REGENESIS WELLNESS CENTER OF SCOTTSDALE

Dr. Alexander de Soler N.M.D.

HEALTH HISTORY QUESTIONNAIRE

(All questions contained in this questionnaire are strictly confidential and will become part of your medical record. All questions within this form have relevance to your overall health and will impact your course of treatment, so it is imperative you be as honest as possible to ensure the greatest therapeutic outcome.)

Name (Last, First, M.I.):		☐ M ☐ F	**Date of Birth:**		
HAPPY WITH YOUR WORK? YES ☐ NO ☐	**Occupation:**		**Hours worked per week:**		
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed				
Previous or referring doctor:			**Date of last physical exam:**		

HOME ADDRESS:

HOME PHONE: _____ **CELL PHONE:** _____ _____ **EMAIL ADDRESS:** _____@_____

My signature gives the center permission to send me monthly self care health articles via the internet:

Signature _____ Date:_____

EMERGENCY CONTACT NAME: _____ **CONTACT NUMBER:** _____

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐ Whooping Cough				
	☐ Frequent infections (location:_____) ☐ Other (please describe: _____)				
Immunizations and Vaccination dates:	☐ Chickenpox	☐ Diphtheria	☐ Hepatitis	☐ Influenza	☐ MMR Measles, Mumps, Rubella
	☐ Pertussis	☐ Polio	☐ Tetanus	☐ Other	

List any medical problems that other doctors have diagnosed:

Have you ever tried other treatments which were successful / unsuccessful for the current complaint(s)?

What is your greatest health concern?

How does it limit you the most?

Accidents / Traumas

Year	Injuries sustained	

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? □Yes □No If yes, when?

List current prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name of Drug	Strength	Frequency Taken

Allergies to medications, foods, or environmental sources

Name of drug, food, or environmental source	Any reactions experienced

What are your emotional expectations about your health?

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	□M □F	
Mother				□M □F	
Sibling	□M □F			□M □F	
	□M □ F			□M □F	
	□M □ F		**Grandmother** Maternal		
	□M □F		**Grandfather** Maternal		
	□M □F		**Grandmother** Paternal		
	□M □F		**Grandfather** Paternal		

SOCIAL HISTORY

Toxin Exposure:	Did you grow up near any refinery, or polluted area, or in home with leaded paint? If so, what sort of pollution were you exposed to? _____ Have you had any jobs where you were exposed to solvents, heavy metals, fumes, or other toxic materials?_____ Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets, or did other refurbishing?:_____ Are you particularly sensitive to perfumes, gasoline, or other vapors? _____ Do you use pesticides, herbicides, other chemicals around your home? _____
Sleep	On average how many hours do you sleep per night? Do you ever wake at night? If yes, for what reason?

CONFIDENTIAL HEALTH HISTORY INTAKE

	Do you wake rested? Do you snore? Do you sleep walk?				
Blood type	What is your blood type?				
Hobbies	What do you like to do for fun?				
Energy Level	On a scale of 0-10 (with 10 being really great energy and 0 being no energy) how would you rate yourself on average?				
Exercise	□ Sedentary (No exercise)				
	□ Mild exercise (i.e., dimb stairs, walk 3 blocks, golf)				
	□ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	□ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?	□ Yes	□ No		
	If yes, are you on a physician prescribed medical diet?	□ Yes	□ No		
	On average what do you eat in a single day? Breakfast: Lunch: Dinner: Snacks: Water intake:				
	Are there any foods you enjoy? Are there any foods you dislike?				
	# of meals you eat in an average day?				
	Have you experienced unexplainable weight loss/gain within the past 6 months?				
Sugar / Candy	Eat sugery candies / foods on a regular basis?	□ Yes	□ No		
	Please indicate preferences and frequency:				
Fast foods / Restaurants	How many times per week do you eat at a fast-food restaurant?				
	How many times per week do you eat at a regular restaurant?				
Liquid intake	□ Water (glasses per day:_____)	□ Coffee (cups per day: _____)	□ Tea (cups per day: _____)	□ Cola (cans per day: _____)	
	□ Energy Drinks (cans per day:_____)	□ Other (amount per day:_____)			
Alcohol	Do you drink alcohol?	□ Yes	□ No		
	If yes, what kind?				
	How many drinks per week?				
Tobacco	Do you use tobacco?	□ Yes	□ No		
	Please indicate type used and frequency:				
	# of years used:	Or year quit:			
Drugs	Do you currently use recreational or street drugs?	□ Yes	□ No		
	Please check which street drugs you currently use or have used in the past:				
	□ Marijuana □ Cocaine / Crack □ Amphetamines □ LSD □ Mushrooms □ Heroin □ Other (_____)				
	Have you ever given yourself street drugs with a needle?	□ Yes	□ No		
Relationships / Sex	Are you currently married / divorced or in a relationship?	□ Yes	□ No		
	Are you sexually active?	□ Yes	□ No		
	If yes, do you use protection?	□ Yes	□ No		
	Are you monogamous?	□ Yes	□ No		
	Any history of having a sexually transmitted disease? (if so, please indicate:_____)	□ Yes	□ No		
	History of sexual, mental/emotional, physical abuse?	□ Yes	□ No		

