NUTRITION INTAKE HISTORY

NoBel Nutrition
Inspired Nutrition for Life

Date _____

Patient Information

Patient _____

Address _____ **Apt.** _____

_____ **Age** _____ **Sex:** **M** ☐ **F** ☐
City State Zip

Home # _____ **Work #** _____ **Ext.** _____ **Birthdate** _____

Cell Phone # _____ **Patient SS#** _____

E-Mail _____

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ **Relationship** _____

Home Phone _____ **Work Phone** _____ **Ext.** _____

Whom may we thank for referring you? _____

Work Information

Occupation _____ **Phone** _____ **Ext.** _____

Company _____ **Address** _____

Spouse Information

Name _____ **SS#** _____ **Birthdate** _____

Occupation _____ **Employer** _____

I verify that all information within these pages is true and accurate.

_____ _____ _____

Patient's Signature | Patient's Name - Please print | Date

Health History

Height _____ **Weight** _____ **Number of Children** _____

Are you recovering from a cold or flu? _____ **Are you pregnant?** _____

Reason for office visit: **Date started:**

_____ _____

_____ _____

Date of last physical exam _____ **Practitioner name & contact** _____

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

_____

Outcome _____

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

☐ Diet modification ☐ Medical ☐ Vitamins/minerals ☐ Herbs ☐ Homeopathy ☐ Chiropractic

☐ Acupunture ☐ Conventional drugs ☐ Physical therapy ☐ Other _____

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

Current medications (prescription and/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., job change, family status change, work related, finances, etc..) _____

Do you consider yourself: ☐ Underweight ☐ Overweight ☐ Just right **Your weight now:** _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last 3 months? ☐ Yes ☐ No

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/prothetics/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 of the following flavors: ☐ Sour ☐ Bitter ☐ Sweet ☐ Rich/Fatty ☐ Spicy/Pungent ☐ Salty

Do you: ☐ Prefer warmth (i.e. foods, drinks, weather, ect…) ☐ Prefer cold (i.e. foods, drinks, weather, ect…) ☐ N/A

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:		**Time of day you feel the worst or your symptoms are aggravated:**	
☐ 6:00 am - 12:00 pm	☐ 6:00 pm - 12:00 am	☐ 6:00 am - 12:00 pm	☐ 6:00 pm - 12:00 am
☐ 12:00 pm - 6:00 pm	☐ 12:00 am - 6:00 am	☐ 12:00 pm - 6:00 pm	☐ 12:00 am - 6:00 am

Do you experience any of these general symptoms EVERYDAY?

☐ Shortness of breath	☐ Nausea	☐ Fecal incontinence	☐ Bleeding	☐ Insomnia
☐ Headaches	☐ Vomiting	☐ Urinary incontinence	☐ Discharge	☐ Constipation
☐ Dizziness	☐ Diarrhea	☐ Low grade fever	☐ Itching/rash	☐ Chronic pain/inflammation

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
- [ ] Inflammatory bowel disease
- [ ] Irritable bowel syndrome
- [ ] Kidney or bladder disease
- [ ] Learning disabilities
- [ ] Liver or gallbladder disease (stones)
- [ ] Mental illness
- [ ] 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 between cycles _____ days

Recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____

Family Healthy History

- [ ] Arthritis
- [ ] Astma
- [ ] Alcoholism
- [ ] Alzheimer's disease
- [ ] Cancer
- [ ] Depression
- [ ] Diabetes
- [ ] Drug addiction
- [ ] 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: # per day _____
- [ ] Alcohol:

Wine: # glasses/d or wk _____

Liquor: #oz./d or wk _____

Beer: # glasses/d or wk _____

- [ ] Caffeine:

Coffee: # 6oz. Cup/day _____

Tea: # 6oz. Cup/day _____

Soda: # cans/day _____

Other _____

- [ ] Water: # glasses/day _____

Exercise

- [ ] 5 - 7 days per week
- [ ] 3 - 4 days per week
- [ ] 1 - 2 days per week
- [ ] 45 min or more duration/wk
- [ ] 30 - 45 min duration/workout
- [ ] Less than 30 min
- [ ] Walk
- [ ] Run, Jog, jump rope
- [ ] Weight-lift
- [ ] Swim
- [ ] Box
- [ ] Yoga

