



**Carefree Health Path
Naturopathic Clinic**

Personal Health Information

Last Name: _____ First Name: _____ Date: ____/____/____

Address: _____ City: _____ State: _____ Zip Code: _____

Social Security# _____ - _____ - _____ Date of Birth: _____ Age: _____ Gender: Female Male

Email Address: _____ would you like to subscribe to our online special? Y N

Height _____ Weight _____ Are you: Married Separated Divorced Widowed Single

Home Phone: _____ Work: _____ Cell: _____

Emergency Contact: _____ Phone: _____ Relationship _____

May we communicate with them re: appt's, RX's, and lab results? Y N

Preferred phone number to contact you: Home Work Cell May we leave a message: Y N

Have you ever seen a Naturopathic Physician before? Y N Reason: _____

How did you hear about us? Friend Physician Relative Internet Magazine Other

Referring person's name: _____

Primary Care Physician: _____ Phone: _____

Address: _____ City: _____ State: _____

When was your last healthcare visit? _____ Where? _____ Reason? _____

Pharmacy: _____ Phone: _____

Please list in order of importance your main health concern(s): _____

Do you have ANY allergies to medications, food, latex, or other substances? Y N Please list: _____

Have you ever been hospitalized? Y N If yes, when and what reason: _____

Have you had any surgeries? Y N If yes, when and for what reason: _____

Do you drink alcohol? Y N If yes, what type, how much and how often? _____

Have you ever smoked cigarettes, cigars, marijuana, pipe or chewed tobacco? Y N If yes, how long did you/have you smoked/tobacco? _____ If yes, do you still smoke? Y N Year you quit smoking: _____ What do you smoke?

Cigarettes, cigars, marijuana or pipe Other _____ How much do you smoke/tobacco? _____

Has any family member had the following: If yes, please identify the family member.

Family History: Please circle

	Yes	No	Past	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Kidney Disease	Y	N	P	_____
Mental Illness	Y	N	P	_____
Pneumonia	Y	N	P	_____
Stroke	Y	N	P	_____
Tuberculosis	Y	N	P	_____
Venereal Disease	Y	N	P	_____
Were any of these a cause of death?	<input type="checkbox"/> Y	<input type="checkbox"/> N		If so, which family member and what age? _____

Childhood Illnesses:

Scarlett Fever Y / N Diphtheria Y / N Rheumatic Fever Y / N Mumps Y / N Measles Y / N German measles Y / N

Immunizations:

Polio	Y / N	Diphtheria	Y / N	Rubella	Y / N	Anthrax	Y / N
Pertussis	Y / N	Hepatitis	Y / N	Pneumonia	Y / N	Measles/Mump	Y / N
Small Pox	Y / N	Tetanus	Y / N	Date of last Tetanus Shot: ____/____/____			

Please list All medications currently taking: include all over-the-counter medications and vitamins.

Medications	Daily Dosage	Side Effects, Results
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Release of Record: In completion of this form, I hereby acknowledge and authorize the release of my records to myself at the above contact information at any requested time. This request may be denied where applicable laws compel **Carefree Health Path** to do so.

Patient Consent

If you have any questions, please ask:

- I acknowledge that no guaranties, either expressed or implied have been made to me regarding the outcome of any treatments or procedures.
- I agree to accept responsibility for payment of all charges relating to the services provided to me. The amounts due for services rendered and that payments must be made directly to Carefree Health Path and that no special arrangements have been made for payment. I understand that all treatments, therapies, medicines and nutritional supplements are non-refundable, and there are no refunds. The services offered are not included in the Medicare program and that if I inadvertently file a Medicare claim it will be denied. Most insurance companies do not pay for these services and any claims I make may be denied.

- I accept t the risks and complications. I agree to follow-up as recommended and to follow any and all of the pre-procedure and/or post-treatment instructions that have been provided to me. I understand that failure to do so can affect my results.
- I have been advised whether, on the days surrounding the treatment or procedure, I should take any and/or all of the medications I informed the doctor I have been taking.
- I understand that some of these therapies are not recognized or approved by the Food and Drug Administration as a standard therapy. I therefore, hereby release Carefree Health Path, and their designates, physician(s), staff, employees, and relatives of such from any liability arriving out of the status of the approval or lack of approval of this therapeutic process.
- As with any therapy, some patients may experience side effects from the therapy(s) chosen and/or agreed to. If they occur, most are likely to be minor or temporary. However, some may be serious or life threatening and need medical attention.