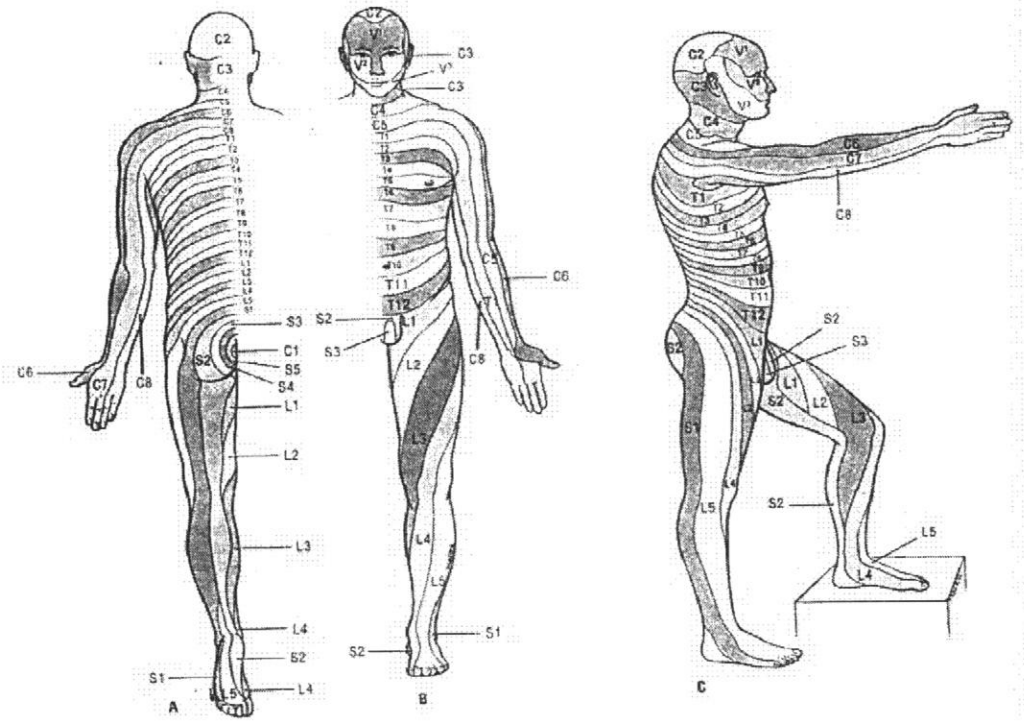
WOMEN ONLY
Age at onset of menstruation:
Date of last menstruation:
Period every _____ days

Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Experience bleeding between periods?	☐ Yes	☐ No
Experience painful intercourse?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine, current or past?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Experienced any vaginal discharge?	☐ Yes	☐ No
Abnormal Pap Smear or Mammogram? (please circle)	☐ Yes	☐ No
Date of last pap smear: _____		
Date of last mammogram: _____		

MEN ONLY		
Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate exam: _____		

Do you experience pain? If so please mark on the figure where you experience pain and when did you first noticed the pain?

CONFIDENTIAL HEALTH HISTORY INTAKE



How committed are you towards making valuable changes?

Is there anything else you would like to mention?

