

Tanya I. Edwards, MD Center for Integrative Medicine Medical History Intake Form

General Info	ormation			Today's Date _		
First Name Preferred Name						
Date of Birth				Age		
Height'"	Weight		Gender 🗖 Male	☐ Female		
Primary Language			_ Secondary Languag	e		
Occupation						
Place of Birth			_ City/ Town and Cou	untry if not U.S.		
Highest Education Level	☐High School	□Graduate	□Post Graduate			
Primary Address	Address					Apt #
	City			State	Zip	
Alternate Address	Address					Apt#
	City			State	Zip	
Home Phone						
Work Phone	·					
Cell Phone						
E-Mail				Fax		
Emergency Contact	Name			Phone Numb	oer	
	Address		-			Apt #
	City			State	Z	ip
Physician	Name					
	Phone Number _			Fax		
Referred By						

PHARMACY INFORMATION

ALLERGIES MEDICATION/ SUPPLEMENT/ FOOD REACTION	Primary Pharmacy	Name	e	Phone Number					
Compounding/ NamePhone Number		Addre	ess	City	State	_ Zip			
Supplement Pharmacy Address		Fax*		E-mail					
Supplement Pharmacy Address		TUX ,	*It is extren	nely important that you list the	pharmacy's fax nu	mber			
Fax* E-mail *It is extremely important that you list the pharmacy's fax number Medical Questionnaire What are your expectations and goals for this visit? HEALTH CONCERNS When was the last time you felt well? Did something trigger your change in health? What makes you feel better? What makes you feel worse? Please rank current and ongoing problems by priority DESCRIBE PROBLEM MILD/MODERATE/SEVERE TREATMENT APPROACH SUCCESS xample: Post Nasal Drip Moderate ALLERGIES MEDICATION/ SUPPLEMENT/ FOOD REACTION	Compounding/	Name	2	Phone Numbe	er				
#It is extremely important that you list the pharmacy's fax number Medical Questionnaire What are your expectations and goals for this visit? HEALTH CONCERNS When was the last time you felt well? Did something trigger your change in health? What makes you feel better? What makes you feel worse? What makes you feel worse? Please rank current and ongoing problems by priority DESCRIBE PROBLEM MILD/MODERATE/SEVERE Elimination Diet Moderate ALLERGIES MEDICATION/ SUPPLEMENT/ FOOD REACTION	Supplement Pharmacy	Addre	ess	City	State	_Zip			
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What makes you feel better? What makes you feel worse? Please rank current and ongoing problems by priority DESCRIBE PROBLEM MILD/MODERATE/SEVERE TREATMENT APPROACH SUCCESS xample: Post Nasal Drip Moderate Elimination Diet Moderate ALLERGIES MEDICATION/ SUPPLEMENT/ FOOD REACTION									
What makes you feel worse? Please rank current and ongoing problems by priority DESCRIBE PROBLEM MILD/MODERATE/SEVERE TREATMENT APPROACH SUCCESS xample: Post Nasal Drip Moderate Elimination Diet Moderate ALLERGIES MEDICATION/ SUPPLEMENT/ FOOD REACTION									
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Described and The This Assumption of The What his 42. How many How long									
DO VOLLIVE WITH A DETAIL IYES LIND ANY FEACTIONS? LIYES LIND WHAT KIND? HOW MAIN HOW MAIN HOW IDIN	Do you live with a net?	lYes □	No Any reactions? TYES TNO W	hat kind?	How many	How long			

