

# Naturopathic and Allergy Clinic

Toronto Office .....: Telephone (416) 207-0207, Telefax (416) 207-0272



**Email: [clinic@live.com](mailto:clinic@live.com)**

## Confidential Adult Patient's Case History

\*\*Version October 2017\*\*

**Dear Patient:** This form was specifically designed by our **Naturopathic Doctor, the clinic director Fateh Srajeldin ND**, to help our medical team evaluate your current health condition. Please complete this health questionnaire to the best of your knowledge. Your answers will help us determine in what ways we can help restore your child's health. We will only accept your child's case if we believe that you are intending to apply our ① instructions, ② remedies, ③ therapies and ④ diet as given to treat your child. Rest assured that all information will remain completely confidential. **Please make sure to answer all questions that have the mark ( \* ), Thank you.**

### Personal information

\*Last name: \_\_\_\_\_ \*First name: \_\_\_\_\_ Middle name: \_\_\_\_\_  
 \*Date of birth: MM. DD. YY. Sex:  Male,  Female, Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Last physical date: \_\_\_\_\_  
 \*My Occupation is: \_\_\_\_\_ My employer is: \_\_\_\_\_  
 \*I have been unwell for: \_\_\_\_\_ Yrs., Physician's name who treated me was: \_\_\_\_\_  
 I was treated by a  Medical Dr.,  Chiropractor,  Naturopath Dr.,  Psychiatrist,  Hospital,  Homeopath,  Herbs.  
 Was treatment terminated? :  Yes,  No, Did treatment achieve its goal % (explain): \_\_\_\_\_  
 \*I was treated for: \_\_\_\_\_  
 \*I am currently suffering from and need treatment for: \_\_\_\_\_  
 Family members who have similar conditions:  Mother,  Father,  Brother(s),  Sister(s),  Daughter(s),  Son(s),  Adopted.  
 I am:  Single,  Married,  Divorced,  Separated,  Common Law,  Widow. Number of children: (Males \_\_\_\_\_, Females \_\_\_\_\_)  
 Number of older brothers: \_\_\_\_\_ Number of older sisters: \_\_\_\_\_ My rank in the family is: \_\_\_\_\_  
 Number of younger brothers: \_\_\_\_\_ Number of younger sisters: \_\_\_\_\_ My favorite sport is: \_\_\_\_\_  
 \*My home address: \_\_\_\_\_ Suite: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_ PC code: \_\_\_\_\_  
 \*My home telephone ( ): \_\_\_\_\_ \*My office telephone ( ): \_\_\_\_\_ Ext. \_\_\_\_\_  
 \*My Cellular number ( ): \_\_\_\_\_ \*My email: \_\_\_\_\_ @ \_\_\_\_\_  
 My Fax number ( ): \_\_\_\_\_

### My Spouse's / Partners Information

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ My spouse's occupation: \_\_\_\_\_ Age: \_\_\_\_\_  
 Home address: † Same as above \_\_\_\_\_ Suite: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_ PC code: \_\_\_\_\_  
 Home telephone ( ): \_\_\_\_\_ Office telephone ( ): \_\_\_\_\_ Ext. \_\_\_\_\_  
 Cellular number ( ): \_\_\_\_\_ email: \_\_\_\_\_ @ \_\_\_\_\_

### In case of an emergency who may we contact

\*First name: \_\_\_\_\_ \*Last name: \_\_\_\_\_ \*Relationship: \_\_\_\_\_  
 Telephone (H): ( ) \_\_\_\_\_ (W): ( ) \_\_\_\_\_ Ext. \_\_\_\_\_ Fax: ( ) \_\_\_\_\_  
 Do you or your spouse have an extended health insurance at work  Yes,  No.? Name of Insurance company: \_\_\_\_\_  
 Do we have your permission to email you information and updates concerning your health plus seasonal promotions Yes , No   
 \*Who referred you to this Clinic : \_\_\_\_\_  
 Office sign,  Our Website,  Surfing the Net,  Office Pamphlet,  Word of mouth.