I have never been the same since _____

Please indicate if you have, have ever or never have experienced any of the following symptoms, by marking an X in the appropriate column

	Yes Now	Yes Past	No	Comments
EYES				
Cataracts	____	____	____	_____
Double vision	____	____	____	_____
Do you wear glasses or contact lenses? (circle)	____	____	____	_____
Itching, burning, or watering of eyes?	____	____	____	_____
Loss of vision	____	____	____	_____
Eye pain	____	____	____	_____
Eye discharge	____	____	____	_____
Color blindness	____	____	____	_____
History of retinal detachment/surgery	____	____	____	_____
Date of last vision examination	____	____	____	_____
EARS, NOSE & THROAT				
Recurrent ears, nose or throat infections (circle)	____	____	____	_____
Frequent nose bleeds	____	____	____	_____
Loud snoring problem	____	____	____	_____
Sleep apnea	____	____	____	_____
Nocturnal CPAP	____	____	____	_____
Loss of hearing	____	____	____	_____
Buzzing or ringing in the ears	____	____	____	_____
Thyroid enlargement	____	____	____	_____
Recurrent hoarseness of voice	____	____	____	_____

Neck pain or neck lumps	____	____	____	_____
Nasal allergies	____	____	____	_____
Ear discharge or bleeding	____	____	____	_____
History of sore throats	____	____	____	_____
Difficulty swallowing	____	____	____	_____
Impaired smell or taste	____	____	____	_____
Nasal lesions or discharge	____	____	____	_____
Sinus disease	____	____	____	_____
Last hearing examination	____	____	____	_____

MOUTH

Recurrent dental problems	____	____	____	_____
Sore tongue	____	____	____	_____
Do you have dentures or bridges? (circle)	____	____	____	_____
Bleeding gums	____	____	____	_____
Teeth, gum or oral lesions	____	____	____	_____
Do you take antibiotics for dental procedures?	____	____	____	_____
Last dental examination	____	____	____	_____

RESPIRATORY

Severe shortness of breath or wheezing	____	____	____	_____
Had cough for more then 1 month	____	____	____	_____
Chest pain when cough hard or take deep breath	____	____	____	_____
Cough up blood	____	____	____	_____
Blood clots in lungs	____	____	____	_____
Difficult breathing other then upright position	____	____	____	_____
Shortness of breath when exertion or at night	____	____	____	_____
Reduced exercise tolerance	____	____	____	_____
Daily sputum production? color?	____	____	____	_____
	Yes Now	Yes Past	No	Comments
Last pulmonary function test	____	____	____	_____
Last chest x-ray	____	____	____	_____

BREAST

Nipple discharge	____	____	____	_____
Breast pain, tenderness, or swelling	____	____	____	_____
Breast mass	____	____	____	_____
History of breast feeding	____	____	____	_____
History of breast infection or trauma	____	____	____	_____
Monthly self breast examinations	____	____	____	_____
Last physician breast examination	____	____	____	_____
Do you know how to examine your breasts?	Yes _____, No _____			
If not, would you like to be taught?	Yes _____, No _____			

CARDIOVASCULAR

Pain in the front of the chest (under sternum)	____	____	____	_____
that is heavy or pressure like?	____	____	____	_____
that is sharp or knife like?	____	____	____	_____
that is aggravated by exercise, stress, or anger?	____	____	____	_____
that improves with rest or Nitro?	____	____	____	_____
Abnormal heart beat - skipped or extra beats	____	____	____	_____
Very rapid unexplained heart beats	____	____	____	_____
Excessive fluid retention/ankle swelling	____	____	____	_____
Impaired circulation to the legs:				

arterial, venous (circle) ____ ____ ____ _____
Varicose veins ____ ____ ____ _____
Phlebitis (inflammation of veins) ____ ____ ____ _____
Poor healing leg sores ____ ____ ____ _____
Smothering spells relieved by sitting up ____ ____ ____ _____
Difficulty breathing at night ____ ____ ____ _____
Blood clots (deep vein thrombosis) ____ ____ ____ _____
Leg pain walking or at rest ____ ____ ____ _____
Color changes on fingers and/or toes ____ ____ ____ _____
Congenital heart defects ____ ____ ____ _____
Enlarged heart or abnormal heart ____ ____ ____ _____
Last echocardiogram_____ performed by/at: _____
Last stress test _____ performed by/at: _____
Last cardiac catherization _____ performed by/at: _____

GASTROINTESTINAL

Recurrent indigestion, heartburn,
or a sense of food regurgitation (reflux) ____ ____ ____ _____
Difficulty swallowing ____ ____ ____ _____
Recurrent abdominal pain ____ ____ ____ _____
Frequent episodes of pressure or discomfort
in the upper right side of the abdomen ____ ____ ____ _____
Major changes in the size or bowel movements ____ ____ ____ _____
Constipation for more than 1 month ____ ____ ____ _____
Diarrhea for more than 1 month ____ ____ ____ _____
Bright red blood on toilet paper or in toilet bowl ____ ____ ____ _____
Blood mixed in with stools ____ ____ ____ _____
Dark blood or black stools ____ ____ ____ _____
Positive stools for occult blood ____ ____ ____ _____

