



Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Occupation: \_\_\_\_\_ Hours of work per week: \_\_\_\_\_

Age: \_\_\_\_ Birth Date: \_\_\_\_\_ Current weight: \_\_\_\_\_ Weight one year ago: \_\_\_\_\_

Email address: \_\_\_\_\_ Relationship status: \_\_\_\_\_

Children: \_\_\_\_\_ Ages: \_\_\_\_\_ Pets: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_

**Present Complaints: List your main health problems:**

1. \_\_\_\_\_ When did it start? \_\_\_\_\_
2. \_\_\_\_\_ When did it start? \_\_\_\_\_
3. \_\_\_\_\_ When did it start? \_\_\_\_\_
4. \_\_\_\_\_ When did it start? \_\_\_\_\_
5. \_\_\_\_\_ When did it start? \_\_\_\_\_

**At what point in your life did you feel best?**

---

---

**What are your health goals?**

---

---

**Medications or nutritional supplements you are currently taking:**

---

---

---

**Section 1– Read each symptom and circle the number that applies.**

Key: 0=no, symptom does not occur

2=Moderate symptom, occurs weekly

1=Yes, mild symptom, rarely occurs

3=Severe symptom, occurs daily

- |  |  |
|--|--|
| 1. 0 1 2 3 Heartburn or Acid Reflux    | 9. 0 1 2 3 Fingernails chip, break, peel |
| 2. 0 1 2 3 Burping or Gas after eating | 10. 0 1 2 3 Anemia unresponsive to iron  |
| 3. 0 1 2 3 Bloating after eating       | 11. 0 1 2 3 Stomach pain or cramps       |
| 4. 0 1 2 3 Bad breath                  | 12. 0 1 2 3 Diarrhea, chronic            |
| 5. 0 1 2 3 Sweat has a strong odor     | 13. 0 1 2 3 Diarrhea after meals         |
| 6. 0 1 2 3 Feel better if I don't eat  | 14. 0 1 2 3 Black or dark stool          |
| 7. 0 1 2 3 Sleepy after meals          | 15. 0 1 2 3 Undigested food in stool     |
| 8. 0 1 2 3 Burning pain in stomach     |  |

**Section 2– Read each symptom and circle the number that applies.**

- |  |                                     |
|--|-------------------------------------|
| 16. 0 1 2 3 Skip days between bowel movm.    | 24. 0 1 2 3 Dark circles under eyes |
| 17. 0 1 2 3 Stools hard or difficult to pass | 25. 0 1 2 3 History of parasites    |
| 18. 0 1 2 3 Cramping on lower abdomen        | 26. 0 1 2 3 Coated tongue           |
| 19. 0 1 2 3 Blood in stool                   | 27. 0 1 2 3 Anus itches             |
| 20. 0 1 2 3 Mucus in stool                   | 28. 0 1 2 3 Constipation            |
| 21. 0 1 2 3 IBS or colitis                   | 29. 0 1 2 3 Stools are loose        |
| 22. 0 1 2 3 Yeast Infections                 | 30. 0 1 2 3 Bad smelling gas        |
| 23. 0 1 2 3 Nail fungus or athletes foot     |                                     |

**Section 3– Read each symptom and circle the number that applies.**

- |   |  |
|---|--|
| 31. 0 1 2 3 Food allergies              | 38. 0 1 2 3 Pulse speeds after eating          |
| 32. 0 1 2 3 Bloating after eating       | 39. 0 1 2 3 Nightmares                         |
| 33. 0 1 2 3 Airborne allergies          | 40. 0 1 2 3 Feel spacy or unreal               |
| 34. 0 1 2 3 Wheat or gluten sensitivity | 41. 0 1 2 3 Alternating diarrhea/ constipation |
| 35. 0 1 2 3 Dairy sensitivity           | 42. 0 1 2 3 Hives                              |
| 36. 0 1 2 3 Sinus congestion            |  |
| 37. 0 1 2 3 Craves bread and pasta      |  |

