold hands & feet |  |  |  |  |  |  |
| Weak digestion (gas, bloating, indigestion) |  |  |  |  |  |  |
| Muscles restless always moving |  |  |  |  |  |  |
| Body jerks when falling asleep |  |  |  |  |  |  |
| Aware of muscle twitching |  |  |  |  |  |  |
|  tight; not flexible |  |  |  |  |  |  |
| Trouble digesting fats (indigestion after eating fatty foods) |  |  |  |  |  |  |
| Can hear heartbeat in ears (especially lying in bed at night) |  |  |  |  |  |  |
| Cracking at the corners of mouth (cheilosis) |  |  |  |  |  |  |
| Friable, easily irritated skin (especially after shaving) |  |  |  |  |  |  |
| Red, irritated tongue (sometimes purple color to tongue) |  |  |  |  |  |  |
| Irritated mucous membranes (sinus, lungs, rectum, etc.) |  |  |  |  |  |  |
| Loss of upper lip (thin upper lip) |  |  |  |  |  |  |
| Burning or itching of eyes |  |  |  |  |  |  |
| Bloodshot eyes |  |  |  |  |  |  |
| Eyes sensitive to light (photophobia) |  |  |  |  |  |  |
| See only part of printed words (like looking through a fishbowl) |  |  |  |  |  |  |
| ***Total score:***  |  |  |  |  |  |  |
| Key: 0-25=not likely an issue. 26-50=minor issue. 51-75=moderate issue. 76-125=major issue. |  |  |  |  |  |  |

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| ***Fatty Acid Deficiency*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| Joint or muscle pain |  |  |  |  |  |  |
| Glaucoma |  |  |  |  |  |  |
| Autoimmune disease (of any kind) |  |  |  |  |  |  |
| Cold-sensitive; always feel cold |  |  |  |  |  |  |
| Chronic headaches |  |  |  |  |  |  |
| Paresthesia (abnormal sensations in body) or neuralgia |  |  |  |  |  |  |
| Muscle cramping |  |  |  |  |  |  |
| Abrupt changes in visual acuity |  |  |  |  |  |  |
| Popping or cracking in ears or tinnitus |  |  |  |  |  |  |
| Problems swallowing |  |  |  |  |  |  |
| Bumps on the back of the arms |  |  |  |  |  |  |
| Depression and/or anxiety |  |  |  |  |  |  |
| Learning disabilities (ADD, ADHD, etc.) |  |  |  |  |  |  |
| Epilepsy or narcolepsy |  |  |  |  |  |  |
| Poor memory |  |  |  |  |  |  |
| Dry or scaling skin (elbows, knees, forearms, shins) |  |  |  |  |  |  |
| Phrynoderma (roughness of upper arms, thighs, buttocks) |  |  |  |  |  |  |
| Dandruff or flaking skin, in general |  |  |  |  |  |  |
| Psoriasis or eczema |  |  |  |  |  |  |
| Dyspigmentation (aging spots, vitiligo) |  |  |  |  |  |  |
| Dry or brittle hair |  |  |  |  |  |  |
| Acne |  |  |  |  |  |  |
| ***Total score:***  |  |  |  |  |  |  |
| Key: 0-22=not likely an issue. 23-44=minor issue. 45-66=moderate issue. 67-110=major issue |  |  |  |  |  |  |

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| ***High Autonomic Nervous System Function*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| High blood pressure |  |  |  |  |  |  |
| Acid Foods upset/sour stomach |  |  |  |  |  |  |
| “Lump” in throat |  |  |  |  |  |  |
| Fast heart rate (pulse) |  |  |  |  |  |  |
| Hard time being/feeling calm |  |  |  |  |  |  |
| Gag occasionally |  |  |  |  |  |  |
| Dilated pupils |  |  |  |  |  |  |
| Tend toward dry mouth/eyes (may have difficulty swallowing) |  |  |  |  |  |  |
| Cold, clammy hands and feet |  |  |  |  |  |  |
| Cold sweats |  |  |  |  |  |  |
| Get overheated easily |  |  |  |  |  |  |
| Staring, rarely blinking |  |  |  |  |  |  |
| Excess muscle tension |  |  |  |  |  |  |
| Quick reflexes |  |  |  |  |  |  |
| Anxious, mind races, and can’t relax/fall asleep |  |  |  |  |  |  |
| Sensitivity to loud noises/music/yelling (or easily startled) |  |  |  |  |  |  |
|  Strong light irritates/need to wear sunglasses outdoors |  |  |  |  |  |  |
| Excessive sweating |  |  |  |  |  |  |
| Lots of energy, but poor stamina or nervous exhaustion |  |  |  |  |  |  |
| Tendency toward constipation |  |  |  |  |  |  |
| Feel like food sits in stomach; queasiness or nausea |  |  |  |  |  |  |
| Tendency toward a strong body odor |  |  |  |  |  |  |
| Women: Difficult to become sexually aroused |  |  |  |  |  |  |
| Men: Difficulty getting an erection or weak erections |  |  |  |  |  |  |
| ***Total score:***  |  |  |  |  |  |  |
| Key: 0-23=not likely an issue. 24-46=minor issue. 47-69=moderate issue. 70-115=major issue. |  |  |  |  |  |  |