	Yes Now	Yes Past	No	Comments
Irritable bowel or spastic colon	____	____	____	_____
Excessive belching or passing of gas	____	____	____	_____
History of hemorrhoids	____	____	____	_____
Vomiting blood ____	____	____	_____	
Nausea or vomiting (circle)	____	____	____	_____
Loss of appetite	____	____	____	_____
Food intolerance	____	____	____	_____
Abnormal swelling	____	____	____	_____
Last upper GI (stomach x-ray)	____	____	____	_____
Last lower GI (barium enema x-ray)	____	____	____	_____

UROLOGICAL

Bladder or kidney infections (circle) ____ ____ ____ _____
Painful urination or burning ____ ____ ____ _____
Blood in your urine or pus in your urine (circle) ____ ____ ____ _____
Problems starting to urinate ____ ____ ____ _____
Impaired, weakened urine stream ____ ____ ____ _____
Dribbling urine after you think you're finished ____ ____ ____ _____
Incontinence/leakage of urine (circle) ____ ____ ____ _____
History of herpes, venereal warts, HIV, or other
sexually transmitted disease (circle) ____ ____ ____ _____
Urinating more than once during the night ____ ____ ____ _____
Bed wetting ____ ____ ____ _____
Urinary frequency ____ ____ ____ _____

Last IVP/kidney x-ray ____ ____ ____ _____
Last PSA level ____ ____ ____ _____

GENITOURINARY/REPRODUCTIVE

MEN ONLY

Pain or lumps in thes testicles ____ ____ ____ _____
Problems initiating or maintaining an erection ____ ____ ____ _____
Do you examine your testicles once per month? ____ ____ ____ _____
Recurrent discharge at the end of the penis ____ ____ ____ _____
Is there a history of sexual abuse? ____ ____ ____ _____
Change in sexual activity ____ ____ ____ _____

WOMEN ONLY

Your age at very first menstrual cycle _____
Date of last period _____ Age of menopause _____
Age at the time of your first pregnancy? _____
How many times have you been pregnant? _____
Number of full term pregnancies _____
Number of stillbirths/abortions _____
Number of premature births _____
Number of living children (twins?) _____
Are you pregnant now? Yes _____, No _____
Are you having irregualr periods? Yes _____, No _____
Do you have heavy or prolonged periods or pass clots? Yes _____, No _____
Do you have severe cramps or pain? Yes _____, No _____
Do you have spotting or bleeding between normal menses? Yes _____, No _____
Do you use birth control medication or devices? Yes _____, No _____
If so, what kind? _____
Have you ever had a cervical or uterine biopsy? Yes _____, No _____
When _____ Results _____
Are you on hormone replacement therapy? Yes _____, No _____
If yes, date started _____
Date of last pelvic examination and Pap smear _____ Results: _____

	Yes Now	Yes Past	No	Comments
MUSCULOSKELETAL				
Bursitis or tendonitis (circle)	____	____	____	_____
Broken bones (fractures) - where?	____	____	____	_____
Major joint injuries in knee or shoulder (circle)	____	____	____	_____
Any artificial joints (prosthesis) (hip, knee, digits) (circle)	____	____	____	_____
Chronic back pain	____	____	____	_____
Muscle pain	____	____	____	_____
Muscle weakness	____	____	____	_____
Limitations on walking or running	____	____	____	_____
Joint stiffness/pain	____	____	____	_____
Amputations (location)	____	____	____	_____
LYMPHATIC/INFECTIOUS, IMMUNOLOGIC DISEASES				
History of chronic infections/ swollen lymph nodes/glands	____	____	____	_____
Measles	____	____	____	_____
Mumps	____	____	____	_____

Chickenpox ____ ____ ____ _____
Rheumatic fever ____ ____ ____ _____
Scarlet fever ____ ____ ____ _____
HIV positive ____ ____ ____ _____
Tuberculosis/positive skin test ____ ____ ____ _____
Immunizations: Vaccines/Dates
Tetanus _____
Hepatitis _____
Influenza _____
Pneumonia _____
Diptheria _____

