

## YOUR FACTS

### Tell us about you . . .

**Please Print** Nickname: " \_\_\_\_\_ "

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

E-mail: \_\_\_\_\_  Do not send me "Your Wellness Connection" newsletter.

D.O.B: \_\_\_\_/\_\_\_\_/\_\_\_\_ S.S. # \_\_\_\_-\_\_\_\_-\_\_\_\_ Gender: M F Marital Status: M D W S

Employer: \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Primary Care Physician (PCP): \_\_\_\_\_ PCP Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Signature: \_\_\_\_\_

### How did you find us . . .

Patient \_\_\_\_\_ (who)  Doctor \_\_\_\_\_ (who)  Staff \_\_\_\_\_ (who)  Newspaper  Internet

Promotion/Event  Yellow Pages  Signage  Business  Insurance  Other \_\_\_\_\_

### Do you know your . . .

Blood-type:  O  A  B  AB Height \_\_\_\_\_ Weight \_\_\_\_\_

### Do you practice Wellness . . .

Mark the wellness disciplines you use.

	Yes	No
Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>
Body Work (Yoga, Pilates, Tai Chi)	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractic	<input type="checkbox"/>	<input type="checkbox"/>
Counseling	<input type="checkbox"/>	<input type="checkbox"/>
Dental	<input type="checkbox"/>	<input type="checkbox"/>
Eye Care	<input type="checkbox"/>	<input type="checkbox"/>
General Medical	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>
Massage	<input type="checkbox"/>	<input type="checkbox"/>
Naturopathic	<input type="checkbox"/>	<input type="checkbox"/>
Nutritional Counseling	<input type="checkbox"/>	<input type="checkbox"/>
Psychological Counseling	<input type="checkbox"/>	<input type="checkbox"/>
Qigong	<input type="checkbox"/>	<input type="checkbox"/>

I would like to know more about the benefits of becoming a Wellness Client.  Yes  No

### Wellness goals I want to achieve are . . .

Example: Sleep through the night

- 1.
- 2.
- 3.
- 4.

**Comments:**

**YOUR LIFE**

Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Date \_\_\_\_\_

**Current symptoms . . .**

<input type="checkbox"/> Knee Pain <input type="checkbox"/> Leg Cramps <input type="checkbox"/> Numbness in Toes <input type="checkbox"/> Tingling in Legs <input type="checkbox"/> Weakness In Legs . . . . . <input type="checkbox"/> Urinating Issues <input type="checkbox"/> Lower Back Pain <input type="checkbox"/> Ringing in Ears . . . . . <input type="checkbox"/> Bladder Infections <input type="checkbox"/> Belching <input type="checkbox"/> Constipation	<input type="checkbox"/> Indigestion <input type="checkbox"/> Vomiting . . . . . <input type="checkbox"/> Arm Pain <input type="checkbox"/> Circulatory Problems <input type="checkbox"/> Hands Cold <input type="checkbox"/> Mid-Back Pain <input type="checkbox"/> Numbness in Fingers <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Shoulder Pain <input type="checkbox"/> Tingling in Arms . . . . . <input type="checkbox"/> Back Pain <input type="checkbox"/> Dizziness	<input type="checkbox"/> Hair Loss <input type="checkbox"/> Hay fever <input type="checkbox"/> Hives <input type="checkbox"/> Loss of Balance/Dizzy <input type="checkbox"/> Neck Pain/Stiffness <input type="checkbox"/> Nervousness . . . . . <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Diarrhea <input type="checkbox"/> Feet Cold <input type="checkbox"/> Frequent Colds <input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Loss of Smell/Taste <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Sight Sensitivity <input type="checkbox"/> Sinus Problems . . . . . <input type="checkbox"/> Cold/Hot Sweats <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Joints Swelling/Pain <input type="checkbox"/> Sleep Problems <input type="checkbox"/> Stress <input type="checkbox"/> <b>Other</b> _____ <input type="checkbox"/> <b>Other</b> _____
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**Patterns are . . .**

Mark those that apply and amount if applicable.  
**Example:** Lift weights 3 X wk

Bowel movements	_____
Drive a stick shift	_____
Eat out frequently	_____
Enjoy work	_____
Exercise	_____
Healthy relationships	_____
Lift weights	_____
Nicotine	_____
Phone work excessive	_____
Skip meals	_____
Sleep comfortably	_____
Sleep on stomach	_____
Two story residence	_____
Wear seat belts	_____
Work hours per week	_____

**Eating preferences . . .**

Record the amount and frequency of those consumed.

	Amount	Frequency
Alcohol	_____	_____
Carbohydrates	_____	_____
Coffee	_____	_____
Dairy	_____	_____
Fast food	_____	_____
Fruit	_____	_____
Meat	_____	_____
Nuts & Seeds	_____	_____
Salt	_____	_____
Soft drinks	_____	_____
Sugar intake	_____	_____
Tea	_____	_____
Vegetables	_____	_____
Water	_____	_____
Other _____	_____	_____

**Rate your activities . . .**

Rate the degree of pain related to performing these activities.