By signing below, you, the patient of Carefree Health Path (or the legal representative or parent of the patients), are requesting and authorizing Carefree Health Path to perform services and to provide you with recommendations on optimizing your present and long-term health goals.

Patient / Legal Guardian Signature: _____ **Date:** ____/____/____

Consent for use and disclosure of health information

Privacy Terms: We keep a record of healthcare services we provide you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the records we keep. Moreover, if you believe that information in your record is inaccurate, you may request that we make corrections or amend that record. These requests must be made in writing. We will not disclose your medical information to others unless you direct us to do so or applicable laws authorize or compel us to do so. Carefree Health Path is required to provide you, at your request, with a copy of its Notice of Privacy Practices and to obtain written acknowledgement that you have reviewed it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of you healthcare information at our clinic, or wish to inquire about your right, please call the Carefree Health Path at (623) 748-9106.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ AND REVIEW IT CAREFULLY.

Please read the following statements carefully.

Purpose of Consent: By signing this form you consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, healthcare operations, and the uses and disclosures we may make of your protected health information, as well as other important matters regarding your protected health information. A copy of our Notice is available and has been provide with this Consent. We encourage you to read the Notice carefully signing this Consent. We reserve the reserve the right to change our privacy practices as described in our Notice of Privacy Practices at any time. If we change our privacy practices, we will issue a revised Notec of Privacy Practices that will contain the changes. This is in accordance with

privacy regulations issued under the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Regulations") Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of any revisions to our Notice at any time by contracting:

Contact Person: Eugene Eihausen, N.M.D. Phone: 623-748-9106

Right to Revoke: You will have the right to revoke this Consent at any time by submitting written notice of your revocation to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

Notice:

Carefree Health Path and many other organization and individuals including physicians, hospitals and health plans are required by law to keep your health information confidential. If you authorize the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

Your Rights:

This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative and delivered to **Carefree Health Path at 2525 W. Carefree Hwy. Bldg. 3, Suite 118, Phoenix, Arizona 85085**. The revocation takes effect when **Carefree Health Path** receives, except to the extent others have already relied on it.

Expiration of Authorization Unless otherwise revoked, this Authorization expires ____/____/____ (insert a date or leave blank). If no date indicated the Authorization expires 12 months after the date of my signing this form.

I _____ (**PRINT NAME**) have had full opportunity to read and consider the contents of this Consent and your Notice of Privacy Practices. I understand that by signing this Consent, I am consenting to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

I hereby acknowledge that I have been offered a copy of the Carefree Health Path Notice of Privacy Practices.

Patient / Legal Guardian Signature: _____ **Date:** ____/____/____

Placed in Chart

Medical Weight Management

Patient Name: _____ Date: ____/____/____

Weight: ____ Target: ____ Pant or dress size? ____ Last B/P reading: ____ Date reading: _____

Once you reach your goal, will you allow us to use your name as a testimonial? Yes ____ No ____

What weight loss/diet programs have you used? _____

*The following are some reactions, which are occasionally experienced by some people when losing weight.

*Please check: Yes__ or No__ where & if application with regards to your previous experience on weight loss programs or diets. Not Well or Nauseous:____ Headaches:____ Missing of 1st period:____ Sleeping problems:____ Weakness:____ Plateaus:____ Slight & Temporary hair thinning:____ Hunger pangs:____ Lethargy:____ Specific or general cravings:____ Leg cramps:____

*America failed at weight loss because diet plans do not address the core reasons of why people put the weight back on again. The metrics need to be measured, and programs that can move these numbers into normal range implemented to allow for sustainable weight loss and wellness.

*Your body fat % is the amount of fat your body contains. If you are 150 pounds and 30% fat, it means that your body consists of 45 pounds of fat and 105 pounds of lean body mass (bone, muscle, organ tissue, blood and everything else). You want to have your body

fat % fall into a healthy range to prevent fat cells from releasing unhealthy chemicals as they enlarge. (Fat %: Goal=women 25-31% men 18-25% depending on age).