NEUROLOGICAL

Migraine headaches ____ ____ ____ _____
Tension/stress headaches ____ ____ ____ _____
Recurrent or persistent dizziness (vertigo) ____ ____ ____ _____
Recurrent episodes of weakness, numbness, pain in one leg, foot, arm or hand (where?) ____ ____ ____ _____
Paralysis ____ ____ ____ _____
Recurrent tremor or twitches ____ ____ ____ _____
Problems with reading or memory ____ ____ ____ _____
Loss of consciousness ____ ____ ____ _____
Abnormal nerve pain ____ ____ ____ _____
Speech or language dysfunction ____ ____ ____ _____
Loss of balance ____ ____ ____ _____

	Yes Now	Yes Past	No	Comments
SKIN/GENERAL				
History of skin cancer / type? / location?	____	____	____	_____
Persistent or recurrent skin rashes (where?)	____	____	____	_____
Delayed healing of skin ulcers or sores	____	____	____	_____
Unexplained itching or hives	____	____	____	_____
Excessive dry skin or scaling	____	____	____	_____
Change in a mole or birth mark / location?	____	____	____	_____
Change in hair or nails - describe	____	____	____	_____
Fatigue	____	____	____	_____
Fever or chils (circle)	____	____	____	_____
HEMATOLOGY/ONCOLOGY				
Anemia / low blood count	____	____	____	_____
Tendency for bleeding or severe bruising	____	____	____	_____
Clotting disorder	____	____	____	_____
Lymphoma / lymph node cancer	____	____	____	_____
Leukemia / blood cancer	____	____	____	_____
Low platelet count	____	____	____	_____
ENDOCRINE				
Borderline blood sugars high / low (circle)	____	____	____	_____
Calcium problems	____	____	____	_____
Thyroid nodule / cyst (circle)	____	____	____	_____
Adrenal or pituitary gland problems (circle)	____	____	____	_____

Unexplained changes in height and weight	____	____	____	_____
Heat or cold intolerance (circle)	____	____	____	_____
Changes in hair distribution or skin pigmentation (describe)	____	____	____	_____
Last thyroid profile (blood tests)	____	____	____	_____
Last thyroid scan, uptake and ultrasound	____	____	____	_____

PSYCHIATRIC

Nervous or emotional problems	____	____	____	_____
Have you been under the care of psychiatrist or psychologist?	____	____	____	_____
Anxiety	____	____	____	_____
Depression	____	____	____	_____
Loss of interest in your normal or fun activities	____	____	____	_____
Do you feel inadequately refreshed after a night's sleep?	____	____	____	_____
Problems falling asleep	____	____	____	_____
Problems maintaining sleep once you have fallen asleep	____	____	____	_____
Loss of sexual desire	____	____	____	_____
Thoughts of worthlessness or hopelessness	____	____	____	_____
Do you find it hard to concentrate, make decisions, remember details, or get things done?	____	____	____	_____
Do you have suicidal thoughts or plans?	____	____	____	_____
In the past year, has a family member or close relative died?	____	____	____	_____
Do you have panic attacks?	____	____	____	_____

Please indicate 0-10, with 10 being the most happy and content, how positive you feel about:

Love and Romance _____	Career & Power _____	Health & Fitness _____	Money & Financial Success_____
Environment & Health Connection _____	Personal Growth & Spirituality _____	Fun & Recreation _____	Family & friends _____

Please circle one number per question for the questions below: 0 being condition does not exist, 10 being worst effect on you have ever experienced.

How limited your activity is as a result of fatigue: 0 1 2 3 4 5 6 7 8 9 10

Do you experience anxiety or depression: 0 1 2 3 4 5 6 7 8 9 10

How difficult is it for you to sleep or stay asleep: 0 1 2 3 4 5 6 7 8 9 10

Do you have night sweats: 0 1 2 3 4 5 6 7 8 9 10

Do you have day sweats: 0 1 2 3 4 5 6 7 8 9 10

How limited your physical activity is as a result of pain: 0 1 2 3 4 5 6 7 8 9 10

Do you currently experience pain? _____ If yes, circle the kind of pain you have:

Dull Sharp Stabbing Radiating Shooting Throbbing Hot Cold

Where is your pain:

_____

_____

REGENESIS WELLNESS CENTER OF SCOTTSDALE
9188 E SAN SALVADOR DR, STE 201
SCOTTSDALE, AZ 85258
Phone 480-443-0004

Name:_____ Email:_____

Address:_____

City:_____ State:_____ Zip:_____ Date:_____

Phone (home/cell):_____ (w):_____

Age: _____Height:_____ Weight:_____ Cholesterol: _____

Blood Pressure: _____ Physician Contact Info: _____

Reason for consultation and/or goals:_____

_____

_____

_____

How many times do you usually eat per day? _____

Please recall your last **3 full day's meals**, snacks, and drinks (please try to be very specific and complete, and be sure to include all foods- especially the ones you don't want me to know about ☺).