Other _____

Nutrition & Diet

- [ ] Mixed food diet (animal & veg)
- [ ] Vegetarian
- [ ] Vegan
- [ ] Salt restriction
- [ ] Fat restriction
- [ ] Starch/carbohydrate restriction
- [ ] Total calorie restriction

Specific food restrictions: _____

_____

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 (hungry or not)
- [ ] 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 (eg, lutein, resveratrol, etc.)
- [ ] Herbs - teas
- [ ] Herbs - extracts
- [ ] Chinese herbs
- [ ] Ayurvedic herbs
- [ ] Homeopathy
- [ ] Bach flowers
- [ ] Protein shakes
- [ ] Superfoods (eg. 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
- [ ] Feel more motivated
- [ ] Be more organized
- [ ] Thisnk more clearly; be more focused
- [ ] Improve memory
- [ ] Do better on tests
- [ ] Not be dependent on over-the-counter meds like aspirin, ibuprofen, 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 (eg. cancer, heart disease, etc..)

Systems Survey Form | Restricted to Professional Use

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NAME: DATE OF BIRTH: EMAIL:

INSTRUCTIONS: Circle the number that applies to you. **If a symptom does not apply, don't circle anything** for that symptom.

Circle the corresponding number.	
1	MILD symptom (occurs rarely)
2	MODERATE symptom (occurs several times a month)
3	SEVERE symptom (occurs almost constantly)

GROUP 1

1. 1 2 3 Acid foods upset
2. 1 2 3 Get chilled often
3. 1 2 3 "Lump" in throat
4. 1 2 3 Dry mouth, eyes, nose
5. 1 2 3 Pulse speeds after meal
6. 1 2 3 Keyed up, fail to calm
7. 1 2 3 Gag occasionally
8. 1 2 3 Unable to relax, startle easily
9. 1 2 3 Extremities cold, clammy
10. 1 2 3 Strong light irritates
11. 1 2 3 Occasionally weak urine flow
12. 1 2 3 Heart pounds after retiring
13. 1 2 3 "Nervous" stomach
14. 1 2 3 Appetite reduced occasionally
15. 1 2 3 Cold sweats often
16. 1 2 3 Get heated easily
17. 1 2 3 Nerve discomfort
18. 1 2 3 Staring, blink little
19. 1 2 3 Sour stomach frequent

____ ____ ____ TOTAL
1 2 3

GROUP 2

20. 1 2 3 Joint stiffness after arising
21. 1 2 3 Muscle, leg, toe cramps at night
22. 1 2 3 "Butterfly" stomach, cramps
23. 1 2 3 Eyes or nose watery
24. 1 2 3 Eyes blink often
25. 1 2 3 Eyelids swollen, puffy
26. 1 2 3 Indigestion soon after meals
27. 1 2 3 Always seem hungry, feel "lightheaded" often
28. 1 2 3 Digestion rapid
29. 1 2 3 Vomit occasionally
30. 1 2 3 Hoarseness frequent
31. 1 2 3 Uneven breathing
32. 1 2 3 Pulse slow
33. 1 2 3 Gagging reflex slow
34. 1 2 3 Difficulty swallowing
35. 1 2 3 Temporary constipation or diarrhea
36. 1 2 3 "Slow starter"
37. 1 2 3 Get "chilled"
38. 1 2 3 Perspire easily
39. 1 2 3 Sensitive to cold
40. 1 2 3 Upper respiratory challenges

____ ____ ____ TOTAL
1 2 3

GROUP 3

41. 1 2 3 Eat when nervous
42. 1 2 3 Excessive appetite
43. 1 2 3 Hungry between meals
44. 1 2 3 Irritable before meals
45. 1 2 3 Get "shaky" if hungry
46. 1 2 3 Fatigue, eating relieves
47. 1 2 3 "Lightheaded" if meals delayed
48. 1 2 3 Heart palpitates if meals missed or delayed
49. 1 2 3 Fatigue in afternoon
50. 1 2 3 Overeating sweets upsets
51. 1 2 3 Awaken after few hours sleep, hard to get back to sleep
52. 1 2 3 Crave candy or coffee in afternoon
53. 1 2 3 Moods of "blues" or melancholy
54. 1 2 3 Craving for sweets or snacks