MEDICAL HISTORY

_			
	-Dact	Condition	
	-rasi	Condition	

3 =Ongoing Condition

Diseases/ Diagnosis/ Conditions Check appropriate box and provide date of onset

Sizani.		GASTROINTESTINAL			
		Irritable Bowel Syndrome			GENITAL AND URINARY SYSTEMS
		Inflammatory Bowel Disease			Kidney Stones
		Crohn's			Gout
		Ulcerative Colitis			Interstitial Cystitis
		Gastric or Peptic Ulcer Disease			Frequent Urinary Tract Infections
		GERD (reflux)			Frequent Yeast infections
		Celiac Disease			Erectile Dysfunction
		Other			Or sexual Dysfunction
					Other
		CARDIOVASCULAR			
					MUSCULOSKELETAL / PAIN
		Heart Attack			
		Other Heart Disease			Osteoarthritis
		Stroke			Fibromyalgia
		Elevated Cholesterol			Chronic Pain
		Arrythmia (irregular heart rate)			Other
		Hypertension (high blood pressure)		lives	INITI ABABAATORY/ ALITOIRABALING
		Rheumatic Fever	Control of the Contro		INFLAMMATORY/ AUTOIMMUNE
		Mitral Valve Prolapse			
		Other			Chronic Fatigue Syndrome
_					Autoimmune Disease
10000		METABOLIC/ ENDOCRINE			Rheumatoid Arthritis
		A CANADA			Lupus SLE
		Type 1 Diabetes			Immune Deficiency Disease
		Type 2 Diabetes			Herpes- Genital
		Hypoglycemia			
		Metabolic Syndrome			Poor Immune Function
		(insulin resistance or pre-diabetes)	2 0.00. 23.		(Frequent infections)
		Hypothyroidism (low thyroid)			Food Allergies
		Hyperthyroidism (overactive thyroid)			Environmental Allergies
		Endocrine Problems			Multiple Chemical Sensitivities
		Polycystic Ovarian Syndrome (PCOS)			Latex Allergy
					Other
		Infertility Weight Gain			other
				ariotes (S.	DECDIDATORY DISEASES
		Weight Loss			RESPIRATORY DISEASES
	_	Frequent Weight Fluctuations			Asthma
		Bulimia			Chronic Sinusitis
		Anorexia			Bronchitis
		Binge Eating Disorder			Emphysema
		Night Eating Syndrome			Pneumonia
		Eating Disorder (non-specific)			Tuberculosis
		Other			Sleep Apnea
		CANCER			
		Lung Cancer		aceda l	SKIN DISEASES
	ם כ	Lung Cancer			Eczema
		Breast Cancer			Psoriasis
		Colon Cancer			Acne
		Ovarian Cancer			Melanoma
		Prostate Cancer			Skin Cancer
		Skin CancerOther			Other

NEUROLOGIC/ MOOD	
Depression	Mild Cognitive Impairment Memory Problems Parkinson's Disease Multiple Sclerosis ALS Seizures Other Surgery Appendectomy Hysterectomy +/- Ovaries Gall Bladder Hernia Tonsillectomy Dental Surgery Joint Replacement - knee/ hip Heart Surgery - bypass valve Angioplasty or Stent Pacemaker Pacemaker Pacemaker Pacemaker Pacemaker Pacemaker Memory Problems Memory
☐ Ultrasound	Other
☐ X-rays	☐ None
INJURIES Back Injury	n Bones
PATIENT BIRTH HISTORY	
☐ Term ☐ Premature	
Pregnancy Complications	
☐ Breast Fed How long? ☐ Bottle-fed Did y	ou eat a lot of candy or sugar as a child? Yes No
Age at introduction of: Solid Foods Dairy	Wheat
GYNECOLOGIC HISTORY (FOR WOMEN ONLY) Obstetric History Check box if yes and provide number of	□ Missawings □ Abortion □ Living Children
☐ Pregnancies ☐ Caesarean ☐ Vaginal Deliveries	
Post-Partum Depression Toxemia Gestational	
☐ Breast Feeding- For how long?	