Day 1:_____

_____

_____

_____

_____

Day 2:_____

_____

_____

_____

_____

Day 3:_____

_____

_____

_____

Nutrition Questionnaire

Do you smoke? _____ If so, _____ per day/week/month
Drink alcohol?_____ If so , type _____
How often? _____ per day/week/month.
How often do you drink coffee? _____ per day/week/month
How often do you have soft drinks? _____ per day/week/month

Do you ever overeat?_____ If so, which foods and how often?_____

_____

Do you have any food allergies, restrictions, or sensitivities?_____

_____

Do you get noticeably irritable, lightheaded, or weak if you haven't eaten in a while?_____

Please list any food aversions and/or foods you dislike: _____

_____

How often do you eat at home/cook your own meals? _____per day/week/month

Do you crave any of the following frequently?

- ❑ Sweets/ Desserts
- ❑ Chocolate
- ❑ Diet Sodas
- ❑ Bread/Pasta
- ❑ Meat
- ❑ Fish
- ❑ Milk or Cheese
- ❑ Fried Foods
- ❑ Peanuts
- ❑ Alcoholic drinks
- ❑ Other_____
  _____

Which oils do you use/consume?

- ❑ Butter
- ❑ Margarine
- ❑ Olive Oil
- ❑ Coconut Oil
- ❑ Flaxseed Oil
- ❑ Sesame Oil
- ❑ Peanut Oil
- ❑ Corn Oil
- ❑ Crisco
- ❑ Vegetable Oil
- ❑ Soybean Oil
- ❑ Canola
- ❑ Sun/Safflower
- ❑ Mayonnaise
- ❑ Other_____

How is your dental health?_____

How often do you have bowel movements? _____ per day/week/month
Urinate? _____ per day

Are your nails weak or brittle?_____

REGENESIS WELLNESS CENTER OF SCOTTSDALE
9188 E SAN SALVADOR DR, STE 201
SCOTTSDALE, AZ 85258
Phone 480-443-0004

Rank the condition of your skin without lotion:

- ❑ Very Dry
- ❑ Dry
- ❑ Normal
- ❑ Oily
- ❑ Combination

Rank the condition of your hair

- ❑ Very Dry
- ❑ Dry
- ❑ Normal
- ❑ Oily
- ❑ Dandruff

Please check off any of the following that pertain to you (recent past or present):

- ❑ Acne/ blemishes
- ❑ Addiction (alcohol, drugs)
- ❑ Anemia
- ❑ Anorexia
- ❑ Anxiety or nervousness
- ❑ Arthritis (Rheumatoid or Osteo)
- ❑ Bladder infections (Cystitis)
- ❑ Bloating, gas, or indigestion
- ❑ Blood Sugar problems
- ❑ Bronchitis
- ❑ Cancer
- ❑ Colds or flu (frequent)
- ❑ Cold Sores
- ❑ Chronic fatigue
- ❑ Constipation
- ❑ Dandruff
- ❑ Depression
- ❑ Diabetes I (insulin dependent)
- ❑ Diabetes II (adult onset)
- ❑ Diarrhea
- ❑ Difficulty *losing* weight
- ❑ Difficulty *gaining* weight
- ❑ Emotional problems (instability or sensitivity)
- ❑ Emphysema
- ❑ Fainting
- ❑ Gall bladder problems
- ❑ Gout
- ❑ Hair loss or poor hair growth
- ❑ Headaches
- ❑ Heart disease or problems
- ❑ Heartburn
- ❑ Hemorrhoids
- ❑ Herpes type I mouth/face
- ❑ Herpes type II genital
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ HIV
- ❑ Hot flashes
- ❑ Hypoglycemia
- ❑ Insomnia
- ❑ Intestinal problems
- ❑ Kidney stones
- ❑ Liver problems
- ❑ Loose stools
- ❑ Memory loss or confusion
- ❑ Menopausal symptoms
- ❑ Nails, poor growth
- ❑ Nails, white spots
- ❑ Panic attacks
- ❑ Parasites
- ❑ Pregnant or nursing mother
- ❑ Respiratory problems
- ❑ Ringing in ears
- ❑ Seizures
- ❑ Severe mood swings
- ❑ Skin conditions
- ❑ Stroke
- ❑ Suicidal tendencies
- ❑ Thyroid condition
- ❑ Ulcer
- ❑ Yeast infections
- ❑ Other: _____