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| ***Low Autonomic Nervous System Function*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| Low blood pressure |  |  |  |  |  |  |
| Slow heart rate (pulse) |  |  |  |  |  |  |
| Joint stiffness after arising in the morning |  |  |  |  |  |  |
| Cramps at night |  |  |  |  |  |  |
| Eyes or nose watery |  |  |  |  |  |  |
| Swollen, puffy eyelids |  |  |  |  |  |  |
| Indigestion soon after meals |  |  |  |  |  |  |
| Always seem hungry, feel “lightheaded” often |  |  |  |  |  |  |
| Rapid digestion/Bowel transit time |  |  |  |  |  |  |
| Vomit occasionally |  |  |  |  |  |  |
| Frequent hoarseness |  |  |  |  |  |  |
| Uneven breathing |  |  |  |  |  |  |
| Difficulty swallowing |  |  |  |  |  |  |
| “Slow starter” in the morning |  |  |  |  |  |  |
| Get cold/chilled easily |  |  |  |  |  |  |
| Perspire/sweat easily |  |  |  |  |  |  |
| Constricted pupils |  |  |  |  |  |  |
| Tendency toward increased saliva |  |  |  |  |  |  |
| Warm, dry skin (warm hands and feet) |  |  |  |  |  |  |
| Family history of diabetes or low thyroid |  |  |  |  |  |  |
| Slow reflexes |  |  |  |  |  |  |
| Unmotivated or lackadaisical |  |  |  |  |  |  |
| Calm, even disposition |  |  |  |  |  |  |
| Low energy but good endurance |  |  |  |  |  |  |
| Get stiff/achy after being in one position (sleeping/sitting) |  |  |  |  |  |  |
| Tendency toward laziness or undisciplined behavior |  |  |  |  |  |  |
| Women: Strong sex drive; easily aroused |  |  |  |  |  |  |
| Men: Easily achieve strong erections; strong sex drive |  |  |  |  |  |  |
| ***Total score:***  |  |  |  |  |  |  |
| Key: 0-27=not likely an issue. 28-54=minor issue. 55-81=moderate issue. 82-135=major issue |  |  |  |  |  |  |
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| ***Over-Active Pituitary Gland*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| Increased sex drive |  |  |  |  |  |  |
| Splitting headaches |  |  |  |  |  |  |
| Failing memory with age |  |  |  |  |  |  |
| Working excessively until exhausted |  |  |  |  |  |  |
| Feeling keyed up; unable to relax |  |  |  |  |  |  |
|  Reduced tolerance for sugar |  |  |  |  |  |  |
| ***Total score:***  |  |  |  |  |  |  |
| Key: 0-6=not likely an issue. 7-12=minor issue. 13-18=moderate issue. 19-30=major issue |  |  |  |  |  |  |

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| ***Under-Active Pituitary Gland*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| Reduced or absent sex drive |  |  |  |  |  |  |
| Abnormal thirst |  |  |  |  |  |  |
| Weight gain around hips or waist |  |  |  |  |  |  |
| Tendency toward ulcers or colitis /stomach issues |  |  |  |  |  |  |
| Ability to eat lots of sugar without symptoms |  |  |  |  |  |  |
| Menstrual disorders (women) |  |  |  |  |  |  |
| Lack of menstruation (teenage girls) |  |  |  |  |  |  |
| Immune system challenges |  |  |  |  |  |  |
| ***Total score:***  |  |  |  |  |  |  |
| Key: 0-7=not likely an issue. 8-14=minor issue. 9-21=moderate issue. 22-40=major issue |  |  |  |  |  |  |

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| ***Increased Thyroid Function*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| Hard to gain weight despite large appetite |  |  |  |  |  |  |
| Heart palpitations/heart races |  |  |  |  |  |  |
| Nervous, emotional, and/or can’t work under pressure |  |  |  |  |  |  |
| Insomnia /difficulty sleeping |  |  |  |  |  |  |
| On edge/inner trembling |  |  |  |  |  |  |
| Highly emotional |  |  |  |  |  |  |
| Rosy/Red Cheeks/Flush easily |  |  |  |  |  |  |
| Thin, moist skin |  |  |  |  |  |  |
| Inward trembling |  |  |  |  |  |  |
| Night sweats |  |  |  |  |  |  |
| Fast pulse at rest |  |  |  |  |  |  |
| Intolerant of high temperatures |  |  |  |  |  |  |
| Easily flushed |  |  |  |  |  |  |
| Irritable/restless |  |  |  |  |  |  |
| ***Total score*** |  |  |  |  |  |  |
| Key: 0-14=not likely an issue. 15-28=minor issue. 29-42=moderate issue. 43-70=major issue. |  |  |  |  |  |  |

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| ***Decreased Thyroid Function*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| Take Thyroid medication/supplements |  |  |  |  |  |  |
| Difficulty losing weight |  |  |  |  |  |  |
| Decrease in appetite |  |  |  |  |  |  |
| Reduced initiative and/or mental sluggishness |  |  |  |  |  |  |
| Easily fatigued; sleepy during the day |  |  |  |  |  |  |
| Sensitive to cold, poor circulation, cold hands and feet |  |  |  |  |  |  |
| Dry or scaly skin |  |  |  |  |  |  |
| Ringing in ears or noises in head |  |  |  |  |  |  |
| Hearing impaired /sounds appear diminished |  |  |  |  |  |  |
| Constipation |  |  |  |  |  |  |
| Excessive hair loss and/or dry/coarse hair |  |  |  |  |  |  |
| Headache upon waking; wears off during day |  |  |  |  |  |  |
| Slow pulse (below 65bpm) |  |  |  |  |  |  |
| Reduced initiative/drive/motivation |  |  |  |  |  |  |
| ***Total score:***  |  |  |  |  |  |  |
| Key: 0-14=not likely an issue. 15-28=minor issue. 29-42=moderate issue. 43-70=major issue. |  |  |  |  |  |  |

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| ***High Adrenal Function*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| Elevated blood pressure |  |  |  |  |  |  |
| Headaches |  |  |  |  |  |  |
| Hot flashes |  |  |  |  |  |  |
| Moon face/swollen cheek bones |  |  |  |  |  |  |
| Hump on upper back (Buffalo Hump/Dowager’s hump) |  |  |  |  |  |  |
| Stress-induced chest pain/tightness |  |  |  |  |  |  |
| Can’t fall asleep at night/more energy at night |  |  |  |  |  |  |
| Wake up in the middle of the night |  |  |  |  |  |  |
| Joints in your body crack easily (knuckles, back, ankles, shoulders, etc.) |  |  |  |  |  |  |
| “Loose” or “Lax” ligaments, or frequent ligament injury/strains |  |  |  |  |  |  |
| Female only: Hair growth on face or body (hirsutism) |  |  |  |  |  |  |
| Female only: Masculine tendencies |  |  |  |  |  |  |
| ***Total score:***  |  |  |  |  |  |  |
| Key: 0-11=not likely an issue. 12-22=minor issue. 23-33=moderate issue. 34-60=major issue. |  |  |  |  |  |  |