Menstrual History					
Age at first period Menses Frequency	Pain 🗖 Yes 🗖 No	Clotting			
Has your period ever skipped? 🗖 Yes 🗖 No For ho	w long?	Date of Last Menstrua	l Period		
Use of Birth Control Pills					
Do you use contraception?	☐ Condom ☐ Diaphi	ragm 🔲 IUD 🗇 Partr	ner Vasectomy		
Women's Disorder Hormonal Imbalances					
☐ Fibrocystic Breasts ☐ Endometriosis ☐ Fibroids ☐	Infertility 🗖 Painful Period	ds 🗖 Heavy Periods 🗖 PMS			
Last Mammogram	☐ Breast Biopsy/ Date _				
Last PAP Test	☐ Normal ☐ Abnormal				
Date of Last Bone Density	Results: 🗆 High 🗖 Low 🗈	J Within Normal Range			
Are you in menopause?	nopause	<u>.</u>			
☐ Hot Flashes ☐ Mood Swings ☐ Concentration/ M	emory Problems 🗖 Vagina	l Dryness 🗖 Decreased Libi	do		
☐ Heavy Bleeding ☐ Joint Pains ☐ Headaches ☐ We	eight Gain 🗖 Loss of Contro	ol of Urine Palpitations			
\square Use of hormone replacement therapy? \square Yes \square	No How long?				
in second half of your cycle, do you have symptoms	of breast tenderness, wate	er retention or irritability (F	PMS)? 🗖 Yes 🗖 No		
Sexual Patterns					
Do you have any questions about sex? 🗖 Yes 🗖 No					
Do you have pain or discomfort with sexual intercou	urse? 🗆 Yes 🗖 No How m	any partners have you had	in the past 10 years?		
Have you ever had a sexually transmitted disease? [□ Yes □ No				
MEN'S HISTORY (FOR MEN ONLY)					
Have you had a PSA done? ☐ Yes ☐ No PSA Level:	: 🗆 0-2 🔘 2-4 🖂 4-10 🔲 > 1	0			
□Prostate Enlargement □Prostate Infection □Cha			Erection		
Difficulty Maintaining an Erection Urgency/ Hesitancy/ Change in Urinary Stream					
□Nocturia (urination at night) How many times at night? □Loss of Control of Urine					
Do you have any questions about sex? ☐ Yes ☐ No					
Do you have pain or discomfort with sexual intercourse? Yes No How many partners have you had in the past 10 years?					
Have you ever had a sexually transmitted disease? ☐ Yes ☐ No					
,					
MEDICATION AND NUTRITIONAL SUPPLEME	ENTS				
Current Medications		I	T		
MEDICATION DOSAGE	FREQUENCY	START DATE (MONTH/YEAR)	REASON FOR USE		
		(INICIALITY LEXITY)			

Any hormones (estrogens, progesterone, DI-	EA, testosterone, growth hormone, steroids)
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Current Nutritional Supplements (Vitamins, Minerals, Herbs, Homeopathy

SUPPLEMEN & BRAND	100	DOS	SAGE FREQUENCY				1 2 2 2 3 3 4 4 4	ART DATE NTH/YEAR)	REASON FOR USE
				 .		<u></u>			
							-		
				•					
		***************************************			•				
Have your medi	catio	ns or supplement	s ever caused	you any side	effe	ts or pro	oblems? 🗖	Yes 🗖 No	
Describ	e								
Have you had pr	olon	ged or regular use	of NSAIDs? (A	Advil, Aleve,	etc.)	Motrin,	Aspirin? 🗖	Yes 🗖 No	
Have you had pr	olon	ged or regular use	of Tylenol?	Yes 🗆 No					
Have you had pr	olon	ged or regular use	e of Acid Block	ing Drugs (Ta	igam	et, Zanta	ac, Prilosec	, etc.?) 🗖 Yes 🗖	No
Use of steroids (pred	inisone, nasal allei	rgy inhalers) in	the past?	J Yes	□ No			
Use of oral conti	race	otives? 🗆 Yes 🗖 I	Vo						
Long term antibi	iotic	s? 🗖 Yes 🗖 No							
How often have	you	taken antibiotics:							
Infancy/ Childho	od: l	□<5 times □> 5 ti	mes	Teen: □ <5 1	times	□>5 tir	mes	Adulthood: 🗖<5	times □>5 times
IMMUNIZATIO	NS/	VACCINATIONS	3						
CHECK ANY YOU RECEIVED	х	DATE	BOOS	TERS	Х		DATE	DESCRIBE AI	NY ADVERSE REACTIONS
Smallpox			Within past	7 years?			****		
DPT									
Diptheria									
Pertussis									
Tetanus			Tetanus boo	ster?					
Measles									
Mumps									
Rubella							*******		
Polio			Within past 2	2 years?					
Hepatîtis									
Influenza			Your last flu	shot?		<u></u>			
Pneumovax									
Other									
Have you been o	ut o	f the country in th	e last 2 years?	Yes 🗆 N	0	When?		Where?	
Tuberculin (TB) S	Skin '	Test: 🗆 Yes 🗖 No	Date:			Result:	☐ Positive	☐ Negative	

FAMILY HISTORY

AMETHOTOR		1	Τ	τ		1			1			
Check family members that apply	Mother	Father	Brother(S)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age (if still alive)												
Age at Death (if deceased)												
Cancers	1 152 5 5 5 5	The said said	\$2,88.0 PM	1000		100	S\$4, 24, 4		3.73 5.66		1 A 14 15	
Colon Cancer						-			 			
Breast or Ovarian Cancer												
Heart Disease											<u></u>	
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Spondylitis) Inflammatory Bowel Disease												
Multiple Sclerosis				 								
Auto Immune Disease (such as Lupus)												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema/ Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia						 						
ADHD			<u> </u>									
Autism		<u> </u>										
Bipolar Disease												