____ ____ ____ TOTAL
1 2 3

GROUP 4

55. 1 2 3 Hands and feet go to sleep easily, numbness
56. 1 2 3 Sigh frequently, "air hunger"
57. 1 2 3 Aware of "breathing heavily"
58. 1 2 3 High-altitude discomfort
59. 1 2 3 Open windows in closed room
60. 1 2 3 Immune system challenges
61. 1 2 3 Afternoon "yawner"
62. 1 2 3 Get "drowsy" often
63. 1 2 3 Swollen ankles worse at night
64. 1 2 3 Muscle cramps, worse during exercise; get "charley horse"
65. 1 2 3 Difficulty catching breath, especially during exercise
66. 1 2 3 Tightness or pressure in chest, worse on exertion
67. 1 2 3 Skin discolors easily after impact
68. 1 2 3 Tendency to anemia
69. 1 2 3 Noises in head or "ringing in ears"
70. 1 2 3 Fatigue upon exertion

____ ____ ____ TOTAL
1 2 3

GROUP 5

71. 1 2 3 Dizziness
72. 1 2 3 Dry skin
73. 1 2 3 Burning feet
74. 1 2 3 Blurred vision
75. 1 2 3 Itching skin and feet
76. 1 2 3 Hair loss
77. 1 2 3 Occasional skin rashes
78. 1 2 3 Bitter, metallic taste in mouth in morning
79. 1 2 3 Occasional constipation
80. 1 2 3 Worrier, feels insecure
81. 1 2 3 Nausea occasionally after eating
82. 1 2 3 Greasy foods upset
83. 1 2 3 Stools light-colored
84. 1 2 3 Skin peels on foot soles
85. 1 2 3 Discomfort between shoulder blades
86. 1 2 3 Occasional laxative use
87. 1 2 3 Stools alternate from soft to watery
88. 1 2 3 Sneezing attacks
89. 1 2 3 Dreaming, nightmare-type bad dreams
90. 1 2 3 Bad breath (halitosis)
91. 1 2 3 Milk products cause upset
92. 1 2 3 Sensitive to hot weather
93. 1 2 3 Burning or itching anus
94. 1 2 3 Crave sweets

____ ____ ____ TOTAL
1 2 3

GROUP 6

95. 1 2 3 Loss of taste for meat
96. 1 2 3 Lower bowel gas several hours after eating
97. 1 2 3 Burning stomach sensations, eating relieves
98. 1 2 3 Coated tongue
99. 1 2 3 Pass large amounts of foul-smelling gas
100. 1 2 3 Indigestion ½-1 hour after eating; may be up to 3-4 hours after
101. 1 2 3 Watery or loose stool
102. 1 2 3 Gas shortly after eating
103. 1 2 3 Stomach "bloating"

____ ____ ____ TOTAL
1 2 3

GROUP 7A

104. 1 2 3 Difficulty sleeping
105. 1 2 3 On edge
106. 1 2 3 Can't gain weight
107. 1 2 3 Intolerance to heat
108. 1 2 3 Highly emotional
109. 1 2 3 Flush easily
110. 1 2 3 Night sweats
111. 1 2 3 Thin, moist skin
112. 1 2 3 Inward trembling
113. 1 2 3 Heart races
114. 1 2 3 Increased appetite without weight gain
115. 1 2 3 Pulse fast at rest
116. 1 2 3 Eyelids and face twitch
117. 1 2 3 Irritable and restless
118. 1 2 3 Can't work under pressure