*Blood pressure is the result of two forces: The heart as it pumps blood into the arteries and throughout the circulatory system, and the force of the arteries as they resist blood flow. It has been shown that high blood pressure directly correlates to excess weight. (Blood Pressure: Goal=Systolic <120-Diastolic <80).

*The thyroid is a small gland located just below the Adam's apple. It plays a very important role in controlling your body's metabolism, (the rate at which your body uses energy). It does this by producing thyroid hormones, chemicals that travel through your blood. These hormones tell the cells in your body how fast to use energy and create proteins. (Thyroid Reading: Goal= 65-120).

*Your waist circumference measurement is a great marker for health risks such as heart disease, some cancers and diabetes. In fact, waist sizes over 35 inches can significantly increase risk for diabetes and those with a waist size of 39.37 and more, most likely have insulin resistance. (Waist: Goal=Men <35 inches Women <33 inches).

*RMR is the resting metabolic rate of the body which is equivalent to the calories burnt by the body while at rest or the calories needed to just maintain life. The majority of calories are burnt at the resting level (about 70-80%). Activity calories are burnt from normal daily activities such as walking, eating, gardening etc. Muscle is the principal determinate of resting metabolism.

Wellness Operating system (WOS) Questionnaire

Please be thoughtful and thorough in answering these questions, as they are very important. Your answers can greatly assist your Health Care Practitioner in successfully recognizing key nutrient support issues, which may be essential to your successfully losing your weight and keeping it off for life, as well as your long term health and well-being. Thank you for your thoughtfulness.

Circle: The number on the blank which best describes the **frequency**, or **severity** of your symptoms. If you do not know the answer to the question, or if the question does not apply, leave it blank. When you are finished, please add the # of points and write on the **Part Score Line**.

(0)Never or rarely (1) twice a week or less (mild) (2) three to six times a week (moderate) (3) daily (severe)

Section 1:

Part 1-A

Indigestion-food repeats on you after you eat?

0 1 2 3

Excessive burping, belching and/or bloating following meals? 0 1 2 3

Carefree Health Path 2525 W. Carefree Hwy. Bldg. 3, Suite 118 Phoenix, AZ 85085 Phone: 623-748-9106 Fax: 623-748-9574

