NUTRITION
ADULT NEW PATIENT
INTAKE FORMS

THESE FORMS & YOUR MEDICAL RECORDS
MUST BE SUBMITTED TO OUR OFFICE
AT LEAST 7 DAYS PRIOR
TO YOUR FIRST APPOINTMENT

TO SAVE PAPER, WE PREFER IF YOU EMAIL OR MAIL YOUR FORMS AND RECORDS TO US, RATHER THAN FAX THEM
DID YOU REMEMBER TO?

- Read all of the practice documents
- Obtain your medical records and/or test results from previously seen physicians and have them sent at least 7 days prior to your appointment date to:
  
  Dr. Amy Myers  
  Westlake Medical Center  
  5656 Bee Caves Road Suite D-203  
  Austin, TX 78746  
  Fax #: 512-721-0348

- Provide us with your pharmacy name, address, phone and FAX number.
- Check with your insurance company about Out of Network lab coverage.

FILL OUT AND/OR SIGN THE FOLLOWING FORMS

- Important Patient Information
- Authorization for Release of Medical Information
- Informed Consent Regarding Email or the Internet Use Of Protected Personal Information
- Notice of Medicare Denial
- General Information
- Medical Questionnaire
- 3-Day Diet Diary
- MSQ - Medical Symptom/Toxicity Questionnaire

Thank you,

We are looking forward to working with you to achieve UltraHealth

*PLEASE KEEP PAGES 1 - 10 FOR YOUR RECORDS*

Fill out page 10 and fax to your other physicians for release of medical records*
Dear Patient,

Welcome! We look forward to meeting you and working with you to achieve UltraHealth.

WHAT TO EXPECT DURING YOUR CONSULTATION AT AUSTIN ULTRAHEALTH

YOU ARRIVE TO THE OFFICE
- Update personal forms and sign consent forms if not done previously
- Vital signs taken

NUTRITION INITIAL CONSULTATION:
- Vitals are taken, picture is taken, HIPPA forms and policies are signed
- Consult with Brianne Herman RD, LD(60 min)
- Blood draw with on site phlebotomist (if doing lab testing)
- Pay for consult, labs, and any supplements purchased

Nutrition Initial Follow Up Consults: (required for patients with food sensitivity testing)
- Consult with Brianne (50 min)

WRAP UP AND CHECK OUT (with Assistant Practice Manager 10-20 minutes)
- Pay for consult, and labs.
- Any supplements purchased that day you will pay for with front desk staff.
- Schedule follow-up appointments
- Obtain an invoice to send to your insurance company for reimbursement
PRACTICE POLICIES FOR PATIENTS

Our goal is to provide you with the highest level of personalized care possible. We are committed to helping you achieve UltraHealth.

It is important to read all of the enclosed information carefully and to scan & mail, email, fax or drop-off at the office this packet (Intake Forms & Medical Records) at least 7 days prior to your appointment.

Having these forms 7 days in advance will allow Brianne to help solve your problems more efficiently and enhance the quality of your care. If your Intake Form and Medical Records have not been received at least 7 days prior to your initial appointment, it may take Brianne up to 30 minutes of your appointment time to review your chart.

WEBSITE
Information about Dr. Myers, Austin UltraHealth and all relevant patient forms are available through the website: www.dramymyers.com and may be found on the new patient page.

MEDICAL RECORDS FROM OTHER DOCTORS/CLINICS/HOSPITALS
Medical records can only be released with your authorization. A medical records release form is enclosed in this packet for your use. It is your responsibility to obtain previous medical records from other physicians, or health care providers that you wish Dr. Myers to review. Please contact your physician or other health care provider to obtain these records and make sure that we have received them at least 7 days prior to your initial appointment.

Your medical records should be mailed or faxed to:
Dr. Amy Myers, 5656 Bee Caves Rd Ste. D-203 Austin, TX 78746
Fax #: 512-721-0348

COPIES OF MEDICAL RECORDS & LABS FROM OUR OFFICE
You will be given a copy of your labs at each visit to keep for your records. [Should you need additional copies of your medical records; a $25 fee will be charged for copies and postage.]

NUTRITION CONSULTATION FEES
Initial Nutrition Consultation is $125
Initial follow up appointment is $85
All other consults with Brianne are $85 (50 min), $45 (25 min), $25 (15 min).

LAB TESTS
We have phlebotomist from CPL at our office to draw your blood just after your appointment. PLEASE CALL YOUR INSURANCE CARRIER PRIOR TO YOUR APPOINTMENT TO KNOW WHAT YOUR COVERAGE IS. Some labs that involve stool, urine or saliva samples are done by you in your home. You will be given all lab kits and step-by-step instructions for at home test at the time of your consult. Once all of the final lab results are received, we will go over them at your follow-up visits.
CPL is at our office Monday – Friday 7:30-1230. You DO NOT need an appointment to get labs drawn.
SUPPLEMENTS
All of the supplements that are recommended at Austin UltraHealth are available for purchase in our office. You are not obligated to purchase supplements from our office.

Supplements may be purchased in our office or mailed directly to you. Please send orders to supplements@dramymyers.com and allow 24 hours for processing.

RETURNS/REFUNDS
Supplements (except for probiotics and protein powders) and Functional Lab kits may be returned for a refund or exchange if in original condition and unopened or unused within 14 days of purchase. Functional Lab kits must be done within 1 year of purchase. CPL Prepaid Labs will be refunded if labs not drawn and notice is given within 7 days of payment.

CREDIT CARDS
We require a credit card number at the time of scheduling your first appointment. This credit card will be used to hold your appointment and will be kept on file to use for all appointments, labs and supplements unless otherwise specified by you at the time of check out. We do not take American Express.

CANCELLATION AND RESCHEDULING OF APPOINTMENTS
There is a 72 hours (3 business days) cancellation and rescheduling policy. Your appointment must be cancelled or rescheduled at least 72 hours (3 business days) prior to your consultation time or you will be charged a cancellation fee, unless we are able to fill your appointment time. The cancellation fee for a new patient appointment is half the cost of the appointment, the cancellation fee for all other appointments is the full cost of the appointment. You may cancel your appointment by calling the office 512-383-5343 or emailing office@dramymyers.com.

LATE ARRIVAL APPOINTMENTS
We are committed to being on time with patients’ appointments in order to prevent clients from waiting. If you arrive late to the office for your consult your appointment will end at the scheduled time and you will be charged for the length of the originally scheduled visit.

FOLLOW UP APPOINTMENTS
At the time of check out you will be scheduled for a follow up appointment. We will assume you will honor this appointment time unless you notify us otherwise at least 72 hours/ 3 business days prior to your scheduled appointment.

PAYMENT OPTIONS
Cash, checks or credit cards (MasterCard, Visa, Discover) are all accepted methods of payment for services. When you schedule the initial visit, we request a credit card on file to hold the appointment for you. No charges will be applied to your credit card unless you miss or cancel an appointment without proper notice. On the day of your scheduled appointment, all charges for consultations, laboratory testing and nutritional supplements will be itemized and payment is due on the day of service.

Follow-up phone, or in person consultations will be billed to your credit card on file unless you provide other payment information and instructions prior to your appointment. If additional lab tests are required and our office sends test kits, the appropriate fees will be charged to your account. Credit card on file will also be used for supplements mailed unless otherwise specified.
INSURANCE INFORMATION
Medical insurance is not accepted and our office cannot assist you with claim resolution. In addition, Dr. Myers is not a Medicare provider. You will be provided with a billing summary that you can submit to your insurance carrier. Dr. Myers nor Brianne submit their medical notes to insurance companies.

