

GENERAL INFORMATION SHEET

Name _____ DOB _____ Age ____ Sex: M F Date _____
Address _____ City _____
State/Prov. _____ Postal Code _____ Country _____
Home Phone _____ Business Phone _____
E-Mail Address _____ Height _____ Weight _____
Occupation _____ How were you referred? _____
What are your main health concerns or conditions? _____

Please list any medications or food supplements you are currently taking:

Please list any recent medical test results you have, such as blood tests:

Any past surgeries and dates:

Please list illness in your family such as heart disease, cancer, TB, diabetes, arthritis etc.

DIET: What are examples of typical breakfasts for you?	Beverages
_____	_____
_____	_____
Mid-morning Snacks:	
What are typical lunches for you?	Beverages
_____	_____
_____	_____
Mid-afternoon Snacks:	
What are typical dinners for you?	Beverages
_____	_____
_____	_____
Evening Snacks:	

How often and what kind of exercise do you do? _____

About how many hours of sleep do you get per day? _____

Alcohol use: Type _____ Ounces _____ How often _____

Tobacco use: Type _____ How often _____

Recreational Drug use: Type _____ How often _____

Signed _____

Date _____

SYMPTOMS SHEET

Name _____

CHECK boxes for any conditions or symptoms that presently describe you.

HIGHLIGHT the symptoms most important to you with the PDF highlighter in the tool bar.

- | | | |
|---|--|--|
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Fungal Infections/Candida | <input type="checkbox"/> Neuritis |
| <input type="checkbox"/> Joint Stiffness | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Eye diseases |
| <input type="checkbox"/> Arthritis, Osteo | <input type="checkbox"/> Hives | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Arthritis, Rheumatoid | <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Slow Wound Healing | <input type="checkbox"/> Intestinal Gas |
| <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Bloating |
| <input type="checkbox"/> Muscle Cramps | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Meniere's Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Tooth Decay | <input type="checkbox"/> Stomach Pain |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Excessive Plaque on Teeth | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Gum Disease | <input type="checkbox"/> Gall Stones |
| <input type="checkbox"/> Sweet Cravings | <input type="checkbox"/> Infections/Viruses | <input type="checkbox"/> Fissures |
| <input type="checkbox"/> Sugar Reactions | <input type="checkbox"/> Tumors/Cancer | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Irritable before meals | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Cirrhosis |
| <input type="checkbox"/> Can't Skip Meals | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Diverticulitis |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Scleroderma | <input type="checkbox"/> Tend to Gain Weight |
| <input type="checkbox"/> Crave Starches | <input type="checkbox"/> Fear | <input type="checkbox"/> Tend to Lose Weight |
| <input type="checkbox"/> Fat Carvings | <input type="checkbox"/> Anger | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Other Food Cravings | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Easy Bruising |
| <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Dental Amalgams |
| <input type="checkbox"/> Excessive hunger | <input type="checkbox"/> Brain Fog | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> No hunger | <input type="checkbox"/> Confusion | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Depression | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Rapid Heart Rate | <input type="checkbox"/> Irritability | |
| <input type="checkbox"/> Skipped Heart Rate | <input type="checkbox"/> Mind Races | |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Mood Swings | WOMEN: |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Obsessive/Compulsive | <input type="checkbox"/> Premenstrual Syndrome |
| <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Water Retention |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Poor Memory | <input type="checkbox"/> Cramps |
| <input type="checkbox"/> Low or High Blood Pressure | <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> No Menstruation |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Trouble Sleeping | <input type="checkbox"/> Heavy periods |
| <input type="checkbox"/> High Cholesterol _____ | <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Light/Irregular Periods |
| <input type="checkbox"/> High Triglycerides _____ | <input type="checkbox"/> Autism | <input type="checkbox"/> Ovarian Cysts |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Attention Deficit | <input type="checkbox"/> Fibroid Tumors |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hyperkinesis | <input type="checkbox"/> Abnormal Pap Smear |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dyslexia | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> Post-nasal Drip | <input type="checkbox"/> Seizures | <input type="checkbox"/> Fibrocystic Breasts |
| <input type="checkbox"/> Sinus Congestion | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Breast Tumors |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Yeast Infections |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Delayed Development | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Bladder Infections | <input type="checkbox"/> Currently pregnant |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Kidney Infections | <input type="checkbox"/> Abuse |
| <input type="checkbox"/> Low Body Temperature | <input type="checkbox"/> Trouble Urinating | <input type="checkbox"/> Rape |
| <input type="checkbox"/> Cold in Winter/Dry Skin | <input type="checkbox"/> Frequent Urination | |
| <input type="checkbox"/> Tend to Gain Weight | <input type="checkbox"/> Painful Urination | MEN: |
| <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Water Retention | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Sinus Headaches | <input type="checkbox"/> Infertility |
| | <input type="checkbox"/> Tension Headaches | <input type="checkbox"/> Vegetarian |
| | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Vegan |

Other Symptoms or Comments: _____