Stomach spasms and cramping during or after eating?	0 1 2 3	Dry skin or scalp?	0 1 2 3
Sensation that food sits in your stomach after eating?	0 1 2 3	General feeling of poor health?	0 1 2 3
Abdominal pain on right side, underneath rib cage?	0 1 2 3	Vegetarian (no eggs, dairy)?	N(0) Y(3)
Offensive breath?	0 1 2 3	Picky eater?	N(0) Y(3)
Diarrhea?	0 1 2 3	Spots on nails?	N(0) Y(3)
Constipation?	0 1 2 3	Thick, coarse hairs on body?	N(0) Y(3)
Alternating Diarrhea and constipation?	0 1 2 3	Consume lots of sweets?	N(0) Y(3)
Belching/Burping?	0 1 2 3	Thinning eyebrows?	N(0) Y(3)
Excessive bloating or Passing of Gas?	0 1 2 3	Most foods you eat come in a box or can?	N(0) Y(3)
Stomach Pains?	0 1 2 3	Diet is low in fiber?	N(0) Y(3)
Acid or spicy foods upset stomach or digestion?	0 1 2 3	Part 1-C Score:	_____
Sour stomach frequently?	0 1 2 3	Part 1-D	
Indigestion soon after meals?	0 1 2 3	Frequently experience confusion?	N(0) Y(3)
Stomach pains before, and or after meals?	0 1 2 3	Poor memory?	N(0) Y(3)
Black stools even though not taking iron supplements or bismuth (Pepto Bismal)?	0 1 2 3	Seem overly sensitive to noise?	N(0) Y(3)
Roughage and fiber causes constipation or indigestion?	0 1 2 3	Decreased sense of smell?	N(0) Y(3)
Poorly formed stools?	0 1 2 3	Irritable?	N(0) Y(3)
Stools shiny, and/or float?	0 1 2 3	Tendency to nightmares?	N(0) Y(3)
Pain on left side of abdomen, underneath rib cage?	0 1 2 3	Long standing tendency to depression?	N(0) Y(3)
Stool-greasy, shiny?	0 1 2 3	Feel apathetic?	N(0) Y(3)
Stool yellowish, foul smelling?	0 1 2 3	Tendency to anxiety?	N(0) Y(3)
Undigested food in your stool?	0 1 2 3	Feeling of impending doom?	N(0) Y(3)
When massaging under your rib cage on your left side.		History of hypothyroidism?	N(0) Y(3)
There is pain, tenderness or soreness?	0 1 2 3	Tendency to hyperactivity?	N(0) Y(3)
Dependency on antacids?	0 1 2 3	History of chronic headaches?	N(0) Y(3)
Part 1-A Score:	_____	Frequent nervousness?	N(0) Y(3)
		Inability to concentrate?	N(0) Y(3)
		Learning problems?	N(0) Y(3)
Part 1-B		Frequent or long standing fatigue?	N(0) Y(3)
Discomfort, pain or cramps in your lower abdominal area?	0 1 2 3	Restlessness?	N(0) Y(3)
Anal itching?	0 1 2 3	Low tolerance to stress?	N(0) Y(3)
Stool is small, hard and dry?	0 1 2 3	History of insulin sensitivity?	N(0) Y(3)
Pass mucus in stool?	0 1 2 3	History of high cholesterol?	N(0) Y(3)
Rectal pain, itching or cramping?	0 1 2 3	History of high homocysteine levels	N(0) Y(3)
No urge to have a bowel movement?	0 1 2 3	History of asthma?	N(0) Y(3)
Almost continual need to have a bowel movement?	0 1 2 3	Muscular weakness?	N(0) Y(3)
Alternating constipation/diarrhea?	0 1 2 3	Irregular heart rhythms?	N(0) Y(3)