**Section 4– Read each symptom and circle the number that applies.**

Key: 0=no, symptom does not occur

2=Moderate symptom, occurs weekly

1=Yes, mild symptom, rarely occurs

3=Severe symptom, occurs daily

- |   |  |
|---|--|
| 43. 0 1 2 3 Nausea                          | 50. 0 1 2 3 Headache over eyes                           |
| 44. 0 1 2 3 Pain between shoulder blades    | 51. 0 1 2 3 Easily intoxicated                           |
| 45. 0 1 2 3 Skin rashes, acne, eczema, etc. | 52. 0 1 2 3 Hemorrhoids or varicose veins                |
| 46. 0 1 2 3 Age or “Liver” spots            | 53. 0 1 2 3 Sensitivity to perfumes or chemicals, etc... |
| 47. 0 1 2 3 Greasy foods upset stomach      | 54. 0 1 2 3 Pain under right rib cage                    |
| 48. 0 1 2 3 Gallbladder attacks or stones   | 55. 0 1 2 3 Insomnia                                     |
| 49. 0 1 2 3 Motion sickness                 |  |

**Section 5– Read each symptom and circle the number that applies.**

- |   |  |
|---|--|
| 56. 0 1 2 3 Carpal Tunnel Syndrome      | 60. 0 1 2 3 Bursitis or tendonitis     |
| 57. 0 1 2 3 Osteoporosis or Osteopenia  | 61. 0 1 2 3 Joints pop or crack        |
| 58. 0 1 2 3 Legs or foot cramps at rest | 62. 0 1 2 3 White spots on fingernails |
| 59. 0 1 2 3 Pain or swelling in joints  | 63. 0 1 2 3 Decreased taste or smell   |

**Section 6- Read each symptom and circle the number that applies.**

- |   |   |
|---|---|
| 64. 0 1 2 3 Intense Fatigue             | 69. 0 1 2 3 Muscle twitching              |
| 65. 0 1 2 3 Brain Fog                   | 70. 0 1 2 3 Unexplained fevers            |
| 66. 0 1 2 3 Memory loss short/long term | 71. 0 1 2 3 Headaches/Migraines           |
| 67. 0 1 2 3 Pain or swelling in joints  | 72. 0 1 2 3 Poor concentration            |
| 68. 0 1 2 3 Stiff joints in morning     | 73. 0 1 2 3 Sore soles of feet in morning |

**Section 7– Read each symptom and circle the number that applies**

- |  |  |
|--|--|
| 74. 0 1 2 3 Body jerks as falling asleep | 79. 0 1 2 3 Nosebleeds                   |
| 75. 0 1 2 3 Restless leg syndrome        | 80. 0 1 2 3 Bruise easily                |
| 76. 0 1 2 3 Small bumps on back of arms  | 81. 0 1 2 3 Gums bleed easily            |
| 77. 0 1 2 3 Heart races                  | 82. 0 1 2 3 Depressed regularly          |
| 78. 0 1 2 3 Worrier, anxious             | 83. 0 1 2 3 Numbness or tingling in body |
|  | 84. 0 1 2 3 Loss of muscle tone          |

**Section 8– Read each symptom and circle the number that applies.**

Key: 0=no, symptom does not occur

2=Moderate symptom, occur

1=Yes, mild symptom, rarely occurs

3=Severe symptom, occurs daily

- |   |                                       |
|---|---------------------------------------|
| 85. 0 1 2 3 Difficulty falling asleep                   | 91. 0 1 2 3 Headache after exercise   |
| 86. 0 1 2 3 Slow starter in the morning                 | 92. 0 1 2 3 Chronic low back pain     |
| 87. 0 1 2 3 Suddenly dizzy when standing                | 93. 0 1 2 3 Clench or grind teeth     |
| 88. 0 1 2 3 Difficulty holding chiropractic adjustments | 94. 0 1 2 3 Perspire too easily       |
| 89. 0 1 2 3 Arthritis                                   | 95. 0 1 2 3 Hives                     |
| 90. 0 1 2 3 Crave salty food                            | 96. 0 1 2 3 Bright light hurts eyes   |
|   | 97. 0 1 2 3 Slow recovery from stress |