Women: Please check any that pertain:

Nutrition Questionnaire

- ❑ PMS
- ❑ Irregular periods
- ❑ Painful menstrual cramps
- ❑ Birth control pills
- ❑ Low or decreased libido
- ❑ Menopause
- ❑ Painful intercourse
- ❑ Hysterectomy
- ❑ Fertility concerns

Men: Please check any that pertain:

- ❑ Frequent urination
- ❑ Difficulty urinating
- ❑ Difficulty with erection
- ❑ Low or decreased libido
- ❑ Prostate Enlargement
- ❑ Un-viable sperm/Fertility concerns

Do you exercise?_____ If so, what kind?_____
How often?_____ Since when?_____
Do you take any nutritional supplements or vitamins?_____ If so, which ones? (be specific. Attach sheet if necessary)_____

_____

_____

Which prescription and over the counter medications do you take currently?

_____

_____

_____

Have you ever done a cleansing fast? _____ If so when and/or how often?

_____

Describe your daily energy levels:_____

Please list any disease, illness, or ailments in your immediate family (i.e. mother-breast cancer, father-type II diabetic, grandfather-heart disease).

_____

_____

_____

_____

Please rate the following:

Daily energy level:

- ❑ Excellent
- ❑ Good
- ❑ Fair
- ❑ Poor

Energy level after exercise:

- ❑ Excellent
- ❑ Good
- ❑ Fair

Please feel free to expand on any concerns you think are important/relevant to your health._____

_____

_____

_____

_____

_____

_____

Please check off the Vegetables, Fruits, & Proteins you WILL NOT or CANNOT eat

Vegetable List

	Alfalfa Sprouts
	Artichoke
	Arugula
	Asparagus
	Beans (black, lima, etc.)
	Beets
	Black eyed peas
	Broccoli
	Brussels sprouts
	Cabbage
	Carrots
	Cauliflower
	Celery
	Chard
	Chives
	Collard greens
	Corn
	Cucumber
	Eggplant
	Endive
	Fennel
	Garlic
	Ginger

	Green beans
	Kale
	Kelp
	Leeks
	Lentils
	Lettuce (romaine, baby greens, etc.)
	Mushrooms
	Mustard greens
	Okra
	Onions
	Parsley
	Parsnips
	Peas
	Peppers (red or green)
	Potato
	Pumpkin
	Radicchio
	Radishes
	Rhubarb
	Rutabaga
	Spinach
	Squash
	Sweet Potato

	Tomato
	Turnips
	Water chestnuts

	Yams
	Zucchini

Fruit List

	Apple
	Apricots
	Avocado
	Banana
	Blackberries
	Blueberries
	Boysenberries
	Cantaloupe
	Cherries
	Crabapples
	Cranberries
	Dates
	Figs

	Grapefruit
	Grapes
	Guava
	Honeydew
	Kiwi
	Lemon
	Lime
	Mandarin
	Mango
	Nectarine
	Orange
	Papaya
	Passionfruit

	Peach
	Pear
	Persimmon
	Pineapple
	Plum
	Pomegranate
	Prunes
	Raisins
	Raspberries
	Strawberries
	Tangerine
	Watermelon

Proteins

Meats:

	Chicken
	Ham
	Beef
	Pork

Fish & Seafood:

	Salmon
	Tuna
	Cod
	Grouper
	Sea Bass
	Snapper
	Herring
	Mackerel
	Crab
	Lobster
	Shrimp
	Mussels
	Oysters

Dairy

	Eggs
	Cheese
	Yogurt
	Cottage Cheese
	Whey Protein Powder

Nuts:

	Almonds
	Walnuts
	Brazilnuts
	Cashews
	Hazelnuts
	Macadamia Nuts
	Pecans
	Pistachio
	Almond Butter
	Cashew Butter
	Sesame Butter
	Natural Peanut Butter

- ❑ Poor

Daily stress level:
- ❑ Very High
- ❑ High
- ❑ Moderate
- ❑ Low
- ❑ None

General enjoyment of life:
- ❑ Excellent
- ❑ Good
- ❑ Fair
- ❑ Poor

How much sleep do you get on average each night?_____
Any problems sleeping?_____

Female Hormone Balancing Questionnaire

1. Read carefully through the list of symptoms in each group, and put a check mark next to each symptom that you have. (If you check off the same symptom in more than one group, that's fine.)