DISABILITY FORMS
Dr. Myers does not fill out medical disability forms for patients. On very rare occasions Dr. Myers will write a letter to detail the medical necessity of testing. Under such circumstances, Dr. Myers bills at her hourly rate to write such letters. Dr. Myers does not submit her medical notes to support disability claims.

OFFICE HOURS
Our office hours are Monday – Friday, 9 am to 5 pm CST.

Should you need to stop by the office to pick up supplements we ask that you kindly call us at 512-383-5343 or email supplements@dramymyers.com to arrange a time to visit. If you need lab kits or anything of that nature please call or email office@dramymyers.com. In order to maintain patient confidentiality, we would ask that you do not stop by the office unannounced.

PHONE CALLS AND MESSAGES
- Phone messages left will be responded to within 24 hours (during business hours).
- To reach the office, please call (512) 383-5343
- If you call after hours, the office staff will return your call on the next business day.
- If you have a medical emergency, call 911 or go directly to the nearest ER.
- When leaving a message, please be brief and include the following information:
  - Full name, spell your last name, and date of birth
  - Reason for call
  - Phone number(s)
  - E-mail address (if desired)

PRESCRIPTION REFILL REQUESTS
For prescription refills, we ask that you contact your pharmacy and have them fax over the medication refill request. Our fax number is (512) 721-0348. It may take up to 72 business hours to process a prescription refill. Please note that Dr. Myers is generally not in the office on Fridays to authorize refills. Please plan ahead to avoid any interruptions in your medications.

EMAIL
If you would like to schedule an appointment or cancel an appointment, have lab kit questions or administrative questions, please email office@dramymyers.com.

If you have a medical question for Dr. Myers please email her at dramy@dramymyers.com. Please note that it can take Dr. Myers up to 48 hours to respond to emails.

If you have a nutrition, supplement or Elimination Diet question please email the Brianne Herman, RD, LD the nutritionist, at nutritionist@dramymyers.com.

If you would like to order supplements from us, or would like us to have a supplement order ready for you to pick up at the office, please send an email to: supplements@dramymyers.com.

If you need immediate assistance please call the office. If you have a medical emergency please call 911.
MISCELLANEOUS
Please refrain from wearing any perfumes, colognes or heavily scented lotions to the office, as Dr. Myers is very sensitive to these products.

Dr. Myers brings Bella, her very sweet 12 year old yellow lab mix to the office. Bella sleeps all day under Dr. Myers’ desk and generally goes unnoticed by patients. If you are allergic to dogs or wish not to have Bella at the office – please let us know prior to your appointment so that Dr. Myers may leave Bella at home.

Wishing you UltraHealth,

The Austin UltraHealth Team
What is your website address?
Information about the practice can be found at www.dramymyers.com.

How may I purchase supplements?
Dr. Myers has extensively researched supplements and recommends only the highest quality of nutritional supplements. All of the supplements that are recommended at Austin UltraHealth are available for purchase in our office. You may purchase supplements after each visit or if you need something in the interim you are welcome to come by the office. To avoid you having to wait and because our office is so small, we ask that you please call or email (supplements@dramymyers.com) prior to coming to pick up supplements.

If you live out of town, you may email supplements@dramymyers.com and we will fill your order and mail it to you within 48 hours.

Do you think you can help me with my health problem?
Dr. Myers uses an innovative systems approach to assessing and treating your health care concerns. Perhaps you have experienced being examined by your doctor, having blood tests done, x-rays or other diagnostic tests taken, only for your doctor to report back that “all your tests are normal”. Yet, both you and your doctor know that you are sick. Unfortunately, this experience is all too common.

Most physicians are trained to look only in specific places for the answers, using the same familiar labs or diagnostic tests. Yet, many causes of illness cannot be found in these places. The usual tests do not look for food allergies, hidden infections, environmental toxins, mold exposures, nutritional deficiencies and metabolic imbalances. New gene testing can uncover underlying genetic predispositions that can be modified through diet, lifestyle, supplements or medications.

Dr. Myers, on the other hand, uses innovative testing to help patients prevent illness and recover from many chronic and difficult-to-treat conditions. Dr. Myers is skilled in evaluating, assessing and treating chronic problems such as fibromyalgia, fatigue syndromes, autoimmune diseases, inflammatory disorders, mood and behavior disorders, Irritable Bowel Syndrome (IBS), seasonal allergies, and other chronic, complex conditions. Dr. Myers also focuses on the prevention and treatment of heart disease, diabetes, dementia, hormonal imbalances and digestive disorders.

How will lab tests be performed at Austin UltraHealth?
Some testing can be done through conventional laboratories and others are only available through functional medicine laboratories. During your medical consultation, Dr. Myers will determine which tests are needed and review with you testing recommendations, instructions (ex. fasting or non-fasting, etc.) and costs. Some testing requires collecting urine, saliva or stool at home. Others may require you to go to a local laboratory to have blood drawn. In all cases, we will assist you in coordinating initial and follow-up testing.

Do you take insurance?
Dr. Myers does not accept insurance or Medicare; we do not file insurance claims on your behalf; nor do we assist with claim resolution. However, we will provide a detailed receipt of services performed and you can submit this to your insurance carrier. For assistance with your reimbursement you may want to contact your insurance provider. We expect payment in full by check, cash or credit card due at the time services are provided.
**What credit cards do you accept?**
We accept the following credit cards: MasterCard, Visa and Discover. We do not accept American Express. It is important to maintain an active credit card on file with our office for billing of follow-up consultations, laboratory testing, and supplement orders.

**Is Dr. Amy Myers a primary care physician?**
Dr. Myers is trained as an emergency physician and can handle many of your primary care needs, however she requests that you maintain a primary care doctor for an annual physical exam, Pap smear, prostate exam, etc. Dr. Myers also does not provide acute care services. She is happy to work with you closely as a consultant and coach in preventive, nutritional and functional medicine to help you address the roots of chronic health problems. Dr. Myers is also happy to confer with your primary care doctor if desired.

**Do I have to see the physician in person for my medical consultation?**
Yes, Texas requires that Dr. Myers meet a patient in person in the state of Texas to provide an initial medical consultation. Follow-up appointments can be arranged by telephone or in person.

**Whom do I contact?**
The office phone number is: (512) 383-5343.

Assistant Practice Manager (appointment scheduling, lab questions): office@dramymyers.com

Practice Manager (all office, insurance, administrative, logistical questions): admin@dramymyers.com

Dr. Myers (medical Questions only): dramymyers@dramymyers.com

Brianne Herman RD,LD, nutritionist (nutritional, elimination diet and basic supplement questions): nutritionist@dramymyers.com

Supplement Orders: supplements@dramymyers.com
**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

Name of Facility or Person: ___________________________________________

Address: ___________________________________________________________

Telephone #: (          ) _______ - _______________ Fax #: (          ) _______ - _______________

**THE PURPOSE OF THIS RELEASE:**

You are hereby authorized to furnish and release to Dr. Amy Myers all information from my medical, psychological, and other health records, with no limitation placed on history of illness, or diagnostic, or therapeutic information, including the furnishing of photocopies of all written documents pertinent thereto.