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| ***Low Adrenal Function*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| Low blood pressure |  |  |  |  |  |  |
| Crave salt |  |  |  |  |  |  |
| A-fib/PVC’s/heart fluttering |  |  |  |  |  |  |
| Brain fog |  |  |  |  |  |  |
| Chronic fatigue or drowsiness |  |  |  |  |  |  |
| Eczema/Psoriasis |  |  |  |  |  |  |
| Shin Splints (anterior and/or posterior) |  |  |  |  |  |  |
| Low Back Hurts |  |  |  |  |  |  |
| Upper Back hurts |  |  |  |  |  |  |
| Knee pain on the inside of the knee |  |  |  |  |  |  |
| Knee pain on the back of the knee |  |  |  |  |  |  |
| Feet are tired/sore/hurting at the end of the day |  |  |  |  |  |  |
| Flat feet |  |  |  |  |  |  |
| Sweaty Feet |  |  |  |  |  |  |
| Varicose Veins |  |  |  |  |  |  |
| Stretch Marks |  |  |  |  |  |  |
| White or Dark skin spots/patches anywhere on the body (not birthmarks) |  |  |  |  |  |  |
| Hazy Vision/Floaters in the eyes |  |  |  |  |  |  |
| Sensitive to Lights/need to wear sunglasses outside |  |  |  |  |  |  |
| Tight Achilles/Calves/Heel Issues |  |  |  |  |  |  |
| Afternoon yawning |  |  |  |  |  |  |
| Feeling tired in the morning/slow to wake up |  |  |  |  |  |  |
| Weakness or dizziness |  |  |  |  |  |  |
| Weakness after colds or slow recovery |  |  |  |  |  |  |
| Poor circulation |  |  |  |  |  |  |
| Cold Hands/Feet |  |  |  |  |  |  |
| Bruise Easily |  |  |  |  |  |  |
| Muscular and nervous exhaustion |  |  |  |  |  |  |
| Susceptible to colds, asthma, or bronchitis |  |  |  |  |  |  |
| Allergies and/or hives, developed after age 12 |  |  |  |  |  |  |
| Difficulty holding chiropractic adjustments |  |  |  |  |  |  |
| Arthritic tendencies |  |  |  |  |  |  |
| Nails weak and/or ridged |  |  |  |  |  |  |
| Perspire easily |  |  |  |  |  |  |
| Need caffeine/coffee/tea/energy drinks to get through the day |  |  |  |  |  |  |
| Want/Take Afternoon naps |  |  |  |  |  |  |
| Afternoon headaches |  |  |  |  |  |  |
| Can’t lose weight with diet and exercise |  |  |  |  |  |  |
| IBS/stomach aches/leaky gut/digestive problems worse with stress |  |  |  |  |  |  |
| Poor handwriting |  |  |  |  |  |  |
| ***Total score:***  |  |  |  |  |  |  |
| Key: 0-40=not likely an issue. 41-80=minor issue. 81-120=moderate issue. 121-200=major issue. |  |  |  |  |  |  |

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| ***Nutrition Challenges*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| Frequent skin rashes and/or hives |  |  |  |  |  |  |
| Muscle cramping of leg or foot when at rest or sleeping |  |  |  |  |  |  |
| Fevers easily raised or frequent |  |  |  |  |  |  |
| Crave chocolate |  |  |  |  |  |  |
| Feet have bad odor |  |  |  |  |  |  |
| Frequent hoarseness |  |  |  |  |  |  |
| Difficulty swallowing |  |  |  |  |  |  |
| Joint stiffness upon arising |  |  |  |  |  |  |
| Frequent vomiting |  |  |  |  |  |  |
| Tendency to anemia |  |  |  |  |  |  |
| Whites of eyes are blue (sclera) |  |  |  |  |  |  |
| Lump in throat |  |  |  |  |  |  |
| Dryness of eyes, mouth, and/or nose |  |  |  |  |  |  |
| White spots on fingernails |  |  |  |  |  |  |
| Cuts heal slowly and/or scar easily |  |  |  |  |  |  |
| Reduced/lost sense of taste and/or smell |  |  |  |  |  |  |
| Susceptible to colds, fevers, and/or infections |  |  |  |  |  |  |
| Strong light irritates eyes |  |  |  |  |  |  |
| Noises in head or ringing in ears |  |  |  |  |  |  |
| Burning sensations in mouth/feet |  |  |  |  |  |  |
| Numbness in hands and feet |  |  |  |  |  |  |
| Intolerant to MSG |  |  |  |  |  |  |
| Cannot recall dreams |  |  |  |  |  |  |
| Frequent nosebleeds |  |  |  |  |  |  |
| Bruise easily |  |  |  |  |  |  |
| Muscle cramping; worse with exercise |  |  |  |  |  |  |
| ***Total score:***  |  |  |  |  |  |  |
| Key: 0-26=not likely an issue. 27-52=minor issue. 53-78=moderate issue. 79-130=major issue |  |  |  |  |  |  |

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| ***Heart Function*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| Aware of heavy and/or irregular breathing |  |  |  |  |  |  |
| Discomfort at high altitude |  |  |  |  |  |  |
| Cold hands/feet |  |  |  |  |  |  |
| Sigh frequently/afternoon yawner |  |  |  |  |  |  |
| Open Windows in closed room |  |  |  |  |  |  |
| Hemorrhoids |  |  |  |  |  |  |
| Tendency to anemia/low blood count/low iron |  |  |  |  |  |  |
| Ringing in ears/tinnitus |  |  |  |  |  |  |
| Get drowsy often |  |  |  |  |  |  |
| Varicose Veins |  |  |  |  |  |  |
| Swollen ankles, worse at night |  |  |  |  |  |  |
| Shortness of breath with exertion |  |  |  |  |  |  |
| Dull pain in chest or radiating into arm, worse with exertion |  |  |  |  |  |  |
| Hands and feet go to sleep easily/numbness |  |  |  |  |  |  |
| “Charley horse” or muscle cramp worse during exercise |  |  |  |  |  |  |
| Sleep Apnea/Snoring |  |  |  |  |  |  |
| Earlobe crease(s) |  |  |  |  |  |  |
| Blue Lips |  |  |  |  |  |  |
| Prostate trouble (for males) |  |  |  |  |  |  |
| ***Total score:***  |  |  |  |  |  |  |
| Key: 0-18=not likely an issue. 19-36=minor issue. 37-54=moderate issue. 55-95=major issue |  |  |  |  |  |  |