### **Dear Patient:**

The following several pages contain ① declaration form, ② consent to examination form, ③ medical health questionnaire, ④ medical history form and ⑤ dietary questionnaire. There is a section that contains some crucial questions concerning both parents which pertain to your total health as well. Please take some time to answer all of the following questions as accurately as possible. The total interview and the actual examination may last approximately ninety minutes more or less. Further, you will spend approximately thirty minutes with your physician to setup your diet thereafter. You are expected to apply the diet as given. Along with the diet, your daily remedies, frequency and therapies will be set too.

**Please note** that naturopathic services are not covered by the Ontario Health Insurance Plan (OHIP). Naturopathic examinations, treatments and therapies could be covered by an extended health insurance plan at your place of Employment. You may consult with your insurance company directly about their coverage. We, at the clinic, do not deal directly with insurance companies and we have no Information about your coverage.

**Privacy:** All your files and information are extremely confidential, however if you have any extra information concerning more steps of privacy concerning mail, email, phone calls or leaving phone messages, then please give us written instructions here: \_\_\_\_\_

Continue on page (2) please

## **Adult Declaration & Consent to Examination and Treatment**

Name (please print) \_\_\_\_\_ Date: \_\_\_\_\_

I understand that the clinic's Naturopath, Dr. Fateh Srajeldin, B.Sc., ND, practices with an eclectic approach to health care. The initial patients' visit to see the naturopath at this clinic will include ① **discussing my medical history from birth to date**, ② **standard external physical examination**, ③ **evaluation of my diet** and ④ **prescribing remedies** based on the outcome of my total visit plus my current symptoms and my current laboratory blood work (if available). I understand that blood testing is not included in today's examination fee. I understand that the treatments may include Clinical Nutrition, Vitamins, Minerals, Enzymes, Co-Enzymes, Anti-Oxidants, Botanical remedies, Homeopathic remedies, Orthomolecular Supplementation, Acupuncture and Intravenous Therapy. I understand that the Dr. Srajeldin's mission statement is to "provide safe and effective treatments to restore health as permanently as possible in the quickest, gentlest, least harmful way." I understand that the success of the treatment hinges on my compliance and application of the treatments.

I understand that Dr. Fateh Srajeldin, B.Sc., ND is a licensed Naturopathic Doctor (ND) not a Medical Doctor and his examinations and treatments are **not covered by OHIP**. I understand that Naturopathic examinations, treatments and therapies could be covered by my extended health insurance plan at my place of employment (if available). It is my responsibility to consult with my insurance company directly. I understand that The Naturopathic and Allergy Clinic does not deal directly with insurance companies and have no information about my coverage.

Any treatment provided to me as a patient of Dr. Fateh Srajeldin B.Sc., ND is not mutually exclusive from any treatment or advice that I may be receiving or may in the future be receiving from another licensed health care provider. I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Ontario or elsewhere. I understand that medical therapy and naturopathic/drugless therapy, including homeopathy, are different kinds of therapies.

I understand that Dr. Fateh Srajeldin, B.Sc., ND strives to provide the best possible diagnosis and course of treatment. However, I understand that many factors will be important in determining actual results. Therefore, no representation or warranty is made with respect to any treatment, action or application of medical advice or information given.

I understand that the total interview and the actual physical examination (without an internal) may last approximately ninety minutes more or less. Further, I understand that the naturopath may spend approximately sixty minutes with me to setup my diet thereafter if I choose to have my diet restructured. I will apply the diet as given. Along with the diet, my daily remedies, frequency and therapies will be set too.

### **For female patients**

I understand that while the option of breast examination on page (6) is recommended during first visit for all females over the age of 40 years or starting at age 30 years for those who use or have used alcohol, use or have used oral contraception and / or smoke or have smoked, the examination will only be performed if my health condition warrants an examination and I consent and initial "**Breast examination**" in the female section on page (6).

### **For male patients**

I understand that the option for prostate examination on page (6) is recommended during first visit for males over the age of 40 years or starting at age 35 years for those men who use or have used steroids for body building, those men who drink or have drank alcohol and those who smoke or have smoked, the examination will be performed if my health condition warrants an examination and I consent and initial "**Prostate examination**" in the male section on page (6).

I understand that, in the event of a medical emergency, I am advised to seek conventional medical care at a hospital if I am unable to Reach my Naturopathic Doctor.

This is to acknowledge that I have read the above information and understand that these are the terms and conditions at the Naturopathic and Allergy Clinic. I also consent to the examination as been described above and as the examining naturopath sees necessary to help me overcome my symptoms.