In addition to the above general authorization to release my protected health information, I further authorize release of the following information if it is contained in those records:

Alcohol or Drug Abuse:  O Yes  O No

*Note: With respect to drug and alcohol abuse treatment information, or records regarding communicable disease related information, the information is from confidential records which are protected by state, or federal laws, that prohibit further disclosure with the specific written consent of the person to whom they pertain, or as otherwise permitted by law. A general authorization for the release of the protected health information is not sufficient for this purpose.*

This authorization can be revoked in writing at any time except to the extent that disclosure made in good faith has already occurred in reliance on this authorization.

I hereby release Dr. Amy Myers from legal responsibility, or liability for the release of the above information to the extent authorized. A copy of this authorization shall be valid as the original.

I understand there may be a fee for this service depending on the number of pages photocopied. However, no such fee will be charged if these records are requested for continuing medical care.

Name: _______________________________________ D.O.B._________________________

Please Print

Signature: ________________________________          Date: __________________________

Information Released: ____________________________   Date: __________________________

Medical Records Technician:_________________________________________________________

Signature:_______________________________________________________________________

Please mail records to:
Dr. Amy Myers Westlake Medical Center 5656 Bee Caves Road Suite D-203 Austin, Tx 78746
IMPORTANT PATIENT INFORMATION

APPOINTMENTS
- Initial consult and first follow up are $500 each. The first appointment consists of 70 minutes with Dr. Myers and 30 minutes with Brianne Herman, RD, the nutritionist. The first follow up consists of 50 minutes with Dr. Myers and 50 minutes with Brianne Herman, RD, the nutritionist.
- Please allow 2.5 to 3 hours for these appointments
- Each additional follow up is priced as follows
  Dr. Myers- $325/hr
  Brianne Herman, RD, LD Nutritionist- $85/50min
- There is a **72 hour/ 3 business day cancellation policy** (please see cancellation policy in Practice Policies for Patients).
  We reserve the right to charge your credit card on file for the full amount of the missed visit for a follow up appointment and half the amount for a new patient appointment if it is not canceled or rescheduled 72 hours (3 business days) prior to your appointment. By signing below you agree to our cancellation policy and authorize Amy Myers MD, PA to charge your credit card on file for any missed visits.

LAB TESTS
- All lab results will be reviewed with you at the time of your follow up appointment. We do not email lab results to patients. The exception to this is if you have a follow up appointment by phone – we will email you your lab results prior to your appointment.

RETURNS/REFUNDS
- Supplements (except probiotics and protein powders) and Functional Lab kits may be returned for a refund or exchange if in original condition and unopened or unused within 14 days of purchase.
- Functional Lab kits must be completed within 1 year of purchase.
- CPL Prepaid Labs will be refunded if labs not drawn and notice is given within 7 days of payment.

RETURN CHECK FEE
- A $35 fee will be assessed for all checks returned for non sufficient funds

BILLING/INSURANCE
- You will receive an invoice at the completion of your visit that you may submit to your insurance for reimbursement. We do not help with insurance claim resolution.
- Payment for the office visit, phone consultation, or lab tests is expected at time of service. All credit card payment will be processed the same day of the visit, or phone call.
- If test kits or supplements are sent to you, you will be charged the day the kit is mailed.
- I (Dr. Amy Myers) do not accept insurance; however, you can submit your patient statement to your insurance carrier.
- We will give you instructions for insurance filing, a copy of your bill and all codes necessary for insurance filing. We do not, however aid you in insurance claim resolution or respond to insurance carrier requests for more information.

PRIMARY CARE PHYSICIAN
- Please note that I (Dr. Amy Myers) am not your primary care physician. I recommend that you have a primary care physician.
ALL MEDICARE PATIENTS MUST SIGN THIS FORM

NOTICE OF POSSIBLE MEDICARE DENIAL
Medicare will only pay for services determined to be reasonable and necessary under Section 1862 (a) (i) of Medicare Law. If a particular service is considered not acceptable and unnecessary under Medicare standards, Medicare will deny payment for those excluded services.

MEDICARE NOTICE
Dr. Amy Myers is not a Medicare provider; therefore, your payment is due at the time services are provided. Any claims submitted will have to be sent by the patient; payment reimbursement is not guaranteed and is subject to Medicare eligibility/reimbursement rules and regulations.

PATIENT ACKNOWLEDGEMENT
My physician, and/or staff have informed me, that he or she believes services provided will likely be denied by Medicare for reasons stated above.

Signature

Print name

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

Dr. Amy Myers provides patients the opportunity to communicate with her 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 e-mail from their place of employment risk having their employer read their e-mail.

2. It is the policy of Dr. Amy Myers 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 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. Dr. Amy Myers 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. 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, other individuals, Dr. Amy Myers, physicians, nurses, other healthcare practitioners, insurance coordinators, and upon written authorization other healthcare providers and insurers will have access to e-mail messages contained in protected personal health information.
   b. Dr. Amy Myers may forward e-mail messages within the practice as necessary for diagnosis and treatment. Dr. Amy Myers will not; however, forward the e-mail outside the practice without the consent of the patient as required by law.
   c. Dr. Amy Myers 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. Because some medical information is so sensitive that unauthorized discloser can be very damaging, e-mail should not be used for communications concerning diagnosis, or treatment of AIDS/HIV infection; other sexually transmissible, or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; Behavioral health, Mental health, or developmental disability; or alcohol and drug abuse.
f. Dr. Amy Myers 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, but Dr. Amy Myers is not liable for improper disclosure of confidential information not caused by its employee's gross negligence, or wanton misconduct.

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

h. It is the responsibility of the patient to protect their password, or other means of access to e-mail sent, or received from Dr. Amy Myers, to protect confidentiality. Dr. Amy Myers 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 e-mail, or written communication, to Dr. Amy Myers.

I have read this form carefully and understand the risks and responsibilities associated with the use of e-mail. I agree to assume all risks associated with the use of e-mail.

Name Printed:  

Signature:  

Date:
# GENERAL INFORMATION

**Name:** First  
**Middle**  
**Last**

**Preferred Name:**

**Date of Birth:**  
**Age:**

**Gender:**  
[ ] Male  
[ ] Female

**Genetic Background:**  
[ ] African  
[ ] European  
[ ] Native American  
[ ] Mediterranean  
[ ] Asian  
[ ] Ashkenazi  
[ ] Middle Eastern

**Highest Education Level:**  
[ ] High School  
[ ] Under-Graduate  
[ ] Post-Graduate

**Job Title:**

**Nature of Business:**

**Primary Address:**  
*Number, Street:*  
*Apt. No.*

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<tr>
<th>City</th>
<th>State</th>
<th>Zip</th>
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**Primary Address:**  
*Number, Street:*  
*Apt. No.*

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<th>City</th>
<th>State</th>
<th>Zip</th>
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**Home Phone 1:**

**Home Phone 2:**

**Work Phone:**

**Cell Phone:**

**Fax:**

**E-mail:**

**Emergency Contact:**  
*Name*  
*Phone Number:*

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<th>Address</th>
<th>Apt. No.</th>
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<th>City</th>
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<th>Zip</th>
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**Physician’s Name:**

**Phone Number**  
**Fax**

**Referred by:**

[ ] Google (which words)  
[ ] Media  
[ ] Family Member  
[ ] Friend  
[ ] Other
## PHARMACY INFORMATION

**Primary Pharmacy:**

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<th>City</th>
<th>State</th>
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*It is extremely important that you list the pharmacy's fax number.*