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| ***Female Hormones*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| PMS/Premenstrual tension/irritability |  |  |  |  |  |  |
| Painful menses (cramping, etc.) |  |  |  |  |  |  |
| Menstruation excessive or prolonged |  |  |  |  |  |  |
| Painful or tender breasts |  |  |  |  |  |  |
| Menstruate too frequently |  |  |  |  |  |  |
| Acne, worse at menses |  |  |  |  |  |  |
| Depressed feeling before menstruation |  |  |  |  |  |  |
| Abnormal Vaginal discharge |  |  |  |  |  |  |
| Menses scanty or missed |  |  |  |  |  |  |
| Hysterectomy or ovaries removed |  |  |  |  |  |  |
| Menopausal hot flashes |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |
| Trouble getting pregnant/infertility |  |  |  |  |  |  |
| ***Total score:***  |  |  |  |  |  |  |
| Key: 0-13=not likely an issue. 14-26=minor issue. 27-39=moderate issue. 40-65=major issue. |  |  |  |  |  |  |

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| ***Male Hormones*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| Prostate trouble |  |  |  |  |  |  |
| Urination difficult or dribbling |  |  |  |  |  |  |
| Frequent night urination |  |  |  |  |  |  |
| Pain on inside of legs or heels |  |  |  |  |  |  |
| Feeling of incomplete bowel movement |  |  |  |  |  |  |
| Leg nervousness at night |  |  |  |  |  |  |
| Tire easily; avoid activity |  |  |  |  |  |  |
| Reduced sex drive /libido |  |  |  |  |  |  |
| Depression/melancholy/ “blues” feeling |  |  |  |  |  |  |
| Migrating aches and pains |  |  |  |  |  |  |
| ***Total score:*** |  |  |  |  |  |  |
| Key: 0-10=not likely an issue. 11-20=minor issue. 21-30=moderate issue. 31-50=major issue. |  |  |  |  |  |  |

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| ***Kidney*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| Urinate Frequently/”small bladder”, liquids go right through you |  |  |  |  |  |  |
| Wake up at night to urinate |  |  |  |  |  |  |
| Low Back Pain |  |  |  |  |  |  |
| Knee Pain |  |  |  |  |  |  |
| Ankle pain |  |  |  |  |  |  |
| Foot pain |  |  |  |  |  |  |
| Born premature |  |  |  |  |  |  |
| 3rd-born child or later |  |  |  |  |  |  |
| Mother was sick during pregnancy |  |  |  |  |  |  |
| ***Total score:***  |  |  |  |  |  |  |
| Key: 0-9=not likely an issue. 10-18=minor issue. 19-27=moderate issue. 28-45=major issue. |  |  |  |  |  |  |

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| ***Brain Health / Endurance*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| Decrease in attention span |  |  |  |  |  |  |
| Mental Fatigue |  |  |  |  |  |  |
| Difficulty Learning new things |  |  |  |  |  |  |
|  Difficulty staying focused and concentrating for extended periods of time |  |  |  |  |  |  |
| Increased “senior moments” or forgetfulness |  |  |  |  |  |  |
| Fatigue when reading sooner than in the past |  |  |  |  |  |  |
| Fatigue when driving sooner than in the past |  |  |  |  |  |  |
| Need for caffeine to stay mentally alert |  |  |  |  |  |  |
| Overall brain function impacts your daily life |  |  |  |  |  |  |
| Walk into rooms and forget why |  |  |  |  |  |  |
| ***Total score:***  |  |  |  |  |  |  |
| Key: 0-10=not likely an issue. 11-20=minor issue. 21-30=moderate issue. 31-50=major issue. |  |  |  |  |  |  |

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| ***Posture/Movement*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| Twitching or tremor in your hands and/or legs when resting |  |  |  |  |  |  |
| Handwriting has gotten smaller and more crowded together |  |  |  |  |  |  |
| A loss of smell to foods |  |  |  |  |  |  |
| Difficulty sleeping/fitful sleep |  |  |  |  |  |  |
| Stiffness in shoulders and hips that goes away with movement |  |  |  |  |  |  |
| ***Total score:***  |  |  |  |  |  |  |
| Key: 0-5=not likely an issue. 6-10=minor issue. 7-15=moderate issue. 16-25=major issue. |  |  |  |  |  |  |

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| ***Memory & Cognition*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| Memory loss that impacts daily activities |  |  |  |  |  |  |
| Difficulty planning, problem solving, or working with numbers |  |  |  |  |  |  |
| Difficulty completing daily tasks |  |  |  |  |  |  |
| Confusion about dates, the passage of time, or place |  |  |  |  |  |  |
| Difficulty understanding visual images and spatial relationships (addresses and locations) or difficulty driving with directions |  |  |  |  |  |  |
| Difficulty finding words when speaking |  |  |  |  |  |  |
| Misplacement of things and inability to retrace steps |  |  |  |  |  |  |
| Poor judgment and bad decisions |  |  |  |  |  |  |
| Disinterest in hobbies, social activities, or work |  |  |  |  |  |  |
| Personality or mood changes |  |  |  |  |  |  |
| ***Total score:***  |  |  |  |  |  |  |
| Key: 0-10=not likely an issue. 11-20=minor issue. 21-30=moderate issue. 31-50=major issue |  |  |  |  |  |  |