I will provide a copy of my most recent blood work done in the past six months. Alternatively, I will arrange, bring, mail or fax all medical tests, ( blood, urine, x- ray, ultrasound, MRI, and surgery results), pertaining to my health from my physician's office or the hospital if I was treated at a hospital. I will answer the questionnaire concerning my health to the best of my ability and knowledge. I will pay for all examinations, treatments, therapies and intravenous therapy immediately when rendered.

I understand that remedies and laboratory blood works are not included in the examination fee. I understand that appointment(s) cancellation requires **48 hours advanced notice** for full refund otherwise there will be a \$50 surcharge applied on each and every examination or therapy missed or cancelled.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

### **Note**

Before the date of your appointment, if possible, please arrange, bring, mail or fax all your medical tests, ( blood, urine, x-ray, ultrasound, MRI, and surgery results), pertaining to your health from your physician's office or the hospital if you were treated at a hospital.

**Fees of Examinations and services**

City	Choice ✓	Code	Explanations (Listed time of visits and therapies are approximate)	Our fee schedule	Exclusion
Toronto Clinic		EX1-ID	First Examination 1½ Hrs. One major symptom examination including diet setting	\$200.00 None Taxable	Remedies and blood work are NOT included in the first examination or any subsequent examination fee.
		EX1-ND	Full First Examination 1½ Hrs. NOT including diet setting	\$200.00 None Taxable	
		EX1-B	Full First Examination 2 Hrs. including diet setting according to my medical health history, my symptoms and my physical examination,	\$300.00 None Taxable	
		EX5	Subsequent Examination 30 Mins.	\$80.00 None Taxable	

**Hints to help you fill in this medical history application:**

The following are some hints on how to fill the application form as accurate as possible. Every question has two forms of answers. The first group of answers are placed under **Value** which explains the intensity of the symptom when it come using numbers from (1 to 10). Intensity of a symptom has nothing to do with the frequency of the symptom whether daily or once a week or one a month.

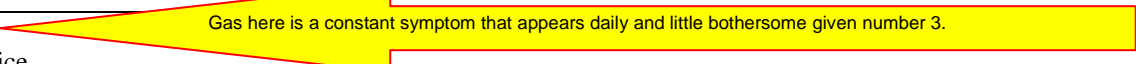
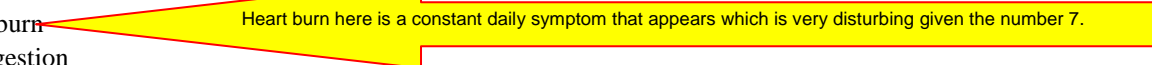
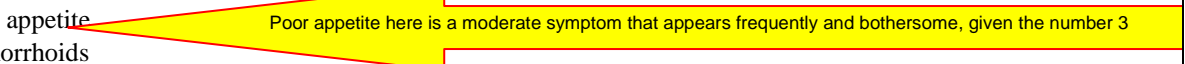
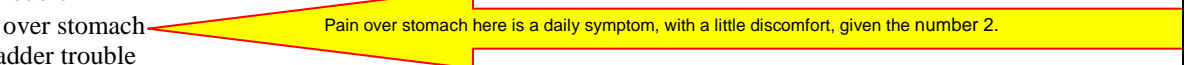
Number (1 to 3) indicates the symptom's intensity is very small when it comes. On the other hand, a number (4 or 7) indicates that the symptom's intensity is disturbing and bothersome when it comes. The number (8 to 10) symptom's intensity is very painful whether the symptom appears every day or once a month. You should assign or estimate number to every question as you see it. This is not a right or wrong questions.

The second group of answers determines whether a symptom should be marked as **one** of the following answers

- C...  symptoms are present daily or
- F...  symptoms come and go frequently every few days, every week or every month or
- P...  symptoms appear every several months or every season.