**Compounding/Supplement Pharmacy:**

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<th>Phone Number:</th>
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*It is extremely important that you list the pharmacy's fax number.*
AUSTIN ULTRAHEALTH MEDICAL QUESTIONNAIRE

ALLERGIES
Medication/ Supplement/Food:

________________________________________________________________________

Reaction:

________________________________________________________________________

COMPLAINTS/CONCERNS
What do you hope to achieve in your visit with us? ____________________________________________

If you had a magic wand and could erase three problems, what would they be?
1. ____________________________________________
2. ____________________________________________
3. ____________________________________________

When was the last time you felt well? ____________________________________________

Did something trigger your change in health? ____________________________________________

What makes you feel worse? ____________________________________________

What makes you feel better? ____________________________________________

Please list current and ongoing problems in order of priority:

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<tr>
<th>Describe Problem:</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
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<tr>
<td>Example: Post Nasal Drip</td>
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<td>X</td>
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<th>Prior Treatment/Approach</th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
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# MEDICAL HISTORY DISEASES/DIAGNOSIS/CONDITIONS

*Check appropriate box and provide date of onset*

## GASTROINTESTINAL
- [ ] Irritable Bowel Syndrome ________________
- [ ] Inflammatory Bowel Disease _____________
- [ ] Crohn’s ________________________________
- [ ] Ulcerative Colitis _____________________
- [ ] Gastritis or Peptic Ulcer Disease ________
- [ ] GERD (reflux) __________________________
- [ ] Celiac Disease _________________________
- [ ] Other ________________________________

## CARDIOVASCULAR
- [ ] Heart Attack ____________________________
- [ ] Other Heart Disease ____________________
- [ ] Stroke ________________________________
- [ ] Elevated Cholesterol ____________________
- [ ] Arrythmia (irregular heart rate) __________
- [ ] Hypertension (high blood pressure) ______
- [ ] Rheumatic Fever ________________________
- [ ] Mitral Valve Prolapse ____________________
- [ ] Other ________________________________

## METABOLIC/ENDOCRINE
- [ ] Type 1 Diabetes ________________________
- [ ] Type 2 Diabetes ________________________
- [ ] Hypoglycemia __________________________
- [ ] Metabolic Syndrome ____________________
- [ ] (Insulin Resistance or Pre-Diabetes) ______
- [ ] Hypothyroidism (low thyroid) ____________
- [ ] Hyperthyroidism (overactive thyroid) ______
- [ ] Endocrine Problems _____________________
- [ ] Polycystic Ovarian Syndrome (PCOS) ______
- [ ] Infertility ______________________________
- [ ] Weight Gain___________________________
- [ ] Weight Loss ___________________________
- [ ] Frequent Weight Fluctuations____________
- [ ] Bulimia _______________________________
- [ ] Anorexia ______________________________
- [ ] Binge Eating Disorder __________________
- [ ] Night Eating Syndrome _________________
- [ ] Eating Disorder (non-specific) __________
- [ ] Other ________________________________

## CANCER
- [ ] Lung Cancer ____________________________
- [ ] Breast Cancer __________________________
- [ ] Colon Cancer __________________________
- [ ] Ovarian Cancer _________________________
- [ ] Prostate Cancer _________________________
- [ ] Skin Cancer _____________________________

## GENITAL AND URINARY SYSTEMS
- [ ] Kidney Stones __________________________
- [ ] Gout _________________________________
- [ ] Interstitial Cystitis _____________________
- [ ] Frequent Urinary Tract Infections ________
- [ ] Frequent Yeast Infections ______________
- [ ] Erectile Dysfunction or Sexual Dysfunction ______________
- [ ] Other _______________________________

## MUSCULOSKELETAL/PAIN
- [ ] Osteoarthritis __________________________
- [ ] Fibromyalgia __________________________
- [ ] Chronic Pain __________________________
- [ ] Other ________________________________

## INFLAMMATORY/AUTOIMMUNE
- [ ] Chronic Fatigue Syndrome ________________
- [ ] Autoimmune Disease _____________________
- [ ] Rheumatoid Arthritis ___________________
- [ ] Lupus SLE ______________________________
- [ ] Immune Deficiency Disease ______________
- [ ] Herpes-Genital __________________________
- [ ] Severe Infectious Disease ________________
- [ ] Poor Immune Function __________________
- [ ] (frequent infections) ___________________
- [ ] Food Allergies __________________________
- [ ] Environmental Allergies _________________
- [ ] Multiple Chemical Sensitivities __________
- [ ] Latex Allergy ___________________________
- [ ] Other ________________________________
**MEDICAL HISTORY (CONTINUED)**

**DISEASES/DIAGNOSIS/CONDITIONS**  
*Check appropriate box and provide date of onset*

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<th>RESPIRATORY DISEASES</th>
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<tr>
<td>□ Asthma</td>
<td>□ Pneumonia</td>
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<td>□ Chronic Sinusitis</td>
<td>□ Tuberculosis</td>
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<td>□ Bronchitis</td>
<td>□ Sleep Apnea</td>
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<td>□ Emphysema</td>
<td>□ Other</td>
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<tr>
<th>SKIN DISEASES</th>
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<td>□ Eczema</td>
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<td>□ Psoriasis</td>
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<td>□ Acne</td>
<td>□ Other</td>
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<th>NEUROLOGIC/MOOD</th>
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<td>□ Depression</td>
<td>□ Mild Cognitive Impairment</td>
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<td>□ Anxiety</td>
<td>□ Memory Problems</td>
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<td>□ Bipolar Disorder</td>
<td>□ Parkinson’s Disease</td>
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<td>□ Schizophrenia</td>
<td>□ Multiple Sclerosis</td>
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<td>□ Headaches</td>
<td>□ ALS</td>
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<td>□ Migraines</td>
<td>□ Seizures</td>
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<td>□ ADD/ADHD</td>
<td>□ Other Neurological Problems</td>
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**PREVENTIVE TESTS AND DATE OF LAST TEST**  
*Check box if yes and provide date*

| □ Full Physical Exam | □ Hemocult Test-stool test for blood |
| □ Bone Density       | □ MRI |
| □ Colonoscopy        | □ CT Scan |
| □ Cardiac Stress Test| □ Upper Endoscopy |
| □ EBT Heart Scan     | □ Upper GI Series |
| □ EKG                | □ Ultrasound |

**INJURIES**  
*Check box if yes: □ Back Injury □ Head Injury □ Neck Injury □ Broken Bones*  

**SURGERIES**  
*Check box if yes and provide date of surgery*

| □ Appendectomy      | □ Joint Replacement –Knee/Hip |
| □ Hysterectomy +/- Ovaries | □ Heart Surgery–Bypass Valve |
| □ Gall Bladder      | □ Angioplasty or Stent |
| □ Hernia            | □ Pacemaker |
| □ Tonsillectomy     | □ Other |
| □ Dental Surgery     | □ None |

**BLOOD TYPE:**  
□ A □ B □ AB □ O □ Rh+ □ Unknown

**HOSPITALIZATIONS**  
□ None

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<th>Date:</th>
<th>Reason:</th>
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GYNECOLOGIC HISTORY (FOR WOMEN ONLY)

OBSTETRIC HISTORY (Check box if yes and provide number)
- √ Pregnancies_________  √ Caesarean_________  √ Vaginal deliveries_________
- √ Miscarriage_________  √ Abortion_________  √ Living Children_________
- □ Post Partum Depression  □ Toxemia  □ Gestational Diabetes Baby Over 8 Pounds
- □ Breast Feeding  For how long?_________