Prone to vaginal yeast infections?	0 1 2 3	Tendency to anemia?	N(0) Y(3)
Stomach pain, burring and/or aching over a period of 1-4 hours after eating?	0 1 2 3	Hair loss?	N(0) Y(3)
Stomach pain, burring/aching relieved by eating food or drinking beverages?	0 1 2 3	Poor circulation?	N(0) Y(3)
Burning sensation in the lower part of your chest, especially when lying down or bending forward?	0 1 2 3	Chronic constipation?	N(0) Y(3)
Feel a sense of nausea or desire to vomit when you eat?	0 1 2 3	Tendency to edema (water retention)?	N(0) Y(3)
Indigestion, fullness or tension in your abdomen is delayed, occurring 2-4 hours after eating a meal?	0 1 2 3	Tendency to nausea?	N(0) Y(3)
Lower abdominal discomfort is relieved with the passage of as or with a bowel movement?	0 1 2 3	History of glaucoma?	N(0) Y(3)
Gas or with a bowel movement?	0 1 2 3	Tendency towards warts or skin tags?	N(0) Y(3)
Stool odor is embarrassing?	0 1 2 3	Part 1-D Score:	_____
Black, tarry stools?	0 1 2 3	SECTION 2	
Bloated?	0 1 2 3	Part 2-A	
Extremely narrow stools, thin stool?	0 1 2 3	When massaging under your rib cage on your right side, there is pain, tenderness and soreness?	0 1 2 3
Rectal (anal) itching?	0 1 2 3	Flushing, or "hot flashes", shortly after you eat?	0 1 2 3
Three or more large bowel movements daily?	0 1 2 3	How often do you experience right shoulder/neck pain ?	0 1 2 3
Bowel movement shortly after eating (within 1 hour)?	0 1 2 3	Feel like you have the "flu"?	0 1 2 3
History of antibiotic use?	N(0) Y(3)	Belch up bitter fluid after eating?	0 1 2 3
Part 1-B Score:	_____	Feel abdominal discomfort or nausea when eating fatty or fried foods?	0 1 2 3
		Unexplained itchy skin, that may be worse at night?	0 1 2 3
Part 1-C		Stool color alternates from clay colored to normal brown?	0 1 2 3
Inflamed corners of mouth?	0 1 2 3	General feeling of poor health?	0 1 2 3
Thirsty often?	0 1 2 3	Easily bruise?	0 1 2 3
Feel thirsty, even after drinking water?	0 1 2 3	More than 10 beers, or 10oz of alcohol, per week?	0 1 2 3
Weird/Strange cravings?	0 1 2 3	Drink caffeinated beverages?	0 1 2 3
Sense of taste seems reduced?	0 1 2 3	Sensitive to even small amounts of alcohol?	0 1 2 3
Sense of smell seems reduced?	0 1 2 3	Personal or family history of cancer?	0 1 2 3
How often do you eat 5 servings of fruits and vegetables per day?	0 1 2 3	Sensitive to fragrances, exhaust fumes, or strong odors?	0 1 2 3
Cuts heal slowly?	0 1 2 3	Abdominal pain on right side?	0 1 2 3
Feel depleted, exhausted?	0 1 2 3	Use artificial sweeteners regularly?	0 1 2 3
		Exposed to chemicals or radiation at work or in home?	0 1 2 3
		How often do you use cosmetics/make-up?	0 1 2 3
		How often do you experience fatigue or sluggishness?	0 1 2 3