For example:

**GASTRO-INTESTINAL**

Value	P	F	C	
③	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Gas 
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Jaundice
②	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
⑦	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Heart burn 
③	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Indigestion
③	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Constipation
③	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Poor appetite 
②	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids
③	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Liver trouble
	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Colon trouble
②	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Pain over stomach 
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Gall bladder trouble

**This way helps your naturopathic doctor see and feel your child's symptoms through his/her nervous system.**

Continue on page (4) please

Read through the following list of symptoms that apply to your child now or in the past. Please ignore symptoms that are not related to your condition. Please check mark  the boxes under the appropriate columns if a symptom is (P) = Past, (F) = Frequent and (C) = Constant and place a numerical number under Value. Thank you.

GENERAL SYMPTOMS					MUSCLE, BONE & JOINTS					GASTRO-INTESTINAL				
Value	P	F	C		Value	P	F	C		Value	P	F	C	
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TMJ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting or Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tremor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fissures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neuralgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Burping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exhausted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Belching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Uric Acid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart burn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Addison's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful tail bone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Growing pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever or Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweats (cold or warm)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colon trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sudden weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal worms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannot lose weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive hunger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leg cramps at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle twitches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>RESPIRATORY</b>					Upper back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Value	P	F	C		Middle back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A / B / C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Croup	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lower back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal distension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pleurisy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain between ribs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Halitosis (bad breath)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sternum joints pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bloated after meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anorexia nervosa	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint stiffness, Reiter's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcerative colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest tightness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tennis elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficult breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Pain or numbness in:</b>					Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spitting blood / phlegm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rectal itch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthmatic symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Between shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis, Chronic/Acute	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whooping cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Elbows	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colon polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleepy after meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Hips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful to swallow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food particles in stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influenza	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Knees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Digestive Meds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoking Now / Past	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>SCALP &amp; HAIR</b>				
Lungs Meds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Value	P	F	C	
<b>SKIN</b>					*Heels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dandruff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Value	P	F	C		*Toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Bottom of feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hair loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Boils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Arch of feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hair lice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Warts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joints Meds					Hair splits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blisters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>CARDIO-VASCULAR</b>					Scalp itchy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rosacea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Value	P	F	C		Scalp painful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shingles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart palpitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hair implant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vitiligo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slow heart beat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry or Oily hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Athletes foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Septal defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Baldness patches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>SLEEP Issues</b>				
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Light headed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Value	P	F	C	
Brittle Nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Angina / Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleeping time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin ring worms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor circulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Waking up time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin itch or burn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweats profusely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Interrupted sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hives Large/Small	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Further:</b>				
Eczema / Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dyspnea on exertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you day-nap?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Cold / Dry feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleepy all day	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Corns on Feet / Toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension meds					Sleeping Meds	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Skin Meds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cholesterol meds									

<b>MOUTH</b>				
	Value	P	F	C
Mercury filling.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bad breath often .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thrush on tongue.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mumps.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Snore.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Teeth trouble.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gums bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive teeth to cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive teeth to hot..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taste changed lately..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drop during sleep ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold sores.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged tonsils.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oral herpes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:				

<b>NOSE</b>				
	Value	P	F	C
Nose tip itch .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose bleed (epistaxis)...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nasal obstruction ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nasal congestion ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sneezing spells.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus infection.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post nasal drip.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>EARS</b>				
	Value	P	F	C
Tinnitus .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear noise.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear aches.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear redness.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear canal itch.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear discharge.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perforated eardrum...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive ear wax...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vertigo.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>EYES</b>				
	Value	P	F	C
Eyes itch.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes redness .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes discharge .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sties on eye lid .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Failing vision.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Near /Far sighted.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes infection .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bags under eyes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dark circle under eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>THROAT</b>				
	Value	P	F	C
Colds .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tonsillitis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold sores.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Throat itch.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged tonsils.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Throat irritation.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Voice changed lately	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Complete voice loss...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>HEAD Symptoms</b>				
	Value	P	F	C
Migraine .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tension Headache ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cluster Headache.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache after MVA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache on waking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache if hungry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache per week				
Migraine Meds				
Headache Meds				

<b>IMMUNIZATION &amp; ALLERGY Shots</b>		
	Yes	No
Immunization (Infant)	<input type="checkbox"/>	<input type="checkbox"/>
Immunization (Child)	<input type="checkbox"/>	<input type="checkbox"/>
Immunization (Teens)	<input type="checkbox"/>	<input type="checkbox"/>
Immunization (Adult)	<input type="checkbox"/>	<input type="checkbox"/>
Allergy shots Now / Past.	<input type="checkbox"/>	<input type="checkbox"/>
Flu shots: _____	<input type="checkbox"/>	<input type="checkbox"/>
Others: _____	<input type="checkbox"/>	<input type="checkbox"/>