	None	Some	Always	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Climbing Stairs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Computer work
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dressing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Driving/riding in cars
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exercise
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Getting in/out of cars
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Getting out of bed
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Using the restroom
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Housework
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Running
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Intercourse
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sitting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Taking care of child
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Walking
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Yard work

**Life events experienced through the years are . . .**

List the events experienced such as births, deaths, divorce, accidents, broken bones, retirement, marriage, moves and tragedies.

Birth to 10 years	11 to 25 years	26 to 40 years	41 to 55 years	56 years and older

**YOUR HISTORY**

Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Date \_\_\_\_\_

**Medical history . . .**

Self	Siblings	Mom	Dad	G-Parents		Self	Siblings	Mom	Dad	G-Parents	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Immune System - Weak
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel Syndrome
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis - Type _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Birth Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer -Type _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cholesterol - High	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shingles
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addictions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastric Reflux/Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glasses/contacts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight Gain/Loss
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Other</b> _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Other</b> _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Other</b> _____

**Recreational activities, sports played, and hobbies. . .**

1. _____ <input type="checkbox"/> past <input type="checkbox"/> present	4. _____ <input type="checkbox"/> past <input type="checkbox"/> present
2. _____ <input type="checkbox"/> past <input type="checkbox"/> present	5. _____ <input type="checkbox"/> past <input type="checkbox"/> present
3. _____ <input type="checkbox"/> past <input type="checkbox"/> present	6. _____ <input type="checkbox"/> past <input type="checkbox"/> present

**Medications . . .**

**Supplements . . .**

List the medications taken, the quantity and frequency.			List the supplements taken, the quantity and frequency.		
Medication	Condition	Freq./Amt.	Supplement	Reason	Freq./Amt.

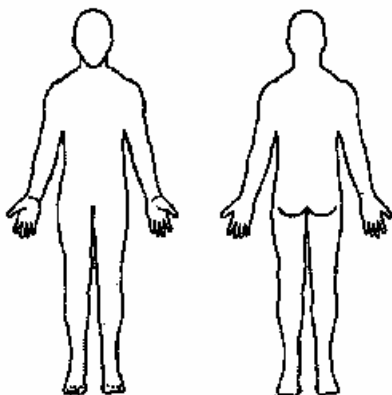
Allergies/Reactions to food, medicine, environment:

**YOUR CONSULTATION**

Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Goals: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Pain Location**



**Front**

**Back**

**Initial**

**Re-Exam**

Date \_\_\_\_\_

**Present Condition . . .**

List conditions in order of concern and mark location of pain.

**Pain Scale**

1-2-3-4-5-6-7-8-9-10

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Minor Extreme

Has condition changed since onset? Yes No Better Worse

Explain: \_\_\_\_\_

What makes pain better? \_\_\_\_\_

Worse? \_\_\_\_\_

Difficult activities: \_\_\_\_\_

**Comments:**

Practitioner: \_\_\_\_\_

**Who have you seen . . .**

Who have you seen for your symptoms, and when?	Date
No One	_____
Chiropractor	_____
Medical Doctor	_____
Physical Therapist	_____
Other	_____

**Have you had . . .**

	Yes	No	When
Blood analysis			_____
Blood pressure check			_____
Bone density			_____
Cardiovascular stress test			_____
Chest x-ray			_____
Colonoscopy			_____
EMG			_____
Eye exam			_____
Flexible sigmoidoscopy			_____
Glaucoma screening			_____
Hearing			_____
Hormone testing			_____
Mammogram			_____
MRI			_____
Pap/pelvic exam			_____
Prostate exam			_____
Spinal x-ray			_____
Test of stool for blood			_____
Urinalysis			_____

**Have you had in the past three months . . .**

	Yes	No
little interest or pleasure in doing things		
financial concerns		
feelings of hopelessness or depression		
a spiritual foundation		
joy in your life		
feelings of anxiety or panic		
pleasure in your work		



# Your Wellness Connection, PA

7410 Switzer / Shawnee Mission, KS 66203  
Phone (913) 962-7408 Fax (913) 962-7416

## METABOLIC ASSESSMENT FORM

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Today's Date: \_\_\_/\_\_\_/\_\_\_

### **PART I** Please list your 5 major health concerns in order of importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

### **PART II** Please circle the appropriate number 0 to 3 on all questions below. 0 = the least / never to 3 = 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 & 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
Frequent use of antacids	0	1	2	3
Feeling 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 or carbonated beverages	0	1	2	3
Digestive problems subside with rest & 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 get 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, 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

Client Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**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 amount 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 break outs	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?	_____			
Do you ever have uterine bleeding since menopause?	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

**PART III**

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

How many times a week do you work out? \_\_\_\_\_

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

Do you smoke? \_\_\_\_\_ If yes, how many times a day \_\_\_\_\_, a week \_\_\_\_\_?

Rate your stress levels on a scale of 1-10 during the average week. \_\_\_\_\_

Please list any medication you currently take and for what conditions: \_\_\_\_\_

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

What have you taken or tried that did not work? \_\_\_\_\_

What time of day do you feel the desire for a boost (coffee, sugar, etc.)? \_\_\_\_\_