MENSTRUAL HISTORY
Age at First Period:______  Menses Frequency:_____  Length:_____  Pain: ○ Yes ○ No  Clotting: ○ Yes ○ No
Has your period ever skipped?_____  For how long?_____
Last Menstrual Period:_________
Use of hormonal contraception such as: □ Birth Control Pills  □ Patch  □ Nuva Ring
How long?_____
Do you use contraception? ○ Yes ○ No
□ Condom  □ Diaphragm  □ IUD  □ Partner Vasectomy

WOMEN’S DISORDERS/HORMONAL IMBALANCES
□ Fibrocystic Breasts  □ Endometriosis  □ Fibroids  □ Infertility
□ Painful Periods  □ Heavy periods  □ PMS
Last Mammogram:_________  Breast Biopsy/Date:_________
Last PAP Test:_________  □ Normal  □ Abnormal
Last Bone Density:_________  Results: □ High □ Low □ Within Normal Range
Are you in menopause? □ Yes □ No
Age at Menopause_________
□ Hot Flashes  □ Mood Swings  □ Concentration/Memory Problems
□ Vaginal Dryness  □ Decreased Libido

WOMEN’S DISORDERS/HORMONAL IMBALANCES (CONTINUED)
□ Heavy Bleeding  □ Joint Pains  □ Headaches  □ Weight Gain
□ Loss of Control of Urine  □ Palpitations
□ Use of hormone replacement therapy  How long?____________________
MEN'S HISTORY  (FOR MEN ONLY)

Have you had a PSA done?  ○ Yes  ○ No  
PSA Level: □0-2  □2-4  □4-10  □>10  
□ Prostate Enlargement  □ Prostate infection  □ Change in Libido  □ Impotence  
□ Difficulty Obtaining an Erection  □ Difficulty Maintaining an Erection  
□ Nocturia (urination at night)  How many times at night? ________  
□ Urgency/Hesitancy/Change in Urinary Stream  □ Loss of Control of Urine

GI HISTORY

Foreign Travel?  ○ Yes  ○ No  Where? ________________________________  
Wilderness Camping?  ○ Yes  ○ No  Where? ________________________________  
Have you ever had severe:  ○ Gastroenteritis  ○ Diarrhea  
Do you feel like you digest your food well?  ○ Yes  ○ No  
Do you feel bloated after meals?  ○ Yes  ○ No

PATIENT BIRTH HISTORY

○ Term  ○ Premature  
Pregnancy Complications: ____________________________________________  
Birth Complications: _______________________________________________  
Age at introduction of:  Solid Foods:_________  Dairy:_________  Wheat:_________  
Did you eat a lot of candy or sugar as a child?  ○ Yes  ○ No

DENTAL HISTORY

□ Silver Mercury Fillings  How many? ________  
□ Gold Fillings  
□ Root Canals  How many? ________  
□ Implants  
□ Tooth Pain  
□ Bleeding Gums  
□ Gingivitis  
□ Problems with Chewing

Do you floss regularly?  ○ Yes  ○ No
### MEDICATIONS

#### CURRENT MEDICATIONS

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<tr>
<th>MEDICATION</th>
<th>DOSE</th>
<th>FREQUENCY</th>
<th>START DATE (MONTH/YEAR)</th>
<th>REASON FOR USE</th>
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#### PREVIOUS MEDICATIONS: Last 10 years

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#### NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

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<tr>
<th>SUPPLEMENT AND BRAND</th>
<th>DOSE</th>
<th>FREQUENCY</th>
<th>START DATE (MONTH/YEAR)</th>
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Have your medications or supplements ever caused you unusual side effects or problems?  ○ Yes  ○ No
Describe: _________________________________________________________________

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin?  ○ Yes  ○ No
Have you had prolonged or regular use of Tylenol?  ○ Yes  ○ No
Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.)  ○ Yes  ○ No
Frequent antibiotics > 3 times/year  ○ Yes  ○ No
Long term antibiotics  ○ Yes  ○ No
Use of steroids (prednisone, nasal allergy inhalers) in the past  ○ Yes  ○ No
Use of oral contraceptives  ○ Yes  ○ No
### FAMILY HISTORY

**Check family members that apply.**

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<th>MOTHER</th>
<th>FATHER</th>
<th>BROTHER(S)</th>
<th>SISTERS</th>
<th>CHILDREN</th>
<th>MATERNL GRANDMOTHER</th>
<th>PATERNAL GRANDMOTHER</th>
<th>PATERNAL GRANDFATHER</th>
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<td>Age (if still alive)</td>
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<td>Substance Abuse (such as alcoholism)</td>
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# SOCIAL HISTORY

## NUTRITION HISTORY

Have you ever had a nutrition consultation?  ○  Yes  ○  No

Have you made any changes in your eating habits because of your health?  ○  Yes  ○  No

Describe: __________________________________________________________

Do you currently follow a special diet or nutritional program?  ○  Yes  ○  No

*Check all that apply:*

- Low Fat
- Low Carbohydrate
- High Protein
- Low Sodium
- Diabetic
- No Dairy
- No Wheat
- Gluten Restricted
- Vegetarian
- Vegan
- Specific Program for Weight Loss/Maintenance Type: _____________________________
- Other ____________________________________________________________________

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<th>Height (feet/inches)</th>
<th>Current Weight</th>
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<table>
<thead>
<tr>
<th>Usual Weight Range +/- 5 lbs</th>
<th>Desired Weight Range +/- 5 lbs</th>
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<table>
<thead>
<tr>
<th>Highest adult weight</th>
<th>Lowest adult weight</th>
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<table>
<thead>
<tr>
<th>Weight Fluctuations (&gt; 10 lbs.)</th>
<th>Yes</th>
<th>No</th>
<th>Body Fat %</th>
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</table>

How often do you weigh yourself?  ○  Daily  ○  Weekly  ○  Monthly  ○  Rarely  ○  Never

Have you ever had your metabolism (resting metabolic rate) checked?  ○  Yes  ○  No

If yes, what was it? __________

Do you avoid any particular foods?  ○  Yes  ○  No

If yes, types and reason __________________________________________________________

If you could only eat a few foods a week, what would they be?

________________________________________________________

Do you grocery shop?  ○  Yes  ○  No

If no, who does the shopping?____________________________________________________

Do you read food labels?  ○  Yes  ○  No

Do you cook?  ○  Yes  ○  No  If no, who does the cooking?___________________________

How many meals do you eat out per week?  □  0-1  □  1-3  □  3-5  □  >5 meals per week

*Check all the factors that apply to your current lifestyle and eating habits:*

- Fast eater
- Erratic eating pattern
- Eat too much
- Late night eating
- Dislike healthy food
- Time constraints
- Eat more than 50% meals away from home
- Travel frequently
- Non-availability of healthy foods
- Do not plan meals or menus
- Reliance on convenience items
- Poor snack choices
- Significant other or family members don’t like healthy

The most important thing I should change about my diet to improve my health is:

______________________________________________________________________________
SMOKING
Currently Smoking? ○ Yes ○ No
How many years? ________ Packs per day: ________ Attempts to quit: ________
Previous Smoking: How many years? ________ Packs per day? ________
Second Hand Smoke Exposure? ________