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| ***Temporal Lobe*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| Reduced function in overall hearing |  |  |  |  |  |  |
| Difficulty understanding language with background/scatter noise |  |  |  |  |  |  |
| Ringing or buzzing in the ear |  |  |  |  |  |  |
| Difficulty comprehending language without perfect pronunciation |  |  |  |  |  |  |
| Difficulty recognizing familiar faces |  |  |  |  |  |  |
| Changes in comprehending the meaning of sentences (written or spoken) |  |  |  |  |  |  |
| Difficulty with verbal memory and finding words |  |  |  |  |  |  |
| Difficulty remembering events |  |  |  |  |  |  |
| Difficulty recalling previously learned facts and names |  |  |  |  |  |  |
| Inability to comprehend familiar words when read |  |  |  |  |  |  |
| Difficulty spelling familiar words |  |  |  |  |  |  |
| Monotone, unemotional speech |  |  |  |  |  |  |
| Difficulty understanding the emotions of others when they speak (nonverbal cues) |  |  |  |  |  |  |
| they speak (nonverbal cues) |  |  |  |  |  |  |
| Disinterest in music and a lack of appreciation for melodies |  |  |  |  |  |  |
| Difficulty with long-term memory |  |  |  |  |  |  |
| Memory impairment when doing the basic activities of daily living |  |  |  |  |  |  |
| Difficulty with directions and visual memory |  |  |  |  |  |  |
| Noticeable differences in energy levels throughout the day |  |  |  |  |  |  |
| ***Total score:*** Key: 0-18=not likely an issue. 19-36=minor issue. 37-54=moderate issue. 55-90=major issue |  |  |  |  |  |  |

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| ***Occipital Lobe*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| Difficulty coordinating visual inputs and hand movements, resulting in an inability to efficiently reach for objects |  |  |  |  |  |  |
| Difficulty comprehending written text |  |  |  |  |  |  |
| Floaters or halos in your visual field |  |  |  |  |  |  |
| Dullness of colors in your visual field during different times of day |  |  |  |  |  |  |
| Difficulty discriminating between similar shades of color |  |  |  |  |  |  |
| ***Total score:***  |  |  |  |  |  |  |
| Key: 0-5=not likely an issue. 6-10=minor issue. 7-15=moderate issue. 16-25=major issue. |  |  |  |  |  |  |

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| ***Frontal Cortex*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| Difficulty with detailed hand coordination |  |  |  |  |  |  |
| Difficulty with making decisions |  |  |  |  |  |  |
| Difficulty with suppressing socially inappropriate thoughts |  |  |  |  |  |  |
| Socially inappropriate behavior |  |  |  |  |  |  |
| Decisions made based on desires, regardless of the consequences |  |  |  |  |  |  |
| Difficulty planning and organizing daily events |  |  |  |  |  |  |
| Difficulty motivating yourself to start and finish tasks |  |  |  |  |  |  |
| A loss of attention and concentration |  |  |  |  |  |  |
| Total score:  |  |  |  |  |  |  |
| Key: 0-8=not likely an issue. 9-16=minor issue. 17-24=moderate issue. 25-40=major issue. |  |  |  |  |  |  |

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| ***Parietal Lobe*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| Hypersensitivities to touch or pain |  |  |  |  |  |  |
| Difficulty with spatial awareness when moving, laying back in a chair, or leaning against a wall |  |  |  |  |  |  |
| Frequently bumping into the wall or objects |  |  |  |  |  |  |
| Difficulty with right-left discrimination |  |  |  |  |  |  |
| Handwriting has become sloppier |  |  |  |  |  |  |
| Difficulty with basic math calculations |  |  |  |  |  |  |
| Difficulty finding words for written or verbal communication |  |  |  |  |  |  |
| Difficulty recognizing symbols, words, or letters |  |  |  |  |  |  |
| ***Total score:***  |  |  |  |  |  |  |
| Key: 0-8=not likely an issue. 9-16=minor issue. 17-24=moderate issue. 25-40=major issue. |  |  |  |  |  |  |

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| ***Pontomedullary Brainstem*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| Difficulty swallowing supplements or large bites of food |  |  |  |  |  |  |
| Bowel motility/movements slow |  |  |  |  |  |  |
| Bloating after meals |  |  |  |  |  |  |
| Dry eyes/dry mouth |  |  |  |  |  |  |
| A racing heart |  |  |  |  |  |  |
| A flutter in the chest or abnormal heart rhythm |  |  |  |  |  |  |
| Bowel or bladder incontinence resulting in staining your underwear |  |  |  |  |  |  |
| ***Total score:***  |  |  |  |  |  |  |
| Key: 0-7=not likely an issue. 8-14=minor issue. 9-21=moderate issue. 22-35=major issue |  |  |  |  |  |  |

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| ***Basal Ganglia (Direct)*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| A decrease in movement speed |  |  |  |  |  |  |
| Difficulty initiating movement |  |  |  |  |  |  |
| Stiffness in muscles (NOT joints) |  |  |  |  |  |  |
| A stooped posture when walking |  |  |  |  |  |  |
| Cramping of your hand when writing |  |  |  |  |  |  |
| ***Total score:***  |  |  |  |  |  |  |
| Key: 0-5=not likely an issue. 6-10=minor issue. 7-15=moderate issue. 16-25=major issue. |  |  |  |  |  |  |

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| ***Basal Ganglia (Indirect)*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| Abnormal body movements (such as twitching legs) |  |  |  |  |  |  |
| Desires to flinch, clear your throat, or perform some type of movement |  |  |  |  |  |  |
| type of movement |  |  |  |  |  |  |
| Constant nervousness and a restless mind |  |  |  |  |  |  |
| Compulsive behaviors |  |  |  |  |  |  |
| Increased tightness and tone in specific muscles |  |  |  |  |  |  |
| ***Total score:***  |  |  |  |  |  |  |
| Key: 0-5=not likely an issue. 6-10=minor issue. 7-15=moderate issue. 16-25=major issue |  |  |  |  |  |  |