____ ____ ____ TOTAL
1 2 3

GROUP 7B

119. 1 2 3 Increase in weight
120. 1 2 3 Decrease in appetite
121. 1 2 3 Fatigue easily
122. 1 2 3 Ringing in ears
123. 1 2 3 Sleepy during day
124. 1 2 3 Sensitive to cold
125. 1 2 3 Dry or scaly skin
126. 1 2 3 Temporary constipation
127. 1 2 3 Mental sluggishness
128. 1 2 3 Hair coarse, falls out
129. 1 2 3 Tension in head upon arising wears off during day
130. 1 2 3 Slow pulse below 65
131. 1 2 3 Changing urinary function
132. 1 2 3 Sounds appear diminished
133. 1 2 3 Reduced initiative

____ ____ ____ TOTAL
1 2 3

GROUP 7C

134. 1 2 3 Failing memory with age
135. 1 2 3 Increased sex drive
136. 1 2 3 Episodes of tension in head
137. 1 2 3 Decreased sugar tolerance

____ ____ ____ TOTAL
1 2 3

GROUP 7D

138. 1 2 3 Abnormal thirst
139. 1 2 3 Bloating of abdomen
140. 1 2 3 Weight gain around hips or waist
141. 1 2 3 Sex drive reduced or lacking
142. 1 2 3 Tendency for stomach issues
143. 1 2 3 Immune system challenges
144. 1 2 3 Menstrual disorders

____ ____ ____ TOTAL
1 2 3

GROUP 7E

145. 1 2 3 Dizziness
146. 1 2 3 Headaches
147. 1 2 3 Hot flashes
148. 1 2 3 Hair growth on face or body (female)
149. 1 2 3 Sugar in urine (not diabetes)
150. 1 2 3 Masculine tendencies (female)

____ ____ ____ TOTAL
1 2 3

GROUP 7F

151. 1 2 3 Weakness, dizziness
152. 1 2 3 Tired throughout day
153. 1 2 3 Nails weak, ridged
154. 1 2 3 Sensitive skin
155. 1 2 3 Stiff joints
156. 1 2 3 Perspiration increase
157. 1 2 3 Bowel discomfort
158. 1 2 3 Poor circulation
159. 1 2 3 Swollen ankles
160. 1 2 3 Crave salt
161. 1 2 3 Areas of skin darkening
162. 1 2 3 Upper respiratory sensitivity
163. 1 2 3 Tiredness
164. 1 2 3 Breathing challenges

____ ____ ____ TOTAL
1 2 3

GROUP 8

165. 1 2 3 Muscle weakness
166. 1 2 3 Lack of stamina
167. 1 2 3 Drowsiness after eating
168. 1 2 3 Muscular soreness
169. 1 2 3 Heart races
170. 1 2 3 Hyperirritable
171. 1 2 3 Feeling of a band around head
172. 1 2 3 Melancholia (feeling of sadness)
173. 1 2 3 Swelling of ankles
174. 1 2 3 Change in urinary function
175. 1 2 3 Tendency to consume sweets/carbohydrates
176. 1 2 3 Muscle spasms
177. 1 2 3 Blurred vision
178. 1 2 3 Involuntary muscle action
179. 1 2 3 Numbness
180. 1 2 3 Night sweats
181. 1 2 3 Rapid digestion
182. 1 2 3 Sensitivity to noise
183. 1 2 3 Redness of palms of hands and bottom of feet
184. 1 2 3 Visible veins on chest and abdomen
185. 1 2 3 Hemorrhoids
186. 1 2 3 Apprehension (feeling that something bad is going to happen)
187. 1 2 3 Nervousness causing loss of appetite
188. 1 2 3 Nervousness with indigestion
189. 1 2 3 Gastritis
190. 1 2 3 Forgetfulness
191. 1 2 3 Thinning hair

____ ____ ____ TOTAL
1 2 3

FEMALE ONLY

192. 1 2 3 Very easily fatigued
193. 1 2 3 Premenstrual tension
194. 1 2 3 Menses more painful than usual
195. 1 2 3 Depressed feelings before menstruation
196. 1 2 3 Painful breasts during menses
197. 1 2 3 Menstruate too frequently
198. 1 2 3 Hysterectomy/ovaries removed
199. 1 2 3 Menopausal hot flashes
200. 1 2 3 Menses scanty or missed
201. 1 2 3 Acne, worse at menses