GI HISTORY .
Have you traveled outside of the U.S.? Yes No If yes, where?
Wilderness Camping? Tyes No Where?
Have you ever had severe □Gastroenteritis □Diarrhea
DENTAL HISTORY
☐Silver Mercury Fillings How many?
□Gold Fillings □Root Canals Implants □Tooth Pain □Bleeding Gums □Gingivitis □Problems with Chewing
How often do you brush your teeth? How many minutes each time?
Do you use fluoridated toothpaste? Yes No
What type of dental floss do you use? ☐Waxed ☐Unwaxed ☐None How often do you floss?
Social History
NUTRITION
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
Are you on a special diet? ☐ Yes ☐ No Check all that apply
□Low Fat □Low Carbohydrate □High Protein □Low Sodium □Diabetic □No Dairy □No Wheat
□No Gluten □Vegetarian □Vegan □Ovo-Lacto □Other/Describe
How often do you weigh yourself? □Daily □ Weekly □Monthly □Rarely □Never
Do you avoid any foods? Yes No If yes, what foods and reason?
Do you crave any foods? ☐ Yes ☐ No What foods?
Do you grocery shop? Yes No If no, who does the shopping?
Do you cook? Yes No If no, who does the cooking?
How many meals do you eat out per week? □0-1 □2-3 □4-5 □>5 meal per week
Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives? Yes
a) If yes, are these symptoms associated with any particular food or supplement?
b) Please name the food or supplement and the symptoms. Example: Milk- gas and diarrhea
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 Describe
Does skipping a meal greatly affect your symptoms? Yes No
ALCOHOL, TOBACCO, SUBSTANCE USE
Alcohol
Have you ever used alcohol? ☐ Yes ☐ No
How many drinks surrently nor week? (1 drinks For wine 120z heer 1 For spirits). Though T1-3 T4-6 T7-10 T>10

Previous alcohol intake? ☐Mild ☐Mode	erate □High □None <i>If "N</i>	lone" skip to	Торассо			
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						
Have you ever been unable to remembe	r what you did during a dri	nking episode	e? ☐ Yes ☐ No			
Have you ever been arrested or hospital	ized because of drinking? [J Yes □ No				
Have you ever thought about getting hel			es 🗆 No			
Tobacco						
	Mo					
Have you ever used tobacco? ☐ Yes ☐ I		11	Cycle a sleen van			
Do you currently smoke? ☐ Yes ☐ No F						
Previous smoking: How many years?						
Number of attempts to quit	Are you exposed to	o second-han	d smoke regularly?	Yes 🗆 No		
Other Substances						
Caffeine Intake: ☐ Yes ☐ No Cups	/day: 🗖 Coffee/ 🗖 Tea 🗆] 1 🗇 2-4 🗇	>4/day			
Caffeinated Soda or Diet Soda Intake: □	Yes □ No Cups/day: □	1 🗆 2-4 🗆>4	4/day			
Green Tea Intake: ☐ Yes ☐ No Cups	s/day: □ 1 □ 2-4 □>4/da	ıv				
How many glasses of water do you drink			Spring	Itered Distilled		
Are you currently using any recreational						
Have you ever used IV or inhaled recreat						
have you ever used to or initialed recreat	Johan drugs: La res La No	nave you ev	er been treated for	arag abase: 12 163 12 140		
SAFETY						
Do you use sunscreen regularly? Yes	□ No How often?		What Brand?			
Do you wear a seat belt? 🗖 Yes 🗖 No						
EXERCISE						
Do you exercise regularly? ☐ Yes ☐ No						
Current Exercise Program ACTIVITY	TYPE	FREOL	JENCY/ WEEK	DURATION IN MINUTES		
Stretching	1112	711202	7211017			
Cardio/ Aerobics						
Strength						
Other (yoga, pilates) Sports (golf, tennis)						
Do you feel you have time to exercise?		nusually fatig	ued after exercise?	Yes No		
List problems that limit activity:						
PSYCHOSOCIAL						
Are you happy? ☐ Yes ☐ No Do yo	ou enjoy your work? 🗖 Yes	s □ No	Do you take vacatio	ons? 🗆 Yes 🗀 No		
Have you made significant occupational			•	cribe them briefly:		
mare you made significant occupational	ondinges in the last to year.	J 103	,,			
What gives your life meaning and purpos	se?					