ALCOHOL INTAKE
How many drinks currently per week? 1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits
☐ None ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ >10 If “None,” skip to Other Substances
Previous alcohol intake? ○ Yes (☐ Mild ○ Moderate ○ High) ○ None
Have you ever been told you should cut down your alcohol intake? ○ Yes ○ No
Do you get annoyed when people ask you about your drinking? ○ Yes ○ No
Do you ever feel guilty about your alcohol consumption? ○ Yes ○ No
Do you ever take an eye-opener? ○ Yes ○ No
Do you notice a tolerance to alcohol (can you “hold” more than others)? ○ Yes ○ No
Have you ever been unable to remember what you did during a drinking episode? ○ Yes ○ No
Do you get into arguments or physical fights when you have been drinking? ○ Yes ○ No
Have you ever been arrested or hospitalized because of drinking? ○ Yes ○ No
Have you ever thought about getting help to control or stop your drinking? ○ Yes ○ No

OTHER SUBSTANCES
Caffeine Intake: ○ Yes ○ No
Coffee cups/day: ☐ 1 ☐ 2-4 ☐ >4 | Tea cups/day: ☐ 1 ☐ 2-4 ☐ >4
Caffeinated Sodas or Diet Sodas Intake: ○ Yes ○ No
12-ounce can/bottle ☐ 1 ☐ 2-4 ☐ >4 per day
List favorite type (Ex. Diet Coke, Pepsi, etc.): __________________________________________
Are you currently using any recreational drugs? ○ Yes ○ No
Type_________________________
Have you ever used IV or inhaled recreational drugs? ○ Yes ○ No

EXERCISE
Current Exercise Program: (List type of activity, number of sessions/week, and duration)

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<thead>
<tr>
<th>Activity</th>
<th>Type</th>
<th>Frequency per Week</th>
<th>Duration in Minutes</th>
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<tbody>
<tr>
<td>Stretching</td>
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<tr>
<td>Cardio/Aerobics</td>
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<tr>
<td>Strength</td>
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<tr>
<td>Other (yoga, pilates, gyrotonics, etc.)</td>
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<tr>
<td>Sports or Leisure Activities</td>
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<tr>
<td>(golf, tennis, rollerblading, etc.)</td>
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Rate your level of motivation for including exercise in your life? ○ Low ○ Medium ○ High
List problems that limit activity:
______________________________________________________________________________
______________________________________________________________________________

Do you feel unusually fatigued after exercise? ○ Yes ○ No
If yes, please describe:
______________________________________________________________________________
______________________________________________________________________________

Do you usually sweat when exercising? ○Yes ○ No
**PSYCHOSOCIAL**

Do you feel significantly less vital than you did a year ago?  ○ Yes  ○ No
Are you happy?  ○ Yes  ○ No
Do you feel your life has meaning and purpose?  ○ Yes  ○ No
Do you believe stress is presently reducing the quality of your life?  ○ Yes  ○ No
Do you like the work you do?  ○ Yes  ○ No
Have you ever experienced major losses in your life?  ○ Yes  ○ No
Do you spend the majority of your time and money to fulfill responsibilities and obligations?  ○ Yes  ○ No
Would you describe your experience as a child in your family as happy and secure?  ○ Yes  ○ No

**STRESS/COPING**

Have you ever sought counseling?  ○ Yes  ○ No
Are you currently in therapy?  ○ Yes  ○ No
Describe: _____________________________________________________________
Do you feel you have an excessive amount of stress in your life?  ○ Yes  ○ No
Do you feel you can easily handle the stress in your life?  ○ Yes  ○ No

Daily Stressors: Rate on scale of 1-10
Work _____ Family _____ Social _____ Finances_____ Health_____ Other_____

Do you practice meditation or relaxation techniques?  ○ Yes  ○ No  How often? __________
Check all that apply: □Yoga □Meditation □Imagery □Breathing □Tai Chi □Prayer
 □Other: __________________________________________

Have you ever been abused, a victim of a crime, or experienced a significant trauma?
 ○Yes  ○ No

**SLEEP/REST**

Average number of hours you sleep per night:  □>10  □8-10  □6-8  □< 6
Do you feel rested upon awakening?  ○ Yes  ○ No
Do you have problems with insomnia?  ○ Yes  ○ No
Do you snore?  ○ Yes  ○ No
Do you use sleeping aids?  ○ Yes  ○ No

Explain: __________________________________________________________________________
ROLES/RELATIONSHIP

Marital status:
○ Single ○ Married ○ Divorced ○ Gay/Lesbian ○ Long Term Partnership ○ Widow

List Children:

<table>
<thead>
<tr>
<th>Child’s Name</th>
<th>Age</th>
<th>Gender</th>
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Who is Living in Household? Number: ______
Names:____________________________________________________________

Their employment/Occupations:________________________________________

Resources for emotional support?
Check all that apply:
☐ Spouse ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other: _________________

Are you satisfied with your sex life? ○ Yes ○ No

How well have things been going for you? | Very Well | Fine | Poorly | Does Not Apply
------------------------------------------|-----------|------|--------|------------------
Overall
At School
In your job
In your social life
With your friends
With sex
With your attitude
With your boyfriend/girlfriend
With your children
With your parents
With your spouse

ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

Do you have known adverse food reactions or sensitivities? ○ Yes ○ No
If yes, describe symptoms:____________________________________________

Do you have any food allergies or sensitivities? ○ Yes ○ No
If yes, list all:________________________________________________________________________

Do you have an adverse reaction to caffeine? ○ Yes ○ No
When you drink caffeine do you feel: ○ Irritable or wired ○ Aches & Pains

Do you adversely react to (Check all that apply):
☐ Monosodium glutamate (MSG) ☐ Aspartame (Nutrasweet) ☐ Caffeine ☐ Bananas
☐ Garlic ☐ Onion ☐ Cheese ☐ Citrus Foods ☐ Chocolate ☐ Alcohol ☐ Red Wine
☐ Sulfite Containing Foods (wine, dried fruit, salad bars) ☐ Preservatives (ex. sodium benzoate)
☐ Other: ___________________________________________________________________________
Which of these significantly affect you? Check all that apply:
☐ Cigarette Smoke ☐ Perfumes/Colognes ☐ Auto Exhaust Fumes ☐ Other: __________________

In your work or home environment, are you exposed to:
☐ Chemicals ☐ Electromagnetic Radiation ☐ Mold

Have you ever turned yellow (jaundiced)? ☐ Yes ☐ No
Have you ever been told you have Gilbert’s syndrome or a liver disorder? ☐ Yes ☐ No
Explain: __________________________________________________________

Do you have a known history of significant exposure to any harmful chemicals such as the following:
☐ Herbicides ☐ Insecticides (frequent visits of exterminator) ☐ Pesticides ☐ Organic Solvents ☐ Heavy Metals ☐ Other __________________
Chemical Name, Date, Length of Exposure: __________________________________________________________

Do you dry clean your clothes frequently? ☐ Yes ☐ No

Do you or have you lived or worked in a damp or moldy environment or had other mold exposures? ☐ Yes ☐ No

Do you have any pets or farm animals? ☐ Yes ☐ No
Please check all current symptoms or those present in during the past the 6 months.