**Section 9– Read each symptom and circle the number that applies.**

- |  |                                  |
|--|----------------------------------|
| 98. 0 1 2 3 Difficulty losing weight   | 106. 0 1 2 3 Sensitive to iodine |
| 99. 0 1 2 3 Loss of outer 1/3 eyebrows | 107. 0 1 2 3 Fast pulse at rest  |
| 100. 0 1 2 3 Mentally sluggish         | 108. 0 1 2 3 Nervousness         |
| 101. 0 1 2 3 Cold hands and feet       | 109. 0 1 2 3 Sensitivity to cold |
| 102. 0 1 2 3 Hair loss                 | 110. 0 1 2 3 Intolerant to heat  |
| 103. 0 1 2 3 Easily fatigued           | 111. 0 1 2 3 Flush easily        |
| 104. 0 1 2 3 Seasonal sadness          | 112. 0 1 2 3 Heart palpitations  |
| 105. 0 1 2 3 Low body temperature      |                                  |

**Section 10- Read each symptom and circle the number that applies.**

- |  |  |
|--|--|
| 113. 0 1 2 3 Crave sweets                                  | 118. 0 1 2 3 Get shaky or weak if hungry |
| 114. 0 1 2 3 Awaken during night, hard to fall back asleep | 119. 0 1 2 3 Sleepy in afternoon         |
| 115. 0 1 2 3 Excessive appetite                            | 120. 0 1 2 3 Fatigue relieved by eating  |
| 116. 0 1 2 3 Crave coffee or sugar in afternoon            | 121. 0 1 2 3 Afternoon headaches         |
| 117. 0 1 2 3 Headache if meals are delayed                 | 122. 0 1 2 3 Irritable before meals      |

**Section 11– *Men Only* - Read each symptom and circle the number that applies.**

- |   |  |
|---|--|
| 138. 0 1 2 3 Prostate problems              | 142. 0 1 2 3 Fatigue                                 |
| 139. 0 1 2 3 Decreased libido               | 143. 0 1 2 3 Pain on inside of legs or heels         |
| 140. 0 1 2 3 Urination difficult            | 144. 0 1 2 3 Feeling of incomplete bowel elimination |
| 141. 0 1 2 3 Pain or burning with urination |  |

**Section 12- Women Only – Read each symptom and circle the number that applies.**

Key: 0=no, symptom does not occur

2=Moderate symptom, occurs weekly

1=Yes, mild symptom, rarely occurs

3=Severe symptom, occurs daily

- |                                       |                                  |
|---------------------------------------|----------------------------------|
| 123. 0 1 2 3 Painful menstrual cycle  | 131. 0 1 2 3 Uterine fibroids    |
| 124. 0 1 2 3 Mood swings around cycle | 132. 0 1 2 3 Fibrocystic breasts |
| 125. 0 1 2 3 Painful breasts at cycle | 133. 0 1 2 3 Hot flashes         |
| 126. 0 1 2 3 Irregular cycles         | 134. 0 1 2 3 Vaginal itchiness   |
| 127. 0 1 2 3 Heavy menstrual flow     | 135. 0 1 2 3 Vaginal discharge   |
| 128. 0 1 2 3 Acne at menstrual cycle  | 136. 0 1 2 3 Night sweats        |
| 129. 0 1 2 3 Yeast Infections         | 137. 0 1 2 3 Menopausal symptoms |
| 130. 0 1 2 3 Endometriosis            |                                  |

**Section 13– Read each symptom and circle the number that applies.**

- |   |  |
|---|--|
| 145. 0 1 2 3 Shortness of breath with moderate exertion | 149. 0 1 2 3 Muscle cramps during exercise         |
| 146. 0 1 2 3 Opens windows in closed room               | 150. 0 1 2 3 Hands and feet go to sleep            |
| 147. 0 1 2 3 Sigh frequently                            | 151. 0 1 2 3 Dull pain in chest, worse on exertion |
| 148. 0 1 2 3 Bruise easily                              |  |

**Section 14- Read each symptom and circle the number that applies.**

- |  |  |
|--|--|
| 152. 0 1 2 3 Pain upon urination           | 156. 0 1 2 3 History of kidney stones                        |
| 153. 0 1 2 3 Frequent bladder infections   | 157. 0 1 2 3 Pain in low back                                |
| 154. 0 1 2 3 Cloudy, bloody, or dark urine | 158. 0 1 2 3 Puffy eyes or dark circles under eyes regularly |
| 155. 0 1 2 3 Urine has strong odor         |  |

**Section 15– Read each symptom and circle the number that applies.**

- |                                       |  |
|---------------------------------------|--|
| 159. 0 1 2 3 Catch colds/flu easily   | 163. 0 1 2 3 Poor wound healing  |
| 160. 0 1 2 3 Runny or drippy nose     | 164. 0 1 2 3 History of Epstein Bar, Mono, Herpes, Shingles or Chronic Fatigue |
| 161. 0 1 2 3 Swollen lymph nodes      |  |
| 162. 0 1 2 3 Gets boils, cysts, styes |  |

**Section 16– Read each symptom and circle the number that applies.**

Key: 0= Never

2=Weekly

1=Occasionally

3=Daily

165. 0 1 2 3 Use of pesticides in home

166. 0 1 2 3 Use of strong chemicals  
(bleach, polish, floor wax, window cleaner, etc)

167. 0 1 2 3 Exposed to tobacco, moth balls,  
incense, varnish, or dust.

168. 0 1 2 3 Treat home for insects

169. 0 1 2 3 Use of perfumes, hairspray,  
cosmetics, nail polish, etc.

170. 0 1 2 3 Exposed to diesel fumes,  
exhaust fumes, or gasoline fumes.

**Rate your overall stress level on a scale of 1 to 10. (10= high, 1= low)**

**1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10**

**What is affecting your stress level the most?**

---

---

---

---

**What do you enjoy most in your life?**

---

---

---

---

**What do you worry about most in your life?**

---

---

---

---

**When it comes to FULLY committing to your desire to be healthy, what is getting in the way?**

---

---

---

---

**Who will sincerely support you consistently with the beneficial lifestyle changes you will be making?**

---

---

---

---

**List any emotional or personal conflicts that you are exposed to repeatedly:**

---

---

---

**How is your diet:**

- Coffee: \_\_\_\_\_ cups per:     Day       Week       Month
- Soft drinks: \_\_\_\_\_ cans per:     Day       Week       Month
- Diet soda: \_\_\_\_\_ cans per:     Day       Week       Month
- Candy: \_\_\_\_\_ times per:     Day       Week       Month
- Chocolate: \_\_\_\_\_ times per:     Day       Week       Month
- Alcohol: \_\_\_\_\_ times per:     Day       Week       Month
- Fast Food: \_\_\_\_\_ times per:     Day       Week       Month
- Milk/cheese: \_\_\_\_\_ times per:     Day       Week       Month
- Fried foods: \_\_\_\_\_ times per:     Day       Week       Month

**Current Diet Information:** Give examples of what foods you typically eat daily:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Snacks: \_\_\_\_\_

Dinner: \_\_\_\_\_

Liquids: \_\_\_\_\_

How many meals do you eat per day? \_\_\_\_\_ What meals do you skip? \_\_\_\_\_

Do you cook? \_\_\_\_\_ What percentage of your meals are home-cooked? \_\_\_\_\_

**Health History:**

List any major illnesses/diagnosed conditions with approximate dates:

Illness:	Date:	Recovered?
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Family Health History:**

Cancer     Heart Disease     Diabetes     Other: \_\_\_\_\_

Please list any surgeries, operations, traumas, car accidents, etc...

---

---

---

What are your hobbies:

---

**Commitment Level to your health:** How serious are you about improving your health?

Very serious     Serious     Moderately interested     Other: \_\_\_\_\_