What does health mean to you?
What do you do for fun?
What interests/hobbies do you have?
Do you have any insight into your illness?
How important is religion or spirituality in your life?
□Not at all important □Somewhat important □Extremely important
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.
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/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
f) Have you had any violent or otherwise traumatic life experiences, or have you witnessed any violence or abuse? The same issues privately?
gy Would you ree, surel discussing any of these issues privately.
SLEEP
Do you have problems with sleep? ☐ Yes ☐ No Do you have trouble falling asleep? ☐ Yes ☐ No
If you awaken during the night, how often? Do you have trouble falling back asleep?
Do you snore? Yes No Do you use sleeping aids? No Describe
Average number of hours you sleep at night □>10 □8-10 □6-8 □<6
Do you feel rested upon awakening? Yes No What time of day are you most awake and alert?
STRESS
Do you feel you have an excessive amount of stress in your life? Yes
Do you feel you have the ability to cope with the stress in your life? 🗖 Yes 🔲 No
Have you ever seen a psychotherapist? ☐Yes ☐ No Are you currently in counseling? ☐ Yes ☐ No
Do you practice meditation or relaxation techniques?
Check all that apply: ☐Yoga ☐Meditation ☐Tai Chi ☐QiGong ☐Imagery ☐Biofeedback ☐Prayer ☐Breath Work
RELATIONSHIPS
Marital Status: ☐Single ☐Married ☐Divorced ☐Gay/Lesbian ☐Long-term Partner ☐Widow
Children's Name (if any), Age and Gender
With whom do you live? List Name, Ages, Relationship

Who are the most impo	tant people in your life? List names and relationship	
ENVIRONMENTAL		
•	erse food reactions or sensitivities? 🗆 Yes 🗖 No D	
Do you have any food al	ergies or sensitivities? Yes No Describe	
Do you have an adverse	reaction to caffeine? \square Yes \square No \square When you drink caffei	ine to you feel □Irritable or Wired □Aches/Pains
Do you adversely react t	o: Check all that apply	
☐Monosodium glutama	te (MSG) □Aspartame (Nutrasweet) □Caffeine □Banana	as □Garlic □Onion □Cheese
□Citrus Foods □Choco	ate □Alcohol □Red Wine □Sulfite-containing Foods (wi	ine, dried fruit, salad bars)
□Preservatives (ex. Sod	ium benzoate) Other	
Which of these significa	ntly affect you? Check all that apply	
□Cigarette Smoke □Pe	rfumes/ Colognes	
In your work or home en	vironment, are you exposed to: 🗆 Chemicals 🗖 Electroma	gnetic Radiation
Do you have a known hi	story of significant exposure to any harmful chemicals such	as: ☐Herbicides ☐Pesticides
□Insecticides (frequent	visits of exterminator)	s 🗆 Other
Chemical Name, Date, L	ength of Exposure	
Do you dry clean your cl	othes frequently? 🗆 Yes 🗖 No 💮 Do you have any or f	arm animals? □Yes □ No
Do you or have you lived	or worked in a damp or moldy environment or had other	mold exposures? ☐Yes ☐ No
Food Diary		
Please list all food and b	everages consumed in a 24-hour period. Include meals, sn	acks, beverages and condiments.
TIME	FOOD/ BEVERAGE	AMOUNT (CUP, OUNCES)
	MANUAL TO THE PARTY OF THE PART	

MSQ- MEDICAL SYMPTOM/TOXICITY QUESTIONNAIRE

0= Never or almost never have the symptom

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. If you are taking this questionnaire for the first time, record your symptoms for the last 48 hours ONLY. If this is a follow-up questionnaire, record your symptoms for the past 30 days.