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| ***Cerebellum*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| Difficulty with balance, or balance that is noticeably, worse on one side |  |  |  |  |  |  |
| A need to hold the handrail or watch every step carefully when going down stairs |  |  |  |  |  |  |
| Episodes of dizziness |  |  |  |  |  |  |
| Nausea, car sickness, sea sickness |  |  |  |  |  |  |
| A quick impact after consuming alcohol |  |  |  |  |  |  |
| A slight hand shake when reaching for something |  |  |  |  |  |  |
| Back muscles that tire quickly when standing or walking |  |  |  |  |  |  |
| Chronic neck or back muscle tightness |  |  |  |  |  |  |
| ***Total score:***  |  |  |  |  |  |  |
| Key: 0-8=not likely an issue. 9-16=minor issue. 17-24=moderate issue. 25-40=major issue. |  |  |  |  |  |  |

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| ***Serotonin*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| Losing interest in hobbies |  |  |  |  |  |  |
| Feeling overwhelmed |  |  |  |  |  |  |
| Feelings of inner rage |  |  |  |  |  |  |
| Feelings of paranoia |  |  |  |  |  |  |
| Feeling sad or down for no reason |  |  |  |  |  |  |
| Feeling like you are not enjoying life |  |  |  |  |  |  |
| Feeling you lack artistic appreciation |  |  |  |  |  |  |
| Feeling depressed in overcast/winter weather |  |  |  |  |  |  |
| Losing enthusiasm for your favorite activities |  |  |  |  |  |  |
| Losing your enjoyment for your favorite foods |  |  |  |  |  |  |
| Losing your enjoyment of friendships and relationships |  |  |  |  |  |  |
| Difficulty falling into deep, restful sleep |  |  |  |  |  |  |
| Feelings of dependency on others |  |  |  |  |  |  |
| Feeling more susceptible to pain |  |  |  |  |  |  |
| Feelings of unprovoked anger |  |  |  |  |  |  |
| Losing interest in life |  |  |  |  |  |  |
| ***Total score:***  |  |  |  |  |  |  |
| Key: 0-16=not likely an issue. 17-32=minor issue. 33-48=moderate issue. 49-80=major issue |  |  |  |  |  |  |

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| ***Dopamine*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| Feelings of hopelessness |  |  |  |  |  |  |
| Self-destructive thoughts |  |  |  |  |  |  |
| Inability to handle stress |  |  |  |  |  |  |
| Anger and aggression while under stress |  |  |  |  |  |  |
| Feeling not rested, even after long hours of sleep |  |  |  |  |  |  |
| Prefer to isolate yourself from others |  |  |  |  |  |  |
| Unexplained lack of concern for family and friends |  |  |  |  |  |  |
| Distracted from your tasks |  |  |  |  |  |  |
| Inability to finish tasks |  |  |  |  |  |  |
| Decreased libido |  |  |  |  |  |  |
| Need to consume caffeine to stay alert/focused |  |  |  |  |  |  |
| Lose your temper for minor reasons |  |  |  |  |  |  |
| Feelings of worthlessness |  |  |  |  |  |  |
| ***Total score:***  |  |  |  |  |  |  |
| Key: 0-13=not likely an issue. 14-26=minor issue. 27-39=moderate issue. 40-65=major issue |  |  |  |  |  |  |

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| ***GABA*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| Feeling anxious or panicky for no reason |  |  |  |  |  |  |
| Feelings of dread or impending doom |  |  |  |  |  |  |
| Feel knots in your stomach |  |  |  |  |  |  |
| Feeling overwhelmed for no reason |  |  |  |  |  |  |
| Feeling guilt about everyday decisions |  |  |  |  |  |  |
| Restless mind |  |  |  |  |  |  |
| Difficult to turn your mind off when you want to relax |  |  |  |  |  |  |
| Disorganized attention |  |  |  |  |  |  |
| Worry about things you were not worried about before |  |  |  |  |  |  |
| Feelings of inner tension and inner excitability |  |  |  |  |  |  |
| ***Total score:***  |  |  |  |  |  |  |
| Key: 0-10=not likely an issue. 11-20=minor issue. 21-30=moderate issue. 31-50=major issue |  |  |  |  |  |  |

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| ***Acetylcholine*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| Decreased visual memory (shapes and images) |  |  |  |  |  |  |
| Verbal memory has decreased |  |  |  |  |  |  |
| Frequent memory lapses |  |  |  |  |  |  |
| Decreased creativity |  |  |  |  |  |  |
| Has your comprehension diminished |  |  |  |  |  |  |
| Difficulty calculating numbers |  |  |  |  |  |  |
| Difficulty recognizing objects and faces |  |  |  |  |  |  |
| Opinion about yourself have changed |  |  |  |  |  |  |
| Experiencing excessive urination |  |  |  |  |  |  |
| Experiencing a slower mental response |  |  |  |  |  |  |
| ***Total score:***  |  |  |  |  |  |  |
| Key: 0-10=not likely an issue. 11-20=minor issue. 21-30=moderate issue. 31-50=major issue |  |  |  |  |  |  |

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| ***Toxicity Exposure*** | ***0*** | 1 | 2 | 3 | 4 | 5 |
| Use trong chemicals used in your home? (disinfectants, bleaches, oven/drain cleaners, furniture polish, floor wax, window cleaners, etc.) |  |  |  |  |  |  |
| Use pesticides used in/around your home |  |  |  |  |  |  |
| Home treated for insects |  |  |  |  |  |  |
| Exposed to dust, old furniture, tobacco smoke, mothballs, incense, candles, or varnish in your office or home |  |  |  |  |  |  |
| Exposed to nail polish, perfume, hair spray, or other cosmetics |  |  |  |  |  |  |
|  Exposed to diesel fumes, exhaust fumes, or gasoline fumes |  |  |  |  |  |  |
| Consume nonorganic foods |  |  |  |  |  |  |
| Noticed any change in your health since you moved into your home or apartment |  |  |  |  |  |  |
| Noticed any change in your health since you started your new job |  |  |  |  |  |  |
| Water purification system in your home | yes or no |  |  |  |  |  |
| Indoor pets | yes or no |  |  |  |  |  |
| Air purification system in your home | yes or no |  |  |  |  |  |
| Are you a dentist, painter, construction worker, or farm worker, or have other type of toxic job exposure? | yes or no |  |  |  |  |  |

**NOTICE OF PRIVACY POLICIES**

Effective Date: August 29, 2018

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

If you have any questions about this notice, please contact:

Dr. Vincent Esposito

3023 Quentin Road

Brooklyn, NY, 11234

917-268-7377

drvincentesposito@gmail.com

**OUR LEGAL DUTY:**

We are required by applicable federal and state law to maintain the privacy of your health information. We reserve the right to change our policy. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available. You may request a copy of our notice at any time. For more information about our privacy practices or for additional copies of this notice, please contact us using the information provided above.