**SYMPTOM REVIEW**

**GENERAL**
- Cold Hands & Feet
- Cold Intolerance
- Low Body Temperature
- Low Blood Pressure
- Daytime Sleepiness
- Difficulty Falling Asleep
- Early Waking
- Fatigue
- Fever
- Flushing
- Heat Intolerance
- Night Waking
- Nightmares
- No Dream Recall

**HEAD, EYES & EARS**
- Conjunctivitis
- Distorted Sense of Smell
- Distorted Taste
- Ear Fullness
- Ear Pain
- Ear Ringing/Buzzing
- Lid Margin Redness
- Eye Crusting
- Eye Pain
- Hearing Loss
- Hearing Problems
- Headache
- Migraine
- Sensitivity to Loud Noises
- Vision problems (other than glasses)
- Macular Degeneration
- Vitreous Detachment
- Retinal Detachment

**MUSCULOSKELETAL**
- Back Muscle Spasm
- Calf Cramps
- Chest Tightness
- Foot Cramps
- Joint Deformity
- Joint Pain
- Joint Redness
- Joint Stiffness
- Muscle Pain
- Muscle Spasms
- Muscle Stiffness
**Muscle Twitches:**
- Around Eyes
- Arms or Legs
- Muscle Weakness
- Neck Muscle Spasm
- Tendonitis
- Tension Headache
- TMJ Problems

**MOOD/NERVES**
- Agoraphobia
- Anxiety
- Auditory Hallucinations
- Black-out
- Depression
**Difficulty:**
- Concentrating
- With Balance
- With Thinking
- With Judgment
- With Speech
- With Memory
- Dizziness (Spinning)
- Fainting
- Fearfulness
- Irritability
- Light-headedness
- Numbness
- Other Phobias
- Panic Attacks
- Paranoia
- Seizures
- Suicidal Thoughts
- Tingling
- Tremor/Trembling
- Visual Hallucinations

**DIGESTION**
- Anal Spasms
- Bad Teeth
- Bleeding Gums
**Bloating of:**
- Lower Abdomen
- Whole Abdomen
- Bloating After Meals
- Blood in Stools
- Burping
- Canker Sores
- Cold Sores
- Constipation
- Cracking at Corner of Lips
- Cramps
- Dentures w/Poor Chewing
- Diarrhea
- Alternating Diarrhea and Constipation
- Difficulty Swallowing
- Dry Mouth
- Excess Flatulence/Gas
- Fissures
- Foods “Repeat” (Reflux)
- Gas
- Heartburn
- Hemorrhoids
- Indigestion
- Nausea
- Upper Abdominal Pain
- Vomiting

**Intolerance to:**
- Lactose
- All Dairy Products
- Wheat
- Gluten (Wheat, Rye, Barley)
- Corn
- Eggs
- Fatty Foods
- Yeast
- Liver Disease/Jaundice (Yellow Eyes or Skin)
- Abnormal Liver Function Tests
- Lower Abdominal Pain
- Mucus in Stools
- Periodontal Disease
- Sore Tongue
- Strong Stool Odor
- Undigested Food in Stomach
- Upper Abdominal Pain
- Vomiting

**EATING**
- Binge Eating
- Bulimia
- Can’t Gain Weight
- Can’t Lose Weight
- Can’t Maintain Healthy Weight
- Frequent Dieting
- Poor Appetite
- Salt Cravings
- Carbohydrate Craving (breads, pastas)
- Sweet Cravings (candy, cookies, cakes)
- Chocolate Cravings
- Caffeine Dependency

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- Sore Tongue
- Strong Stool Odor
- Undigested Food in Stomach
- Upper Abdominal Pain
- Vomiting
SKIN PROBLEMS
- Acne on Back
- Acne on Chest
- Acne on Face
- Acne on Shoulders
- Athlete’s Foot
- Bumps on Back of Upper Arms
- Cellulite
- Dark Circles Under Eyes
- Ears Get Red
- Easy Bruising
- Lack Of Sweating
- Eczema
- Hives
- Jock Itch
- Lackluster Skin
- Moles w/Color/Size Change
- Oily Skin
- Pale Skin
- Patchy Dullness
- Rash
- Red Face
- Sensitivity to Bites
- Sensitivity to Poison Ivy/Oak
- Shingles
- Skin Darkening
- Strong Body Odor
- Hair Loss
- Vitiligo

ITCHING SKIN
- Skin in General
- Anus
- Arms
- Ear Canals
- Eyes
- Feet
- Hands
- Legs
- Nipples
- Nose
- Penis
- Roof of Mouth
- Scalp

SKIN, DRYNESS OF
- Eyes
- Feet
- Cracking?
- Peeling?
- Hair Unmanageable?
- Hands
- Cracking? Peeling?
- Mouth/Throat
- Scalp
- Dandruff?
- Skin In General

LYMPH NODES
- Enlarged/neck
- Tender/neck
- Other Enlarged/Tender
- Lymph Nodes

NAILS
- Bitten
- Brittle
- Curve Up
- Frayed
- Fungus-Fingers
- Fungus-Toes
- Pitting
- Ragged Cuticles
- Ridges
- Soft

Thickening of:
- Fingernails
- Toenails
- White Spots/Lines

RESPIRATORY
- Bad Breath
- Bad Odor in Nose
- Cough-Dry
- Cough-Productive
- Hoarseness
- Sore Throat

Hay Fever:
- Spring
- Summer
- Fall
- Change Of Season
- Nasal Stuffiness
- Nose Bleeds
- Post Nasal Drip
- Sinus Fullness
- Sinus Infection
- Snoring
- Wheezing
- Winter Stuffiness

CARDIOVASCULAR
- Angina/chest pain
- Breathlessness
- Heart Murmur
- Irregular Pulse
- Palpitations
- Phlebitis
- Swollen Ankles/Feet
- Varicose Veins

URINARY
- Bed Wetting
- Hesitancy (trouble getting started)
- Infection
- Kidney Disease
- Leaking/Incontinence
- Pain/Burning
- Prostate Infection
- Urgency

MALE REPRODUCTIVE
- Discharge From Penis
- Ejaculation Problem
- Genital Pain
- Impotence
- Prostate or Urinary Infection
- Lumps In Testicles
- Poor Libido (Sex Drive)

FEMALE REPRODUCTIVE
- Breast Cysts
- Breast Lumps
- Breast Tenderness
- Ovarian Cyst
- Poor Libido (Sex Drive)
- Vaginal Discharge
- Vaginal Odor
- Vaginal Itch
- Vaginal Pain with Sex

Premenstrual:
- Bloating Breast Tenderness
- Carbohydrate Cravings
- Chocolate Cravings
- Constipation
- Decreased Sleep
- Diarrhea
- Fatigue
- Increased Sleep
- Irritability

Menstrual:
- Cramps
- Heavy Periods
- Irregular Periods
- No Periods
- Scanty Periods
- Spotting Between
READINESS ASSESSMENT

Rate on a scale of 5 (very willing) to 1 (not willing):
In order to improve your health, how willing are you to:

Significantly modify your diet............................................................... O 5  O 4  O 3  O 2  O 1
Take several nutritional supplements each day...................................... O 5  O 4  O 3  O 2  O 1
Keep a record of everything you eat each day...................................... O 5  O 4  O 3  O 2  O 1
Modify your lifestyle (e.g., work demands, sleep habits) ...................... O 5  O 4  O 3  O 2  O 1
Practice a relaxation technique ......................................................... O 5  O 4  O 3  O 2  O 1
Engage in regular exercise ................................................................. . O 5  O 4  O 3  O 2  O 1
Have periodic lab tests to assess your progress.................................... O 5  O 4  O 3  O 2  O 1

Comments __________________________________________________________________________________
__________________________________________________________________________________
______________________________________________

Rate on a scale of 5 (very confident) to 1 (not confident at all):
How confident are you of your ability to organize and follow through on the above health related activities? O 5  O 4  O 3  O 2  O 1

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities?
__________________________________________________________________________________
__________________________________________________________________________________
____________________________________________________________

Rate on a scale of 5 (very supportive) to 1 (very unsupportive):
At the present time, how supportive do you think the people in your household will be to your implementing the above changes? O 5  O 4  O 3  O 2  O 1

Comments: __________________________________________________________________________________
__________________________________________________________________________________
____________________________________________________________

Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact):
How much on-going support and contact (e.g., telephone consults, e-mail correspondence) from our professional staff would be helpful to you as you implement your personal health program? O 5  O 4  O 3  O 2  O 1

Comments: __________________________________________________________________________________
__________________________________________________________________________________
____________________________________________________________
3-DAY DIET DIARY INSTRUCTIONS

PLEASE SUBMIT WITH THE ENTIRE INTAKE FORM. DO NOT WAIT AND BRING WITH YOU TO THE APPOINTMENT. WE NEED TO REVIEW PRIOR TO YOUR APPOINTMENT.