1= Occasionally have it, effect is not severe

2= Occasionally have it, eff 4= Frequently have it, effe	•	e it, effect is not severe
DIGESTIVE TRACT	HEAD	MOUTH/THROAT
Nausea or Vomiting	Headaches	-
Diarrhea	Faintness	Chronic Coughing
Constipation	Dizziness	Gagging, Frequent Need to Clear Throat
Bloated Feeling	Insomnia	Sore Throat, Hoarseness, Loss of Voice
Belching or Passing Gas	Total	Swollen/ Discolored Tongue, Gum, Lips
Heartburn	HEART	Total
Intestinal/Stomach Pain	Irregular or Skipped Heartbeat	NOSE
Total	Rapid or Pounding Heartbeat	Stuffy Nose
EARS	Chest Pain	Sinus Problems
Itchy Ears	Total	Hay Fever
Earaches, Ear Infections	JOINTS/MUSCLES	Sneezing Attacks
Drainage from Ear	Pain or Aches in Joints	Excessive Mucus Formation
Ringing in Ears, Hearing Loss	Arthritis	Total
Total	Stiffness or Limitation of Movement	SKIN
EMOTIONS	Pain or Aches in Muscles	Acne
Mood Swings	Feeling of Weakness or Tiredness	Hives, Rashes or Dry Skin
Anxiety, Fear or Nervousness	Total	Hair Loss
Anger, Irritability, or Aggressiveness	LUNGS	Flushing or Hot Flashes
Depression	Chest Congestion	Excessive Sweating
Total	Asthma, Bronchitis	Total
ENERGY/ ACTIVITY	Shortness of Breath	WEIGHT
Fatigue, Sluggishness	Difficult Breathing	Binge Eating/ Drinking
Apathy, Lethargy	Total	Craving Certain Foods
Hyperactivity	MIND	Excessive Weight
Restlessness	Poor Memory	Compulsive Eating
Total	Confusion, Poor Comprehension	Water Retention
EYES	Poor Concentration	Underweight
Watery or Itchy Eyes	Poor Physical Coordination	Total
Swollen, Reddened or Sticky Eyelids	Difficulty in Making Decisions	OTHER
Bags or Dark Circles under Eyes	Stuttering or Stammering	Frequent Illness
Blurred or Tunnel Vision (Does not	Slurred Speech	Frequent or Urgent Urination
include near- or far-sightedness	Learning Disabilities	Genital Itch or Discharge
Total	Total	Total
	GF	RAND TOTAL

KEY TO QUESTIONNAIRE

POINT SCALE

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

•Optimal is less than 10

•Mild Toxicity: 10-50

•Moderate Toxicity: 50-100

•Severe Toxicity: over 100

SYMPTOM REVIEW

Please check all current symptoms occurring in the past 6 months

GENERAL		☐Caffeine Dependent
Cold Hands & Feet	Muscle Twitches:	DIGESTION
Cold Intolerance	☐Around Eyes	
JLow Body Temperature	☐Arms or Legs	☐Bad Teeth
□Low Blood Pressure	☐Muscle Weakness	☐Bleeding Gums
□Daytime Sleepiness	□Neck Muscle Spasm	Bloating of:
Difficulty Falling Asleep	☐ Tendonitis	□Lower Abdomen
∃Early Waking	☐Tension Headache	■Whole Abdomen
T Fatigue	☐TMJ Problems	☐Bloating after meals
□Fever	MOOD/NERVES	☐Blood in Stools
∃ Flushing	WOOD/NERVES	☐Burping
☐Heat Intolerance	□Agoraphobia	☐Canker Sores
□Night Waking	□Anxiety	□Cold Sores
□Nightmares	□Black-out	□Constipation
□No Dream Recall	□ Depression	□Cracking at Corner of Lips
HEAD EVEC 9 FADC	Difficulty:	□ Cramps
HEAD, EYES & EARS	□Concentrating	☐Dentures w/Poor Chewing
□Conjunctivitis	☐With Balance	□ Diarrhea
□Distorted Sense of Smell	With Thinking	☐Alternating Diarrhea & Constipation
□Distorted Taste	☐With Judgment	□Difficulty Swallowing
□Ear Fullness	☐With Speech	☐Dry Mouth
🗖 Ear Pain	☐With Memory	☐Excess Flatulence/ Gas
□Ear Ringing/ Buzzing	□Dizziness (Spinning)	□Fissures
□Eye Crusting	☐Fainting	☐Foods "Repeat" (Reflux)
□Eye Pain	☐ Fearfulness	□Gas
Hearing Loss	☐Irritability	☐Heartburn
☐Hearing Problems	☐Light-Headedness	☐Hemorrhoids
☐Headache	☐ Numbness	□Indigestion
□ Migraine	☐Other Phobias	□Nausea
Sensitivity to Loud Noises	☐Panic Attacks	□Upper Abdominal Pain
☐Vision Problems (Other than glasses)	□Paranoia	□ Vomiting
	□Seizures	Intolerance to:
MUSCULOSKELETAL	☐Suicidal Thoughts	□Lactose
Back Muscle Spasm	☐Tingling	☐All Dairy Products
Calf Cramps	☐Tremor/ Trembling	□Wheat
☐Chest Tightness	☐Visual Hallucinations	☐Gluten (wheat, rye, barley)
☐Foot Cramps		☐Corn
Joint Deformity	EATING	□Eggs
Joint Pain	☐Binge Eating	☐Fatty Foods
Joint Redness	□Bulimia	□ Yeast
Joint Stiffness	□Can't Gain Weight	☐Liver Disease/Jaundice
□ Muscle Pain	☐Can't Lose Weight	☐Abnormal Liver Function Tests
□Muscle Spasms	☐Poor Appetite	☐Lower Abdominal Pain
JMuscle Stiffness	☐Salt Cravings	☐Mucus in Stools
	☐Carbohydrate Craving (breads, pastas)	
	Sweet Cravings (Candy, Cookies, Cakes)	