3. The more symptoms you check off, the higher the likelihood that you have the hormone imbalance represented by that group. (Some people may have more than one type of hormonal imbalance.)

SYMPTOM GROUP 1

- ☐ PMS
- ☐ Early miscarriage
- ☐ Unexplained weight gain
- ☐ Anxiety
- ☐ Insomnia
- ☐ Painful and/or lumpy breasts
- ☐ Cyclical headaches
- ☐ Infertility

TOTAL BOXES CHECKED

SYMPTOM GROUP 2

- ☐ Vaginal dryness
- ☐ Painful intercourse
- ☐ Bladder infections
- ☐ Hot flashes
- ☐ Night sweats
- ☐ Memory problems
- ☐ Lethargic depression

TOTAL BOXES CHECKED

SYMPTOM GROUP 3

- ☐ Puffiness and bloating
- ☐ Rapid weight gain
- ☐ Mood swings
- ☐ Anxious depression
- ☐ Insomnia
- ☐ Red flush on face
- ☐ Weepines
- ☐ Cervical dysplasia (abnormal pap smear)
- ☐ Breast tenderness
- ☐ Heavy bleeding
- ☐ Migraine headaches
- ☐ Foggy thinking
- ☐ Gallbladder problems

TOTAL BOXES CHECKED

SYMPTOM GROUP 4

- ☐ A combination of the symptoms in #1 and #3

TOTAL BOXES CHECKED

SYMPTOM GROUP 5

- ☐ Acne
- ☐ Excessive hair on the face and arms
- ☐ Thinning hair on the head
- ☐ Ovarian cysts
- ☐ Polycystic ovary syndrome (PCOS)
- ☐ Hypoglycemia and/or unstable blood sugar
- ☐ Infertility
- ☐ Mid-cycle pain

TOTAL BOXES CHECKED

SYMPTOM GROUP 6

- ☐ Debilitating fatigue
- ☐ Foggy thinking
- ☐ Thin and/or dry skin
- ☐ Brown spots on face
- ☐ Unstable blood sugar
- ☐ Low blood pressure
- ☐ Intolerance to exercise

TOTAL BOXES CHECKED

BHRT CHECKLIST FOR WOMEN

Name: _____ **Date:** _____

Symptom *(please check mark)*	**Never**	**Mild**	**Moderate**	**Severe**
Depressive mood (feeling down/sad/lack of drive)				
Memory Loss (forgetfulness)				
Mental confusion (feeling in a mental fog)				
Decreased sex drive/libido (decreased desire for sex)				
Sleep problems (difficulty falling/staying asleep/wake up tired)				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and Wrinkled Skin				
Hair is Falling Out				
Cold all the time				
Swelling all over the body				
Joint pain				

Other symptoms that concern you:

THYROID TRACKING SHEET

NAME: _____ **Date:** _____

In the spaces provided please rate your current symptoms on the following scale:

0= No symptoms
1= Symptoms are Mild
2= Symptoms are Mild to Moderate
3= Symptoms are Moderate
4= Moderately Severe
5= Severe/ Frequent Symptoms

Do you have fatigue?	_____
Do you have elevated cholesterol?	_____
Do you have difficulty losing weight?	_____
Do you have cold hands and feet?	_____
Are you sensitive to the cold?	_____
Do you have difficulty thinking or concentrating?	_____
	0
Do you experience brain fog or short term memory?	_____
	0
Are your moods depressed?	_____
Are you experiencing hair loss?	_____
Are you tired when you awaken?	_____
Do you have dry skin?	_____
	0
Do you have fluid retention?	_____
Do you have recurrent headaches?	_____
Do you sleep restlessly?	Yes or No
Do you have afternoon fatigue?	_____
Do you experience tingling or numbness in your hands or feet?	_____
Do you have decreased sweating?	_____
Have you had problems with infertility or miscarriages?	Yes or No
Do you have recurrent infections?	_____
Do your muscles ache?	_____
	0
Do you have thinning of your eyebrows or eyelashes?	_____
	0
Is your skin pasty, puffy or pale?	_____
	0
Is your voice hoarse?	_____
	0
Do you have low blood pressure?	_____
	0
Do you have sleep apnea?	_____

Current Medication Name & Strength: _____

Current Medication Name & Strength: _____

Current Medication Name & Strength: _____