It is important to keep an accurate record of your usual food and beverage intake as a part of your treatment plan.

Please complete this Diet Diary for 3 consecutive days including one weekend day.

• Do not change your eating behavior at this time, as the purpose of this food record is to analyze your present eating habits.
• Record information as soon as possible after the food has been consumed
• Describe the food or beverage as accurately as possible e.g., milk - what kind? (whole, 2%, nonfat); toast (whole wheat, white, buttered); chicken (fried, baked, breaded); coffee (decaffeinated with sugar and ½ & ½).
• Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, ½ cup, 1 teaspoon, etc.
• Include any added items. For example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.
• Record all beverages, including water, coffee, tea, sports drinks, sodas/diet sodas, etc.
• Include any additional comments about your eating habits on this form (ex. craving sweet, skipped meal and why, when the meal was at a restaurant, etc).
• Please note all bowel movements and their consistency (regular, loose, firm, etc.)

DIET DIARY

Name: ________________________________________________  Date: ___________________

DAY 1

<table>
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<tr>
<th>TIME</th>
<th>FOOD/BEVERAGE/AMOUNT</th>
<th>COMMENTS</th>
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Bowel Movements (#, form,color):_________________________________________________________
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<th>COMMENTS</th>
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Bowel Movements (#, form, color):

Stress/Mood/Emotions:

Other Comments:

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<th>FOOD/BEVERAGE/AMOUNT</th>
<th>COMMENTS</th>
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Bowel Movements (#, form, color):

Stress/Mood/Emotions:

Other Comments:
**MSQ - MEDICAL SYMPTOM/TOXICITY QUESTIONNAIRE**

**NAME:** ____________________________ **DATE:** __________________

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are completing this after your first time, then record your symptoms for **ONLY** the last 48 hours.

**POINT SCALE**

- 0 = Never or almost never have the symptom
- 1 = Occasionally have it, effect is not severe
- 2 = Occasionally have, effect is severe
- 3 = Frequently have it, effect is not severe
- 4 = Frequently have it, effect is severe

**KEY TO QUESTIONNAIRE**

Add individual scores and total each group. Add each group score and give a grand total.

- Optimal is less than 10 • Mild Toxicity: 10-50 • Moderate Toxicity: 50-100 • Severe Toxicity: over 100

<table>
<thead>
<tr>
<th>GROUP</th>
<th>SYMPTOMS</th>
<th>SCORE</th>
<th>TOTAL</th>
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<tbody>
<tr>
<td>DIGESTIVE TRACT</td>
<td>___ Nausea or vomiting</td>
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<td>___ Diarrhea</td>
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<td></td>
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<td>___ Constipation</td>
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<tr>
<td></td>
<td>___ Bloating</td>
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<td></td>
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<td></td>
<td>___ Belching or passing gas</td>
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<td></td>
<td>___ Heartburn</td>
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<td></td>
<td>___ Intestinal/Stomach pain</td>
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<tr>
<td>EARS</td>
<td>___ Itchy ears</td>
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<tr>
<td></td>
<td>___ Earaches, ear infections</td>
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<td></td>
<td>___ Drainage from ear</td>
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<td></td>
<td>___ Ringing in ears, hearing loss</td>
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<tr>
<td>EMOTIONS</td>
<td>___ Mood swings</td>
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<tr>
<td></td>
<td>___ Anxiety, fear or nervousness</td>
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<tr>
<td></td>
<td>___ Anger, irritability or aggressiveness</td>
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<tr>
<td></td>
<td>___ Depression</td>
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<tr>
<td>ENERGY/ACTIVITY</td>
<td>___ Fatigue, sluggishness</td>
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<tr>
<td></td>
<td>___ Apathy, lethargy</td>
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<td></td>
<td>___ Hyperactivity</td>
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<tr>
<td></td>
<td>___ Restlessness</td>
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<tr>
<td>EYES</td>
<td>___ Watery or itchy eyes</td>
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<tr>
<td></td>
<td>___ Swollen, reddened or sticky eyelids</td>
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<tr>
<td></td>
<td>___ Bags or dark circles under eyes</td>
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<tr>
<td></td>
<td>___ Blurred or tunnel vision (does not include near or far-sightedness)</td>
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<tr>
<td>HEAD</td>
<td>___ Headaches</td>
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<tr>
<td></td>
<td>___ Fainting</td>
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<tr>
<td></td>
<td>___ Dizziness</td>
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<td></td>
<td>___ Insomnia</td>
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<tr>
<td>HEART</td>
<td>___ Irregular or skipped heartbeat</td>
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<tr>
<td></td>
<td>___ Rapid or pounding heartbeat</td>
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<tr>
<td></td>
<td>___ Chest pain</td>
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<tr>
<td>JOINTS/MUSCLES</td>
<td>___ Pain or aches in joints</td>
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<tr>
<td></td>
<td>___ Arthritis</td>
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<td></td>
<td>___ Stiffness or limitation of movement</td>
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<tr>
<td></td>
<td>___ Pain or aches in muscles</td>
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<td></td>
<td>___ Feeling of weakness or tiredness</td>
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<tr>
<td>LUNGS</td>
<td>___ Chest congestion</td>
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<tr>
<td></td>
<td>___ Asthma, bronchitis</td>
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<td></td>
<td>___ Shortness of breath</td>
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<tr>
<td>MOUTH/THROAT</td>
<td>___ Difficult breathing</td>
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<tr>
<td>NOSE</td>
<td>___ Chronic coughing</td>
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<td></td>
<td>___ Gagging, frequent need to clear throat</td>
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<td></td>
<td>___ Sore throat, hoarseness, loss of voice</td>
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<tr>
<td>SKIN</td>
<td>___ Swollen/discolored tongue, gum, lips</td>
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<tr>
<td></td>
<td>___ Canker sores</td>
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<tr>
<td>WEIGHT</td>
<td>___ Acne</td>
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<td></td>
<td>___ Hives, rashes or dry skin</td>
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<td></td>
<td>___ Hair loss</td>
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<td></td>
<td>___ Flushing or hot flushes</td>
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<tr>
<td>OTHER</td>
<td>___ Binge eating/drinking</td>
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<td></td>
<td>___ Craving certain foods</td>
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<td></td>
<td>___ Excessive weight</td>
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<td></td>
<td>___ Compulsive eating</td>
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<td></td>
<td>___ Water retention</td>
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<tr>
<td></td>
<td>___ Underweight</td>
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<td>GRAND TOTAL</td>
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