**USE AND DISCLOSURE OF HEALTH INFORMATION:**

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment for Services:** We may use or disclose your health information to obtain payment for services provided to you.

**Healthcare Operations:** We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, case management, review the competence of or qualification of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, and other activities. We reserve the right, at our discretion, to change, modify, add or remove portions of these terms and conditions of use, at any time without giving prior notice. All changes will become immediately applicable to all users of this website. You should check these terms and conditions of use periodically for changes. By using this website after we post/publish any changes to these terms and conditions of use, you agree to accept and be bound by those changes, whether or not you have reviewed them. If you do not agree to these terms and conditions of use, please do not use our websites and, if applicable, please arrange to terminate your registration with us by notifying us of your unwillingness to accept the changes to the Terms and Conditions of Use.

**Required By Law:** We will disclose your health information about you when required to by federal, state, or local law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe you are a victim of abuse, neglect, or domestic violence, or other possible victim of other crimes. We may disclose this type of information to the extent necessary to avert serious threat to your health or safety or the health or safety of others.

**Business Associate:** We may disclose information to business associates who perform services on our behalf (such as billing companies), however we require them to appropriately safeguard your information.

**Appointment Reminders:** We may use or disclose your health information to contact you as a reminder (such as a voicemail, messages, email, postcards, or letters) that you have an appointment for treatment or medical care with Dr. Vincent Esposito.

**PATIENT/CLIENT RIGHTS:**

**Access:**  You have the right to inspect and copy your health information, with limited exceptions. Submit your request in writing to Dr. Vincent Esposito. A fee will be charged for the costs associated with these requests. There are certain situations in which we are not required to comply with your request/. In these circumstances, we will respond to you in writing, stating why we will not grant your request and describe any rights you may have to request a review of our denial.

**Disclosures Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain activities, for the last 6 years but not before the effective date listed above. If you request an accounting more than once in a 12-month period, you will be charged a reasonable cost-based fee for responding to these requests.

**Amendment:**  You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended). We may deny your request under certain circumstances.

**Restrictions:** You have the right to request we place additional restrictions on our use of your health information. We are not required to agree to these additional restrictions, but if we do, we still abide by our agreement (except in an emergency).

**Alternative Communications:** You have the right to request that we communicate with you about medical manners in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request alternative communications, you must request it in writing. We will accommodate all reasonable requests.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this Notice at any time by contacting Dr. Vincent Esposito.

**INFORMED CONSENT REGARDING E-MAIL OR THE INTERNET USE OF PROTECTED PERSONAL INFORMATION**

Inside Out Health & Wellness provides patients the opportunity to communicate with them by e-mail. Transmitting confidential health information by e-mail, however, has a number of risks, both general and specific, that should be considered before using e-mail.

**1. Risks:**

a. General e-mail risks are the following: e-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward e-mail to other recipients without the original sender(s) permission, or knowledge; users can easily misaddress an e-mail; e-mail is easier to falsify than handwritten, or signed documents; backup copies of e-mail may exist even after the sender, or recipient has deleted his/her history.

b. Specific e-mail risks are the following: e-mail containing information pertaining to diagnosis and/or treatment must be included in the protected personal health information; all individuals who have access to the protected personal health information will have access to the e-mail messages; patients who send, or receive email from their place of employment risk having their employer read their e-mail.

**2. Inside Out Health & Wellness Email and Internet Policies:**

It is our policy that all e-mail messages sent or received, which concern the diagnosis, or treatment, of the patient will be a part of that patient’s protected personal health information and we will treat such e-mail messages, or internet communications, with the same degree of confidentiality as afforded other portions of the protected personal health information. We will use reasonable means to protect the security and confidentiality of e-mail, or internet communication. Because of the risks outlined above, we cannot, however, guarantee the security and confidentiality of e-mail, or internet communications.

**3. Patient Consent**

Patients must consent to the use of e-mail for confidential medical information after having been informed of the above risks. Consent to the use of e-mail includes agreement with the following conditions:

a. All e-mail to, or from, patients concerning diagnosis and/or treatment will be made a part of the protected personal health information. As a part of the protected personal health information, all of our health coaching practitioners and upon written authorization other healthcare providers will have access to e-mail messages contained in protected personal health information.

b. Our practitioners may forward e-mail messages within the practice as necessary for diagnosis and treatment. We will not, however, forward the e-mail outside the practice without the consent of the patient as required by law.

c. We at Inside Out Health & Wellness will endeavor to read e-mail promptly, but can provide no assurance that the recipient of the particular e-mail will read the e-mail message promptly. Therefore, e-mail must not be used in a medical emergency.

d. It is the responsibility of the sender to determine whether the intended recipient received the e-mail and when the recipient will respond.

e. We cannot guarantee that electronic communications will be private. However, we will take reasonable steps to protect the confidentiality of the e-mail, or internet communication. However, insideouthealthwellness.com is not liable for improper disclosure of confidential information not caused by its employee’s gross negligence, or wanton misconduct.

f. If consent is given for the use of e-mail, it is the responsibility of the patient to inform our staff of any type of information you do not want to be sent by e-mail.

g. It is the responsibility of the patient to protect their password or other means of access to email sent, or received, from our staff, to protect confidentiality. Inside Out Health & Wellness is not liable for breaches of confidentiality caused by the patient.