How often do you experience apathy or fatigue?	0 1 2 3	Difficulty getting up in the morning (don't really wake up until about 10:00 am)?	0 1 2 3
How often do you experience hyperactivity or racing thoughts?	0 1 2 3	Experience chronic fatigue?	0 1 2 3
How often do you experience restlessness?	0 1 2 3	Tenderness in my back near my spine at the bottom of my rib cage, when pressed?	0 1 2 3
How often do you experience headaches or migraines?	0 1 2 3	Need coffee or some other stimulant to get going in the morning?	0 1 2 3
How often do you experience poor memory?	0 1 2 3	Crave salt and/or foods high in salt?	0 1 2 3
How often do you experience confusion?	0 1 2 3	Crave high protein foods (meats, cheeses, etc..)?	0 1 2 3
How often do you experience poor concentration, and/or coordination?	0 1 2 3	Feel better if I lie down?	0 1 2 3
Have you ever been diagnosed with multiple chemical sensitivity?	N(0) Y(3)	Experience light, non-restful sleep?	0 1 2 3
Have you ever been diagnosed with Fibromyalgia, Chronic Fatigue, Gulf War Syndrome?	N(0) Y(3)	Feel anxiety?	0 1 2 3
Yellowish tint to white part of eyes?	N(0) Y(3)	Pr-mature graying of hair?	0 1 2 3
Yellowish tint to skin?	N(0) Y(3)	Best, most refreshing sleep often comes between 7:00-9:00 am?	N(0) Y(3)
Personal or family history of Parkinson's, Alzheimer's or other neurological diseases?	N(0) Y(3)	Low blood pressure?	N(0) Y(3)
Personal or family history of lupus, rheumatoid arthritis, multiple sclerosis, ankylosing spondylitis or other autoimmune disease?	N(0) Y(3)	Spinal curvature, and/or scoliosis?	N(0) Y(3)
Do you feel poorly after consuming grapefruit/grapefruit juice?	N(0) Y(3)	Overwork with little play or relaxation for extended periods?	N(0) Y(3)
Part 2-A Score:	_____	Tend to gain weight, especially around the middle (spare tire)?	N(0) Y(3)
SECTION 3		Get light-headed or dizzy when rising rapidly from a sitting or lying position?	N(0) Y(3)
Part 3-A		Experience constant stress in my life or work?	N(0) Y(3)
Upper eyelids look swollen?	0 1 2 3	I suffer, or have suffered, from nervous breakdowns?	N(0) Y(3)
Feel chilled?	0 1 2 3	My relationships at work and/or home are unhappy?	N(0) Y(3)
Have difficulty getting "going" in the morning?	0 1 2 3	Type A personality?	N(0) Y(3)
Hands and feet feel cold?	0 1 2 3	My best work is late at night (or early morning hours)?	N(0) Y(3)
Slow, sluggish speech?	0 1 2 3	Part 3-B Score:	_____
Voice get coarse or horse?	0 1 2 3	Part 3-C	
Swelling or dark circles, around eyes?	0 1 2 3	Decrease or loss of muscle tone?	0 1 2 3
Constipation?	0 1 2 3	High cholesterol or triglycerides?	0 1 2 3
High cholesterol or blood lipids?	0 1 2 3	Bone Loss (Osteopenia or Osteoporosis)?	0 1 2 3
Periods that are irregular (too heavy or too light)?	0 1 2 3	Loss of hair?	0 1 2 3
Breast pain, and/or fibrocystic breast disease?	0 1 2 3	Sagging skin, loss of skin elasticity?	0 1 2 3
Feel fatigued, exhausted?	0 1 2 3	Feel pessimistic, like things won't or don't go right?	0 1 2 3
Weight gain or difficulty losing weight?	0 1 2 3	Wounds heal slowly?	0 1 2 3
Water retention?	0 1 2 3	Weak immune system, frequent infections?	0 1 2 3
Frequent infections?	0 1 2 3	Decreased sexual function, ability or desire?	0 1 2 3
Muscle weakness, cramps or pains?	0 1 2 3	Excess abdominal fat ("spare tire")?	0 1 2 3
Ligaments are lax?	0 1 2 3	Decreased energy, especially in the morning?	0 1 2 3
Slow, weak heart rate?	0 1 2 3	Depression, especially in the morning?	0 1 2 3
Congestive heart failure?	0 1 2 3	Poor metabolism, weight gain?	N(0) Y(3)
Skin, and/or hair dry/coarse?	0 1 2 3	Part 3-C Score:	_____
Slow wound healing?	0 1 2 3	Part 3-D	
Thick, brittle nails with ridges?	N(0) Y(3)	Increased thirst?	0 1 2 3
Hair loss?	N(0) Y(3)	Nightmares, possibly associated with going to bed on an empty stomach?	0 1 2 3
Loss of eyebrow hair?	N(0) Y(3)	Unusual thirst-feeling like you can't drink enough water?	0 1 2 3
History of multiple miscarriages?	N(0) Y(3)	Polycystic ovary syndrome? (Women only)	0 1 2 3
Infertility?	N(0) Y(3)	Headaches that are relieved by eating sweets or alcohol?	0 1 2 3
PMS type symptoms?	N(0) Y(3)	Irritable if meals missed?	0 1 2 3
Menstrual cramps?	N(0) Y(3)	Crave sweets, often?	0 1 2 3
Tongue is thick with ridges?	N(0) Y(3)	Hungry, even shortly after you eat?	0 1 2 3
Carpal tunnel syndrome or other nerve compression?	N(0) Y(3)	Suffer from poor memory or concentration when skip meals?	0 1 2 3
Part 3-A Score:	_____	Feel tired, or hungry, an hour or so after eating?	0 1 2 3
Part 3-B		Feel shaky when miss meals?	0 1 2 3
Wounds heal slowly?	0 1 2 3	Afternoon fatigue?	0 1 2 3
Your body-or parts of your body-feel tender, sore, sensitive to the touch, hot and/or painful?	0 1 2 3	Suffer from mood swings, and/or depression, when meals are missed?	0 1 2 3
Brown spots on face?	0 1 2 3	Anxious if meals skipped?	0 1 2 3
Lack of exposure to full-spectrum natural light on a daily basis for at least 15 min.	0 1 2 3	Desire to loose weight?	0 1 2 3
Thin, and/or dry skin?	0 1 2 3	Clothes don't fit anymore?	N(0) Y(3)
Unstable blood sugar?	0 1 2 3	Have diabetes or borderline diabetic?	N(0) Y(3)
Physical intolerance to exercise?	0 1 2 3	Eat snacks frequently?	N(0) Y(3)
Feelings of graying out or blacking out?	0 1 2 3	Family history of diabetes?	N(0) Y(3)
Chronic fatigue; not relieved by sleep?	0 1 2 3	Tend to gain weight around middle, "Spare tire"?	N(0) Y(3)
Feelings of heart racing when rising rapidly from a sitting or lying position?	0 1 2 3	Overweight?	N(0) Y(3)
		Part 3-D Score:	_____
		SECTION 4	
		Part 4-A	