____ ____ ____ TOTAL
1 2 3

MALE ONLY

202. 1 2 3 Less involved in exercise/social activities
203. 1 2 3 Difficult to postpone urination
204. 1 2 3 Weak urinary stream
205. 1 2 3 Feeling of "blues" or melancholy
206. 1 2 3 Feeling of incomplete bowel evacuation
207. 1 2 3 Lack of energy
208. 1 2 3 Muscles in arms and legs seem softer/smaller
209. 1 2 3 Tire too easily
210. 1 2 3 Avoid activity
211. 1 2 3 Leg nervousness at night
212. 1 2 3 Diminished sex drive

____ ____ ____ TOTAL
1 2 3

IMPORTANT | Please list below the five main physical complaints you have in order of their importance.

1. _____
2. _____
3. _____
4. _____
5. _____

ADDITIONAL COMMENTS:

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HEALTH PROFILE

NAME _____ **DATE** _____ **E-MAIL** _____

Rate each of the following symptoms based upon your typical health profile for: ☐ Past 30 days ☐ Past 48 hours

Point Scale	
0 *Never* or *almost never* have the symptom	**3** *Frequently* have it, effect is *not severe*
1 *Occasionally* have it, effect is *not severe*	**4** *Frequently* have it, effect *severe*
2 *Ocassionally* have it, effect is *severe*	

HEAD
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia
_____ TOTAL

EYES
_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision
(does not include near- or far-sightedness)
_____ TOTAL

NOSE
_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation
_____ TOTAL

MOUTH/ THROAT
_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums or lips
_____ Canker sores
_____ TOTAL

SKIN
_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating
_____ TOTAL

HEART
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain
_____ TOTAL

LUNGS
_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing
_____ TOTAL

DIGESTIVE TRACT
_____ Nausea, vomitting
_____ Diarrhea
_____ Constipation
_____ Cbloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain
_____ TOTAL

JOINTS/ MUSCLE
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness
_____ TOTAL

WEIGHT
_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight
_____ TOTAL

ENERGY/ ACTIVITY
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness
_____ TOTAL

MIND
_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities
_____ TOTAL

EMOTIONS
_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression
_____ TOTAL

OTHER
_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge
_____ TOTAL

GRAND TOTAL _____

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NAME_____EMAIL_____
DATE_____

Toxicity Questionnaire

Please rate each of the following based on your health profile based on the last 90 days:

*(**0** = Rarely or never experience the symptom **1**= Occasionally experience but effective is not severe **2** = Occasionally experience but effect is severe **3** = Frequently experience and effect is not severe **4** = Frequently experience and effect is severe)*

Digestive:

Nausea	0 1 2 3 4
Diarrhea or Vomiting	0 1 2 3 4
Heartburn, Reflux	0 1 2 3 4
Straining on bowel Mvmt	0 1 2 3 4
Day without bowel mvmt	0 1 2 3 4
Gas, Belch, Bloating	0 1 2 3 4
Hemorrhoids	0 1 2 3 4
Total for section:	_____

Heart:

Shortness of Breath	0 1 2 3 4
Skipped, Rapid Heartbeat	0 1 2 3 4
High/Low Blood Pressure	0 1 2 3 4
Chest Pain	0 1 2 3 4
Tightness in chest	0 1 2 3 4
Total for section:	_____

Emotions:

Mood Swings	0 1 2 3 4
Anxiety / Fear / Nervous	0 1 2 3 4
Anger / Irritability	0 1 2 3 4
Panic Attacks	0 1 2 3 4
Depression	0 1 2 3 4
Sense of Despair	0 1 2 3 4
Total for section:	_____

Energy:

Fatigue / Tired	0 1 2 3 4
Sluggishness	0 1 2 3 4
Hyperactivity	0 1 2 3 4
Restlessness	0 1 2 3 4
Brain Fog	0 1 2 3 4
Irritable if miss meals	0 1 2 3 4
Swelling hands and feet	0 1 2 3 4
Total for section:	_____