Any further use of e-mail initiated by the patient that discusses diagnosis, or treatment, constitutes informed consent to the foregoing. I understand that my consent to the use of e-mail may be withdrawn at any time by email, or written communication, to Inside Out Health & Wellness and I have read this form carefully and understand the risks and responsibilities associated with the use of email. I agree to assume all risks associated with the use of email.

**Terms & Conditions**

Inside Out Health & Wellness does not aim to diagnose or treat any sort of medical condition. We are not acting as primary care physicians at all and are not licensed to treat any medical condition. Instead, we provide health coaching to help people improve their health. Our health coaching does not substitute for a Doctor – Patient relationship and we encourage you to work and consult with your primary care physician before beginning any lifestyle change. With any sort of lifestyle change or use of nutritional supplements, there are risks, and although the chances are slim, your health may get worse during this process. Inside Out Health & Wellness does not take legal responsibility for any changes in your health but will work with you to get the best health outcome. I understand that the health coaches at Inside Out Health & Wellness are not diagnosing or treating any medical condition I may have. I also understand that there are risks to any lifestyle change and to taking supplements. I accept full responsibility for my health condition and for any risks that may come with following the instructions set out by Inside Out Health & Wellness.

The information contained in this website has been prepared solely for the purpose of providing general information about, its partners and the services that they offer and no information given is an alternative to seeking professional medical advice where appropriate.

While every effort has been made to ensure that the information provided is accurate, it does not constitute any form of advice, recommendation, representation, endorsement or arrangement by Inside Out Health & Wellness.

The information presented is believed to be reliable but it is subject to change at any time without notice. Inside Out Health 7 Wellness does not guarantee its completeness or accuracy. By working together, you agree that Inside Out Health & Wellness will not be liable for any direct, indirect, or consequential loss arising from the use of the information and material contained in this website or from your access of other material on the internet via web links from this site.

**Inside Out Health & Wellness RECOMMENDS THAT YOU ALWAYS CONSULT A MEDICAL PRACTITIONER BEFORE FOLLOWING ANY COMPLEMENTARY THERAPIES IF YOU HAVE ANY SYMPTOMS OF ILLNESS, HAVE ANY DIAGNOSED AILMENT, OR ARE RECEIVING CONVENTIONAL MEDICATION OR ANY TREATMENT FOR AN EXISTING CONDITION. DO NOT STOP CONVENTIONAL TREATMENT OR MEDICATION FOR ANY REASON WITHOUT CONSULTING A DOCTOR. ALWAYS INFORM BOTH YOUR DOCTOR AND YOUR COMPLEMENTARY MEDICAL PRACTITIONERS OF ANY TREATMENT, MEDICATION OR REMEDIES, BOTH CONVENTIONAL AND UNCONVENTIONAL THAT YOU ARE TAKING, OR ARE INTENDING TO TAKE. DO NOT DELAY IN SEEKING MEDICAL ADVICE AS A RESULT OF ANY INFORMATION OBTAINED FROM THIS WEBSITE WHICH SHOULD NOT BE REGARDED AS AN ALTERNATIVE TO MEDICAL ADVICE CONCERNING PARTICULAR MEDICAL CONDITIONS OR TREATMENTS.**

**WE WOULD ALWAYS ADVISE THAT YOU SEEK A PROFESSIONAL OPINION BEFORE COMMENCING ANY NUTRITIONAL SUPPLEMENTATION.**

**Inside Out Health& Wellness, OR ANY, OR ALL OF ITS DIRECTORS AND STAFF SHALL NOT BE HELD RESPONSIBLE FOR ANY CLAIMS RELATING TO ILLNESS OR AILMENTS OR DAMAGE THAT IS DEEMED TO HAVE POSSIBLY ARISEN AS A CONSEQUENCE OF USING ANY PART, OR ALL OF THE CONTENT PROVIDED ON THIS OR RELATED WEBSITES OR IN THE USE OF ANY PRODUCTS SOLD ON THIS WEB SITE. THE CONTENT IS PROVIDED FOR GENERAL USE, AND MAY BE INAPPLICABLE, UNSUITABLE OR BOTH TO PERSONS SUFFERING FROM CONDITIONS DIAGNOSED OR NOT.**

**QUESTIONS AND COMPLAINTS:**

If you want more information about our privacy policies or have questions or concerns, please contact use using the information provided above.

If you are concerned that we may have violated your privacy rights or disagree with a decision we made about access to your health information or in response to a request you may have made to amend or restrict the use of disclosure of your health information or to have use communicate with you by alternative means or at alternative locations, you may record a complaint to us by using the information provided at the beginning of this Notice. You may submit a request to the Secretary of the Department of Health and Human Services. We support the right to the privacy of your health information. If you file a complaint, we will not take any action against you or change our treatment of you in any way. We support the right to the privacy of your health information.

*Your signature with date acknowledges that you have received and read Dr. Vincent Esposito’s Notice of Privacy Practices.*

Signature:

Relationship to Patient:

Print Name:

Date:

***Office Payment Policies***

1. You are responsible for obtaining a referral if your insurance policy requires one. You will not be seen if you do not have a referral. If you want to be seen without a referral from an insurance provider, you then agree to pay the amount agreed upon for the initial visit and/or for a follow-up visit.
2. If your insurance company denies coverage or payment, you are financially responsible for the visit
3. If we are not a provider for your insurance, a superbill will be provided to you. You can submit the superbill to your insurance company for you to be reimbursed.
4. Payments can be made via cash, check, or credit card (Visa, MasterCard, American Express) via PayPal.
5. You will be responsible for the full fee or the first payment twenty-four (24) hours prior to the first appointment’s scheduled time.
6. Cancellations must be done no later than 24 hours prior to the appointment time, otherwise you are subject to $75 late cancellation fee.
7. You will not be seen if you have an outstanding balance.
8. Outstanding balances after 60 days will be sent out to collection. When an account is sent out for collection, you are responsible for a 20% fee on the balance.

I have read, understand, and agree to these statements.

Signature Date