Prone to lots of phlegm or mucus associated with seasonal changes?	0 1 2 3
Puffiness, and/or dark circles under eyes?	0 1 2 3
Migraine headaches?	0 1 2 3
Hyperactivity?	0 1 2 3
Chinese food causes anxiety, irregular heart beat or fatigue?	0 1 2 3
Sneeze more than 3 times after meals or drinks?	0 1 2 3
Pulse "speeds" after meals?	0 1 2 3
Prone to lots of phlegm or mucus associated with certain foods?	0 1 2 3
Joint, and/or muscle pain, stiffness or achyness?	0 1 2 3
Stomach, and/or intestinal disturbances?	N(0) Y(3)

Part 4-A Score: _____

SECTION 5

Part 5-A

Poor wound healing?	0 1 2 3
Fatigue?	0 1 2 3
Blood sugar imbalances/hypoglycaemia?	0 1 2 3
Tendency towards, or presence of anaemia?	0 1 2 3
Feel tired, fatigued?	0 1 2 3
Shortness of breath?	0 1 2 3
Feels like heart races?	0 1 2 3
Depression?	0 1 2 3
Skin ulcers of the legs or feet?	0 1 2 3
Varicose or "spider" veins?	0 1 2 3
Nose bleeds frequent?	0 1 2 3
Bruise easily, "black/blue" sports?	0 1 2 3
Noises in head or "ringing in ears"?	0 1 2 3
One leg or arm-shiny, hairless skin?	0 1 2 3

Part 5-A Score: _____

Part 5-B

Pain in big toe?	0 1 2 3
Pain in joints?	0 1 2 3
Stiffness in joints lasting more than 30 mins. on arising in mornings?	0 1 2 3
Stiffness in joints lasting more than 30 mins. After prolonged in-activity?	0 1 2 3
Deformed joints?	0 1 2 3
Redness, and/or heat in joints?	0 1 2 3
Chronic pain or stiffness?	0 1 2 3
Pain in muscles?	0 1 2 3
Muscle cramps or spasms?	0 1 2 3
Muscle twitch or tremor-eyelids, thumb, calf-muscle?	0 1 2 3
Irresistible urge to move legs often?	0 1 2 3
Muscles stiff, sore, tense and/or ache?	0 1 2 3
Feel "tense" in body?	0 1 2 3
Legs move during sleep?	0 1 2 3
Stomach or intestinal disturbances?	N(0) Y(3)

Part 5-B Score: _____

SECTION 6

Part 6-A

Elevated blood cholesterol?	N(0) Y(3)
High triglyceride levels?	N(0) Y(3)
Low HDL levels?	N(0) Y(3)
Overweight?	N(0) Y(3)
Lack of social support or fulfillment?	N(0) Y(3)
History of diabetes?	N(0) Y(3)

Part 6-A Score: _____

Part 6-B

Exhaustion with minor exertion?	0 1 2 3
Difficulty catching breath, especially during exercise?	0 1 2 3
Cold feet and/or toes appear blue?	0 1 2 3
When standing legs get heavy and fatigued?	0 1 2 3
Leg discomfort or fatigue relieved by elevating legs?	0 1 2 3
Swollen ankles, worse at night?	0 1 2 3
Temper—"fuse"—short?	0 1 2 3
Dull pain in chest or radiating into left arm, worse with activity or excitement?	0 1 2 3
Smoker?	N(0) Y(3)
Overweight?	N(0) Y(3)
Type A personality?	N(0) Y(3)
High blood pressure (Hypertension)?	N(0) Y(3)
Muscle cramps when active?	N(0) Y(3)

Part 6-B Score: _____

SECTION 7

Part 7-A

Blood in urine or cloudy urine?	0 1 2 3
Strong,, foul smelling urine?	0 1 2 3
Pain in back, at base of ribcage (one or both sides)?	0 1 2 3
Feel like you have the "flu"?	0 1 2 3
Pain or burning during urination?	0 1 2 3
Cloudy urine?	0 1 2 3
Dark urine?	0 1 2 3
Kidney Stones?	N(0) Y(3)

Part 7-A Score: _____

Please answer YES or NO to the following questions:

- Are you now taking, or have taken in the past, Thyroid medication? N(0) Y(3)
- Are you now taking, or have taken in the past, Blood pressure or Cholesterol medication? N(0) Y(3)
- Have you been diagnosed as diabetic or Borderline diabetic? N(0) Y(3)
- Have you ever had a seizure? N(0) Y(3)
- Have you ever been diagnosed with Gout, Kidney, Liver, or Heart disease? (if Yes, circle one) N(0) Y(3)
- Do you react to milk product – now or in the past? N(0) Y(3)

Patient signature: _____