☐Chocolate Cravings

SYMPTOM REVIEW continued

☐Throat

Please check all current symptoms occurring in the past 6 months

☐Periodontal Disease		
☐Sore Tongue	LYMPH NODES	URINARY
☐Strong Stool Odor	□Enlarged/ Neck	☐Bed Wetting
☐Undigested Food in Stool	☐Tender/ Neck	☐Hesitancy (trouble starting)
	☐Other Enlarged/ Tender	□Infection
SKIN PROBLEMS	☐Lymph Nodes	☐Kidney Disease
☐Acne on Back		☐Leaking/Incontinence
☐Acne on Chest	NAILS	☐Pain/Burning
☐Acne on Face	□Bitten	☐Prostate Infections
☐Acne on Shoulders	□ Brittle	□Urgency
☐Athlete's Foot	☐Fungus/ Fingers	
☐Bumps on Back of Upper Arms	☐Fungus/ Toes	MALE REPRODUCTION
☐Cellulite	☐ Pitting	☐Discharge from Penis
□Dryness	□Ridges	☐Ejaculation Problem
☐ Dark Circles Under Eyes	□ Soft	☐Genital Pain
□Ears Get Red	☐White Spots/ Lines	□Impotence
☐Easy Bruising		☐Prostate or Urinary Infection
☐Lack of Sweating	RESPIRATORY)	☐Lumps in Testicles
□Eczema	☐Bad Breath	☐Poor Libido (sex drive)
☐Hives	□Cough (FEMALE REPRODUCTION
□Jock Itch	□Hoarseness	FEIVIALE REPRODUCTION
☐Moles w/ Color/Size Change	☐Sore Throat	☐Breast Cysts
☐Oily Skin	Hay Fever:	☐Breast Lumps
□Rash	□Spring	☐Breast Tenderness
☐Red Face	□Summer	☐Ovarian Cyst
☐Sensitive to Bites	□Fall	☐Poor Libido (sex drive)
☐Sensitivities to Poison Ivy/ Oak	☐Change of Season	□Vaginal Discharge
☐ Shingles	□Nasal Stuffiness	□Vaginal Odor
☐Skin Darkening	□Nose Bleeds	□Vaginal Itch
☐Strong Body Odor	☐Post Nasal Drip	□Vaginal Pain with Sex
☐Hair Loss	☐Sinus Fullness	Premenstrual:
☐ Vitiligo	☐Sinus Infection	☐Bloating, Breast Tenderness
TOWNS SIZE	□Snoring	☐Carbohydrate Cravings
ITCHING SKIN	□Wheezing	☐Chocolate Cravings
☐Skin in General	☐Winter Stuffiness	□Constipation
□Anus		□ Decreased Sleep
□Arms	CARDIOVASCULAR	□Diarrhea
☐ Ear Canals	☐Angina/Chest Pain	☐ Fatigue
□Eyes	☐Breathlessness	☐Increased Sleep
□Feet		
_	☐Heart Murmur	□Irritability
☐Hands	☐Heart Murmur ☐Irregular Pulse	□Irritability Menstrual:
□Hands □Legs		
	☐Irregular Pulse	Menstrual:
□Legs	☐Irregular Pulse ☐Palpitations	Menstrual: GCramps
□Legs □Nipples	□Irregular Pulse □Palpitations □Phlebitis	Menstrual: □Cramps □Heavy Periods
□Legs □Nipples □Nose	□Irregular Pulse □Palpitations □Phlebitis □Swollen Ankles/ Feet	Menstrual: