HEALTH HISTORY

Name ______________________ Date of Birth __________ Today's Date __________

Occupation ______________________ Age _____ Height _____ Sex _____ Number of Children _____

Marital Status: ☐ Single ☐ Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er)

Are you recovering from a cold or flu? __________ Are you pregnant? __________

Reason for office visit: ______________________ Date began: __________

______________________ __________

Date of last physical exam __________ Practitioner name and phone number ______________________

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

____

Outcome ______________________

What types of therapy have you tried for this problem(s):

☐ diet modification ☐ fasting ☐ vitamins/minerals ☐ herbs ☐ homeopathy ☐ chiropractic ☐ acupuncture ☐ conventional drugs

☐ other ______________________

List current health problems for which you are being treated: ______________________

____

Current medications (prescription or over-the-counter): ______________________

____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): ______________________

Do you consider yourself: ☐ underweight ☐ overweight ☐ just right Your weight today __________

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? __________

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, farmer, miner)?

____

☐ Corrective lenses ☐ Dentures ☐ Hearing aid ☐ Medical devices/prosthetics/implants, describe: __________

Recent changes in your ability to: ☐ see ☐ hear ☐ taste ☐ smell ☐ feel hot/cold sensations

☐ move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)

Strong like for any of the following flavors: ☐ sour ☐ bitter ☐ sweet ☐ rich/fatty ☐ spicy/pungent ☐ salty

Strong dislike for any one of the following flavors: ☐ sour ☐ bitter ☐ sweet ☐ rich/fatty ☐ spicy/pungent ☐ salty

Do you: ☐ Prefer warmth (i.e., food, drinks, weather, etc.) ☐ Prefer cold (i.e., food, drinks, weather, etc.) ☐ No preference

Is your sleep disturbed at the same time each night? ______ If yes, what time? ______

Time of day you feel the most energy or the least symptoms:

☐ 7 a.m. - 9 a.m. ☐ 9 a.m. - 11 a.m. ☐ 11 a.m. - 1 p.m.
☐ 1 p.m. - 3 p.m. ☐ 3 p.m. - 5 p.m. ☐ 5 p.m. - 7 p.m.
☐ 7 p.m. - 9 p.m. ☐ 9 p.m. - 11 p.m. ☐ 11 p.m. - 1 a.m.
☐ 1 a.m. - 3 a.m. ☐ 3 a.m. - 5 a.m. ☐ 5 a.m. - 7 a.m.

Time of day you feel the worst or your symptoms are aggravated:

☐ 7 a.m. - 9 a.m. ☐ 9 a.m. - 11 a.m. ☐ 11 a.m. - 1 p.m.
☐ 1 p.m. - 3 p.m. ☐ 3 p.m. - 5 p.m. ☐ 5 p.m. - 7 p.m.
☐ 7 p.m. - 9 p.m. ☐ 9 p.m. - 11 p.m. ☐ 11 p.m. - 1 a.m.
☐ 1 a.m. - 3 a.m. ☐ 3 a.m. - 5 a.m. ☐ 5 a.m. - 7 a.m.

Do you experience any of these general symptoms EVERY DAY?

☐ Debilitating fatigue ☐ Shortness of breath ☐ Insomnia ☐ Constipation ☐ Chronic pain/inflammation
☐ Depression ☐ Panic attacks ☐ Nausea ☐ Fecal incontinence ☐ Bleeding
☐ Disinterest in sex ☐ Headaches ☐ Vomiting ☐ Urinary incontinence ☐ Discharge
☐ Disinterest in eating ☐ Dizziness ☐ Diarrhea ☐ Low grade fever ☐ Itching/rash

Medical History

- ☐ Arthritis
- ☐ Allergies/hay fever
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Autoimmune disease
- ☐ Blood pressure problems
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chronic fatigue syndrome
- ☐ Carpal tunnel syndrome
- ☐ Cholesterol, elevated
- ☐ Circulatory problems
- ☐ Colitis
- ☐ Dental problems
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticular disease
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Eyes, ears, nose, throat problems
- ☐ Environmental sensitivities
- ☐ Fibromyalgia
- ☐ Food intolerance
- ☐ Gastroesophageal reflux disease
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart disease
- ☐ Infection, chronic
- ☐ Inflammatory bowel disease
- ☐ Irritable bowel syndrome
- ☐ Kidney or bladder disease
- ☐ Learning disabilities
- ☐ Liver or gallbladder disease (stones)
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological problems (Parkinson's, paralysis)
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Sexually transmitted disease
- ☐ Seasonal affective disorder
- ☐ Skin problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary tract infection
- ☐ Varicose veins

Other ______________________

____

Medical (Men)

- ☐ Benign prostatic hyperplasia (BPH)
- ☐ Prostate cancer
- ☐ Decreased sex drive
- ☐ Infertility
- ☐ Sexually transmitted disease

Other ______________________

____

Medical (Women)

- ☐ Menstrual irregularities
- ☐ Endometriosis
- ☐ Infertility
- ☐ Fibrocystic breasts
- ☐ Fibroids/ovarian cysts
- ☐ Premenstrual syndrome (PMS)
- ☐ Breast cancer
- ☐ Pelvic inflammatory disease
- ☐ Vaginal infections
- ☐ Decreased sex drive
- ☐ Sexually transmitted disease

Other ______________________

Age of first period ______

Date of last gynecological exam ____

Mammogram ☐ + ☐ –

PAP ☐ + ☐ –

Form of birth control ____________

# of children ____________

# of pregnancies ____________

- ☐ C-section ____________
- ☐ Surgical menopause
- ☐ Menopause

Date of last menstrual cycle ________

Length of cycle _____ days

Interval of time between cycles ______ days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) ____________

Family Health History (Parents and Siblings)

- ☐ Arthritis
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Heart disease
- ☐ Infertility
- ☐ Learning disabilities
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological disorders (Parkinson's, paralysis)
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Suicide

Other ______________________

Health Habits

- ☐ Tobacco:

Cigarettes: #/day ____________

Cigars: #/day ____________

- ☐ Alcohol:

Wine: #glasses/d or wk ________

Liquor: #ounces/d or wk ________

Beer: #glasses/d or wk ________

- ☐ Caffeine:

Coffee: #6 oz cups/d ________

Tea: #6 oz cups/d ________

Soda w/caffeine: #cans/d ________

Other sources ____________

- ☐ Water: #glasses/d ____________

Exercise

- ☐ 5-7 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 45 minutes or more duration per workout
- ☐ 30-45 minutes duration per workout
- ☐ Less than 30 minutes
- ☐ Walk
- ☐ Run, jog, jump rope
- ☐ Weight lift
- ☐ Swim
- ☐ Box
- ☐ Yoga

Nutrition & Diet

- ☐ Mixed food diet (animal and vegetable sources)
- ☐ Vegetarian
- ☐ Vegan
- ☐ Salt restriction
- ☐ Fat restriction
- ☐ Starch/carbohydrate restriction
- ☐ The Zone Diet
- ☐ Total calorie restriction

Specific food restrictions:

☐ dairy ☐ wheat ☐ eggs

☐ soy ☐ corn ☐ all gluten

Other ____________

Food Frequency

Servings per day:

Fruits (citrus, melons, etc.) ________

Dark green or deep yellow/orange vegetables ________

Grains (unprocessed) ________

Beans, peas, legumes ________

Dairy, eggs ________

Meat, poultry, fish ________

Eating Habits

- ☐ Skip breakfast
- ☐ Two meals/day
- ☐ One meal/day
- ☐ Graze (small frequent meals)
- ☐ Food rotation
- ☐ Eat constantly whether hungry or not
- ☐ Generally eat on the run
- ☐ Add salt to food

Current Supplements

- ☐ Multivitamin/mineral
- ☐ Vitamin C
- ☐ Vitamin E
- ☐ EPA/DHA
- ☐ Evening Primrose/GLA
- ☐ Calcium, source ________
- ☐ Magnesium
- ☐ Zinc
- ☐ Minerals, describe ________
- ☐ Friendly flora (acidophilus)
- ☐ Digestive enzymes
- ☐ Amino acids
- ☐ CoQ10
- ☐ Antioxidants (e.g., lutein, resveratrol, etc.)
- ☐ Herbs - teas
- ☐ Herbs - extracts
- ☐ Chinese herbs
- ☐ Ayurvedic herbs
- ☐ Homeopathy
- ☐ Bach flowers
- ☐ Protein shakes
- ☐ Superfoods (e.g., bee pollen, phytonutrient blends)
- ☐ Liquid meals

Other ____________

Would you like to:

- ☐ Have more energy
- ☐ Be stronger
- ☐ Have more endurance
- ☐ Increase your sex drive
- ☐ Be thinner
- ☐ Be more muscular
- ☐ Improve your complexion
- ☐ Have stronger nails
- ☐ Have healthier hair
- ☐ Be less moody
- ☐ Be less depressed
- ☐ Be less indecisive
- ☐ Feel more motivated
- ☐ Be more organized
- ☐ Think more clearly and be more focused
- ☐ Improve memory
- ☐ Do better on tests in school
- ☐ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- ☐ Stop using laxatives or stool softeners
- ☐ Be free of pain
- ☐ Sleep better
- ☐ Have agreeable breath
- ☐ Have agreeable body odor
- ☐ Have stronger teeth
- ☐ Get less colds and flus
- ☐ Get rid of your allergies
- ☐ Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)

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Metabolic Assessment Form™

Name: ______________________ **Age:** ____ **Sex:** ____ **Date:** ____________

PART I

Please list your 5 major health concerns in order of importance:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

PART II **Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.**

Category I

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3

Category II

Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3

Category III

Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV

Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting proteins and meats; undigested food found in stools	0	1	2	3

Category V

Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3

Category VI

Difficulty digesting roughage and fiber	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0	1	2	3
Frequent loss of appetite	0	1	2	3

Category VII

Abdominal distention after consumption of fiber, starches, and sugar	0	1	2	3
Abdominal distention after certain probiotic or natural supplements	0	1	2	3
Decreased gastrointestinal motility, constipation	0	1	2	3
Increased gastrointestinal motility, diarrhea	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Suspicion of nutritional malabsorption	0	1	2	3
Frequent use of antacid medication	0	1	2	3
Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/ Diverticulitis, or Leaky Gut Syndrome?	Yes	No		

Category VIII

Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?	Yes	No		

Category IX

Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3

Category X

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful between meals	0	1	2	3
Blurred vision	0	1	2	3

Category XI

Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

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Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XII

Symptom				
Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XIII

Symptom				
Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIV

Symptom				
Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XV

Symptom				
Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XVI

Symptom				
Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3

Category XVI *(Cont.)*

Symptom				
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVII *(Males Only)*

Symptom				
Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XVIII *(Males Only)*

Symptom				
Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XIX *(Menstruating Females Only)*

Symptom				
Perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle (greater than 32 days)	Yes	No		
Shortened menstrual cycle (less than 24 days)	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XX *(Menopausal Females Only)*

Symptom				
How many years have you been menopausal?	______ years			
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? ________

How many caffeinated beverages do you consume per day? ________

How many times do you eat out per week? ________

How many times do you eat raw nuts or seeds per week? ________

Rate your stress level on a scale of 1-10 during the average week: ________

How many times do you eat fish per week? ________

How many times do you work out per week? ________

List the three worst foods you eat during the average week: ________ ________ ________

List the three healthiest foods you eat during the average week: ________ ________ ________

PART IV

Please list any medications you currently take and for what conditions:

____

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

____

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Identi-T™ Stress Assessment

Name ______________________ Age ________ Sex ________ Date ____________

Stress is a normal part of life. Every day, we're faced with stimuli, called stressors, which can elicit the body's "fight or flight" response, setting off a cascade of physiological reactions and resulting in emotions ranging from mild to intense. But while occasional stress is natural and even healthy, chronic or acute stress can be harmful.

Please take a few moments to discover your body's response to situations you perceive as stressful. By honestly assessing how you feel, your healthcare provider can create a natural stress relief program for your individual needs.

Directions:
Please read each statement and circle the number 0, 1, 2, or 3 that best describes your feelings or reactions throughout the course of the day. Determine the subtotal score for each section, then determine the total scores for sections A-C and C-E. Some questions may appear redundant between sections. There's a reason for each question. Don't spend much time on any one question.

0 = Never true 1= Seldom true 2= Sometimes true 3= Often true

When under stress for two weeks or longer, I...

Section A:

1. Get wound up when I get tired and have trouble calming down 0 1 2 3
2. Feel driven, appear energetic but feel "burned out" and exhausted 0 1 2 3
3. Feel restless, agitated, anxious, and uneasy 0 1 2 3
4. Feel easily overwhelmed by emotion 0 1 2 3
5. Feel emotional — cry easily or laugh inappropriately 0 1 2 3
6. Experience heart palpitations or a pounding in my chest 0 1 2 3
7. Am short of breath 0 1 2 3
8. Am constipated 0 1 2 3
9. Feel warm, over-heated, and dry all over 0 1 2 3
10. Get mouth sores or sore tongue 0 1 2 3
11. Get hot flashes 0 1 2 3
12. Sleep less than seven hours a night 0 1 2 3
13. Have trouble falling asleep and staying asleep 0 1 2 3
14. Worry about high blood pressure, cholesterol, and triglycerides 0 1 2 3
15. Forget to eat and feel little hunger 0 1 2 3

Total points: ________

Section B:

1. Find myself worrying about things big and small 0 1 2 3
2. Feel like I can't stop worrying, even though I want to 0 1 2 3
3. Feel impulsive, pent up, and ready to explode 0 1 2 3
4. Get muscle spasms 0 1 2 3
5. Feel aggressive, unyielding, or inflexible when pressed for time 0 1 2 3
6. See, hear, and smell things that others do not 0 1 2 3
7. Stay awake replaying the events of the day or planning for tomorrow 0 1 2 3
8. Have upsetting thoughts or images enter my mind again and again 0 1 2 3
9. Have a hard time stopping myself from doing things again and again, like checking on things or rearranging objects over and over 0 1 2 3
10. Worry a lot about terrible things that could happen if I'm not careful 0 1 2 3

Total points: ________

Section C:

1. Have muscle and joint pains 0 1 2 3
2. Have muscle weakness 0 1 2 3
3. Crave salt or salty things 0 1 2 3
4. Have multiple points on my body that when touched are tender or painful 0 1 2 3
5. Have dark circles under my eyes 0 1 2 3
6. Feel a sudden sense of anxiety when I get hungry 0 1 2 3
7. Use medications to manage pain 0 1 2 3
8. Get dizzy when rising or standing up from a kneeling or sitting position 0 1 2 3
9. Have diarrhea or bouts of nausea with or without vomiting for no apparent reason 0 1 2 3
10. Have headaches 0 1 2 3

Total points: ________

Section D:

1.	Have trouble organizing my thoughts	0	1	2	3
2.	Get easily distracted and lose focus	0	1	2	3
3.	Have difficulty making decisions and mistrust my judgment	0	1	2	3
4.	Feel depressed and apathetic	0	1	2	3
5.	Lack the motivation and energy to stay on task and pay attention	0	1	2	3
6.	Am forgetful	0	1	2	3
7.	Feel unsettled, restless, and anxious	0	1	2	3
8.	Wake up tired and unrefreshed	0	1	2	3
9.	Experience heartburn and indigestion	0	1	2	3
10.	Catch colds or infections easily	0	1	2	3

Total points: ______

Section E:

1.	Feel tired for no apparent reason	0	1	2	3
2.	Experience lingering mild fatigue after exertion or physical activity	0	1	2	3
3.	Find it difficult to concentrate and complete tasks	0	1	2	3
4.	Feel depressed and apathetic	0	1	2	3
5.	Feel cold or chilled – hands, feet, or all over – for no apparent reason	0	1	2	3
6.	Have little or no interest in sex	0	1	2	3
7.	Sweat spontaneously during the day	0	1	2	3
8.	Feel puffy and retain fluids	0	1	2	3
9.	Sleep more than nine hours a night	0	1	2	3
10.	Have poor muscle tone	0	1	2	3
11.	Have trouble losing weight	0	1	2	3
12.	Wake up tired even though I seem to get plenty of sleep	0	1	2	3
13.	Have no energy and feel physically weak	0	1	2	3
14.	Am susceptible to colds and the flu	0	1	2	3
15.	Feel dragged down by multiple symptoms, such as poor digestion and body aches	0	1	2	3

Total points: ______

Add points from sections A, B & C	**Total for A, B & C:** ______
Add points from sections C, D & E	**Total for C, D & E:** ______

Lifestyle and Health Status:

1. Circle the level of stress you experience on the scale of 1-10, 10 being the worst:
   1 2 3 4 5 6 7 8 9 10
2. What do you consider to be the major causes of your stress (for example — spouse, family, friends, work, finances, wedding, pregnancy, legal, commute):
   ____
3. I eat breakfast ______ times a week. My typical breakfast is: ______________________
4. I take a multiple vitamin/mineral ______ days per week. I take a fish oil supplement ______ days per week.
5. I participate in 30 minutes of physical activity such as walking, aerobics (e.g., running), resistance training (e.g., weights, pilates), sports (e.g. biking), or yoga:
   ❑ Daily ❑ 5-6 times per week ❑ 3-4 times per week ❑ 1-2 times per week ❑ Less than once a week
6. I smoke ______ cigarettes daily.
7. I drink two or more 8 ounce cups of caffeinated coffee or other caffeinated beverages like energy/diet drinks, colas, or black or green teas:
   ❑ Daily ❑ 5-6 times per week ❑ 3-4 times per week ❑ 1-2 times per week ❑ Less than once a week
8. I drink two or more ounces of alcoholic beverages:
   ❑ Daily ❑ 5-6 times per week ❑ 3-4 times per week ❑ 1-2 times per week ❑ Less than once a week
9. List your current health problems and any over-the-counter or prescription medications that you are now taking:

Current health problem(s)	Date of onset	List all current medication(s)

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Metabolic Detoxification Questionnaire

Part 1: Symptoms

Name: ______________________________ Date: ____________

Rate each of the following symptoms based on the last week using the point scale below:

0 Never or rarely have the symptom
1 Occasionally have it, effect is not severe
2 Occasionally have it, effect is severe
3 Frequently have it, effect is not severe
4 Frequently have it, effect is severe

Category	Symptom	Rating
Digestive Tract	Nausea, vomiting	⓪ ① ② ③ ④
	Diarrhea	⓪ ① ② ③ ④
	Constipation	⓪ ① ② ③ ④
	Bloated feeling	⓪ ① ② ③ ④
	Heartburn	⓪ ① ② ③ ④
	Intestinal, stomach pain	⓪ ① ② ③ ④
	Digestive Total:	
Joints / Muscles	Pain or aches in joints	⓪ ① ② ③ ④
	Arthritis, joint swelling	⓪ ① ② ③ ④
	Stiff or limitation of movement	⓪ ① ② ③ ④
	Pain or aches in muscles	⓪ ① ② ③ ④
	Feeling of weakness or tired	⓪ ① ② ③ ④
	Joints / Muscles Total:	
Emotional	Mood swings	⓪ ① ② ③ ④
	Anxiety, fear, nervousness	⓪ ① ② ③ ④
	Anger, irritability, aggression	⓪ ① ② ③ ④
	Depression	⓪ ① ② ③ ④
	Emotional Total:	
Weight / Food	Binge eating, drinking	⓪ ① ② ③ ④
	Craving certain foods	⓪ ① ② ③ ④
	Excessive weight	⓪ ① ② ③ ④
	Compulsive eating, food addictions	⓪ ① ② ③ ④
	Water retention	⓪ ① ② ③ ④
	Underweight	⓪ ① ② ③ ④
	Weight / Food Total:	
Energy / Sleep	Fatigue, sluggishness	⓪ ① ② ③ ④
	Apathy, lethargy	⓪ ① ② ③ ④
	Hyperactivity	⓪ ① ② ③ ④
	Restlessness, achiness	⓪ ① ② ③ ④
	Sleep disturbances	⓪ ① ② ③ ④
	Energy / Sleep Total:	
Skin	Acne	⓪ ① ② ③ ④
	Hives, rashes, dry skin, redness	⓪ ① ② ③ ④
	Hair loss	⓪ ① ② ③ ④
	Flushing, hot flashes	⓪ ① ② ③ ④
	Excessive sweating	⓪ ① ② ③ ④
	Skin Total:	
Heart	Irregular or skipped heartbeat	⓪ ① ② ③ ④
	Rapid or pounding heartbeat	⓪ ① ② ③ ④
	Chest pain	⓪ ① ② ③ ④
	Heart Total:	
Other	Frequent illness	⓪ ① ② ③ ④
	Frequent or urgent urination	⓪ ① ② ③ ④
	Genital itch or discharge	⓪ ① ② ③ ④
	Other Total:	
Respiratory	Chest congestion	⓪ ① ② ③ ④
	Asthma, bronchitis	⓪ ① ② ③ ④
	Shortness of breath	⓪ ① ② ③ ④
	Difficulty breathing	⓪ ① ② ③ ④
	Respiratory Total:	
Eyes	Watery or itchy eyes	⓪ ① ② ③ ④
	Swollen, red, or sticky eyelids	⓪ ① ② ③ ④
	Bags or dark circles under eyes	⓪ ① ② ③ ④
	Blurred or restricted vision	⓪ ① ② ③ ④
	Eyes Total:	
Nose	Stuffy nose	⓪ ① ② ③ ④
	Sinus problems or dripping nose	⓪ ① ② ③ ④
	Hay fever	⓪ ① ② ③ ④
	Sneezing attacks	⓪ ① ② ③ ④
	Excessive mucus	⓪ ① ② ③ ④
	Nose Total:	
Mouth / Throat	Frequent, consistent coughing	⓪ ① ② ③ ④
	Gagging, need to clear throat	⓪ ① ② ③ ④
	Sore throat, hoarse, loss of voice	⓪ ① ② ③ ④
	Swollen or discolored tongue, gums, or lips	⓪ ① ② ③ ④
	Canker sores, other mouth sores	⓪ ① ② ③ ④
	Mouth / Throat Total:	
Ears	Itchy ears	⓪ ① ② ③ ④
	Earaches, ear infections	⓪ ① ② ③ ④
	Drainage from ear, waxy buildup	⓪ ① ② ③ ④
	Ringing in ears, hearing loss	⓪ ① ② ③ ④
	Ears Total:	
Head	Headaches	⓪ ① ② ③ ④
	Faintness or lightheadedness	⓪ ① ② ③ ④
	Dizziness	⓪ ① ② ③ ④
	Head Total:	
Cognitive	Poor memory, recall	⓪ ① ② ③ ④
	Confusion, poor comprehension	⓪ ① ② ③ ④
	Poor concentration	⓪ ① ② ③ ④
	Poor physical coordination	⓪ ① ② ③ ④
	Difficulty in making decisions	⓪ ① ② ③ ④
	Stuttering, stammering	⓪ ① ② ③ ④
	Slurred speech	⓪ ① ② ③ ④
	Learning disabilities	⓪ ① ② ③ ④
	Cognitive Total:	

Grand Total __________

For Practitioner Use Only:

Urinary pH__________

Metagenics

Metabolic Detoxification Questionnaire

Part 2: Xenobiotic Tolerability Test (XTT)

1. **Are you presently using prescription drugs?**
○ Yes (1 pt.) ○ No (0 pt.)
If yes, how many are you currently taking? ____ (1 pt. each)

2. **Are you presently taking one or more of the following over-the-counter drugs?**
○ Cimetidine (2 pts.) ○ Acetaminophen (2 pts.) ○ Estradiol (2 pts.)

3. **If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them:**
○ Experience side effects; drug(s) is (are) efficacious at lowered dose(s) (3 pts.)
○ Experience side effects; drug(s) is (are) efficacious at usual dose(s) (2 pts.)
○ Experience no side effects; drug(s) is (are) usually not efficacious (2 pts.)
○ Experience no side effects; drug(s) is (are) usually efficacious (0 pt.)

4. **Do you currently (within the last 6 months) or have you regularly used tobacco products?**
○ Yes (2 pts.) ○ No (0 pt.)

5. **Do you have strong negative reactions to caffeine or caffeine-containing products?**
○ Yes (1 pt.) ○ No (0 pt.) ○ Don't know (0 pt.)

6. **Do you commonly experience "brain fog," fatigue, or drowsiness?**
○ Yes (1 pt.) ○ No (0 pt.)

7. **Do you develop symptoms with exposure to fragrances, exhaust fumes, or strong odors?**
○ Yes (1 pt.) ○ No (0 pt.) ○ Don't know (0 pt.)

8. **Do you feel ill after you consume even small amounts of alcohol?**
○ Yes (1 pt.) ○ No (0 pt.) ○ Don't know (0 pt.)

10. **Do you have a personal history of:**
○ Environmental and/or chemical sensitivities (5 pts.)
○ Chronic fatigue syndrome (5 pts.)
○ Multiple chemical sensitivity (5 pts.)
○ Fibromyalgia (3 pts.)
○ Parkinson's type symptoms (3 pts.)
○ Alcohol or chemical dependence (2 pts.)
○ Asthma (1 pt.)

11. **Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?**
○ Yes (1 pt.) ○ No (0 pt.)

12. **Do you have an adverse or allergic reaction when you consume sulfite-containing foods such as wine, dried fruit, salad bar vegetables, etc.?**
○ Yes (1 pt.) ○ No (0 pt.) ○ Don't know (0 pt.)

Total ________

Part 3: Alkalizing Assessment

1. **Do you have a history of or currently have kidney dysfunction?**
○ Yes (1 pt.) ○ No (0 pt.)

2. **Have you ever been diagnosed with hyperkalemia?**
○ Yes (1 pt.) ○ No (0 pt.)

3. **Are you currently taking diuretics or blood pressure medication?**
○ Yes (1 pt.) ○ No (0 pt.)

Total ________

Overall Score Tabulation

For Practitioner Use Only:

Part 1: Symptoms Grand Total ________ (High >50; moderate 15-49; low <14)
Part 2: XTT Total ________ (High >10; moderate 5-9; low <4)
Part 3: Alkalizing Assessment Total ________ (High ≥1)
Urinary pH ________

Notes:

- Patients with high symptoms but low XTT may be exhibiting reactions that are not related to toxic load. Other mechanisms should be considered, such as inflammation/immune/allergy, gastrointestinal dysfunction, oxidative stress, hormonal/neurotransmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.
- Recommend non-alkalizing nutrients if patient answers "yes" to any questions in the Alkalizing Assessment.

Disclaimer: This questionnaire is for informational purposes only. It is not meant to diagnose or treat any condition or illness. All medical symptoms should be addressed by a qualified medical professional.

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DATE:	
Goals for today:	
Breakfast / Time:	
Snack / Time:	
Lunch / Time:	
Snack / Time:	
Dinner / Time:	
Water (8oz): 1 2 3 4 5 6 7 8 9 10	
Other Drinks:	
Exercise:	
Relaxation:	
Sleep time:	Supplements: Y N
Energy Levels and notes: ____	

DATE:	
Goals for today:	
Breakfast / Time:	
Snack / Time:	
Lunch / Time:	
Snack / Time:	
Dinner / Time:	
Water (8oz): 1 2 3 4 5 6 7 8 9 10	
Other Drinks:	
Exercise:	
Relaxation:	
Sleep time:	Supplements: Y N
Energy Levels and notes: ____	

DATE:

Goals for today:

Breakfast / Time:

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Lunch / Time:

Snack / Time:

Dinner / Time:

Water (8oz): 1 2 3 4 5 6 7 8 9 10

Other Drinks:

Exercise:

Relaxation:

Sleep time: Supplements: Y N

Energy Levels and notes: ______

______

DATE:

Goals for today:

Breakfast / Time:

Snack / Time:

Lunch / Time:

Snack / Time:

Dinner / Time:

Water (8oz): 1 2 3 4 5 6 7 8 9 10

Other Drinks:

Exercise:

Relaxation:

Sleep time: Supplements: Y N

Energy Levels and notes: ______

______

Nutritional Informed Consent

A vitamin is <u>not</u> a drug, neither is a mineral, trace element, enzyme, amino acid, herb, or homeopathic remedy.

Although a vitamin, mineral, trace element, enzyme, amino acid, herb, or homeopathic remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as any primary treatment and/or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological biomechanical process of the human body.

Please acknowledge by signing below that you have read the aforementioned and understand that any nutritional recommendations given to you by the doctor are nutritional recommendations and dietary or disease process that you may possess.

Patient Signature:______________________________

Patient Name:______________________________

Date:______________________________