Skin, Hair, Nails:

Flushing	0 1 2 3 4
Cold hands & feet	0 1 2 3 4
Acne	0 1 2 3 4
Dry skin /Oily skin	0 1 2 3 4
Hives, rashes	0 1 2 3 4
Eczema, Psoriasis	0 1 2 3 4
Hair loss	0 1 2 3 4
Cracked heels on feet	0 1 2 3 4
Bruising	0 1 2 3 4
Brittle nails	0 1 2 3 4
Total for section:	_____

Hormones:

Oily Skin, Acne	0 1 2 3 4
Pain during period	0 1 2 3 4
Breast tenderness	0 1 2 3 4
Irregular cycle	0 1 2 3 4
Weight gain	0 1 2 3 4
Cry easily	0 1 2 3 4
Vaginal dryness	0 1 2 3 4
Hot flashes	0 1 2 3 4
Loss of sex drive	0 1 2 3 4
Erectile dysfunction	0 1 2 3 4
Balding	0 1 2 3 4
Anger easily	0 1 2 3 4
Total for section:	_____

Head, Eyes:

Blurred Vision	0 1 2 3 4
Pressure	0 1 2 3 4
Faintness	0 1 2 3 4
Dizziness	0 1 2 3 4
Headaches	0 1 2 3 4
Total for section:	_____

Allergies:

Watery, Itchy Eyes	0 1 2 3 4
Runny Nose	0 1 2 3 4
Sneezing	0 1 2 3 4
Itchy throat	0 1 2 3 4
Itchy skin	0 1 2 3 4
Post nasal drip	0 1 2 3 4
Total for section:	_____

Immune:

Frequent illness	0 1 2 3 4
Sore throat	0 1 2 3 4
Fever	0 1 2 3 4
Genital itch, Discharge	0 1 2 3 4
Yellow nail fungus	0 1 2 3 4
Total for section:	_____

Urinary Tract:

Frequent urination	0 1 2 3 4
Burning on urination	0 1 2 3 4
Dribbling urine	0 1 2 3 4
Leaky bladder	0 1 2 3 4
Blood in urine	0 1 2 3 4
Kidney stones	0 1 2 3 4
Total for section:	_____

Ears, Sinus, Nose:

Popping ears	0 1 2 3 4
Fluid in ears	0 1 2 3 4
Ringing ear	0 1 2 3 4
Hearing loss	0 1 2 3 4
Ear Infections	0 1 2 3 4
Excessive mucous	0 1 2 3 4
Stuffy nose	0 1 2 3 4
Sinus headache	0 1 2 3 4
Nose bleeds	0 1 2 3 4
Total for section:	_____

Mouth, Throat, Teeth:

Dry Mouth	0 1 2 3 4
Canker sores	0 1 2 3 4
Cold sores	0 1 2 3 4
Tooth pain	0 1 2 3 4
Bleeding gums	0 1 2 3 4
Gagging, clearing throat	0 1 2 3 4
Total for section:	_____

Lungs:

Difficulty breathing	0 1 2 3 4
Chest congestion	0 1 2 3 4
Coughing	0 1 2 3 4
Asthma	0 1 2 3 4
Total for section:	_____

Joints, Muscles, Bones:

Twitching	0 1 2 3 4
Cramping	0 1 2 3 4
Stiff & achy joints	0 1 2 3 4
Pain in joints	0 1 2 3 4
Swelling in Joints	0 1 2 3 4
Muscle aches	0 1 2 3 4
Muscle pains	0 1 2 3 4
Osteoporosis	0 1 2 3 4
Numbness, Burning	0 1 2 3 4
Flat feet, Fallen arch	0 1 2 3 4
Total for section:	_____

Sleep:

Can't fall asleep	0 1 2 3 4
Wake up often	0 1 2 3 4
Nighttime Urination	0 1 2 3 4
Wake up tired	0 1 2 3 4
Bad dreams/Nightmare	0 1 2 3 4
Night sweats	0 1 2 3 4
Total for section:	_____

Signature:_____ Date:_____

Total For All Sections:_____