<b>ALLERGIES</b>				
	Value	P	F	C
Seasonal allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Summer .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fall.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Winter.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy- house dust	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy- dust mites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy- dairy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy- perfumes...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy- Sulfur.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergy- medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____				
Allergy- weeds.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____				
Allergy- food additives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____				
Allergy- trees.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____				
Allergy- grains.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____				
Allergy- vegetables..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____				
Allergy- food.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____				
Allergy- grasses.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____				
Allergy- animals.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____				
Allergy- chemicals ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____				
Allergy- insects.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____				
Allergy- hay fever..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Winter: _____				
Allergy- cosmetics.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name: _____				
Allergy Meds				
Alergy Meds				

<b>ENDOCRINE GLANDS</b>				
	Value	P	F	C
Goiter.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Mellitus.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Juvenile.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Puffy face.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Protruded eyes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperthyroidism.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypothyroidism.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intolerant to heat/cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Addison's disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>GENITAL URINARY</b>				
	Value	P	F	C
UTI .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pubic itch.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bed wetting.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidneys stones.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent urination.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannot hold urine.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidneys infections.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning urination.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genital Herpes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine incontinence.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Slow urination.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen ankles.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficult starting urine.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>NERVOUS SYSTEM</b>				
	Value	P	F	C
OCD.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unhappy .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressed.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Panic Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADD Symptoms.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADHD Symptoms.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Anxiety.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety due to abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post Traumatic Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phobic Disorder.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficult to relax.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tendency to worry...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loses temper often...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tendency to cry.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low self esteem.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hopeless outlook.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tendency to be shy....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dislike criticism.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frightening dreams...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frightening thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weather affects mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor memory.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hard to concentrate....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thoughts of suicide...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multiple sclerosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure Grand Mal / Petit...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wets pants constantly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any Meds.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**MALIGNANCIES**

	Value	P	F	C
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lymphoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Type of Cancer	_____			
Malignancy Stage	_____			
Metastasized Cancer	Yes <input type="checkbox"/>		No <input type="checkbox"/>	
Receiving Chemo	Yes <input type="checkbox"/>		No <input type="checkbox"/>	
Receiving Radiation	Yes <input type="checkbox"/>		No <input type="checkbox"/>	

**Date of past and current surgeries:**

Hernia operation	_____
Gallbladder removed	_____
Tonsillectomy	_____
Tubes in ears	_____
Appendectomy	_____
Nasal adenoids	_____
Cancer surgery	_____
Knee operation	_____
Hysterectomy	_____
C Section	_____
Prosthesis (Implants)	_____

**List drugs known to you whether :**

<u>Medications</u>	<u>Past</u>	<u>Taking</u>	<u>Allergic</u>
Antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inhalers Ventolin, Symbicort ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insulin meds. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin, Tylenol.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety meds. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression meds.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metformin meds.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Warfarin meds.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hormones.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gravol /Antacids.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid meds.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping pills.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intravenous Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chelation Therapy....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Myer's cocktail IV.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Date of Tests:**

Chest X-Ray	_____
Kidney X-Ray	_____
Colon X-Ray	_____
Sinus X-Ray	_____
Gallbladder X-Ray	_____
Electrocardiogram	_____
Sigmoidoscopy	_____
Polio series	_____
Flu shots	_____
Pap Smear	_____
Tetanus shots	_____
Typhoid shots	_____
Mumps shots	_____
Measles shots	_____
Gastro-intestinal series	_____

**SEXUALITY**

	No	Yes
Abstainer	<input type="checkbox"/>	<input type="checkbox"/>
Sexually active	<input type="checkbox"/>	<input type="checkbox"/>
Heterosexual	<input type="checkbox"/>	<input type="checkbox"/>
Homosexual	<input type="checkbox"/>	<input type="checkbox"/>
Bisexual	<input type="checkbox"/>	<input type="checkbox"/>

**FOR MEN**

	Value	P	F	C
*Enlarged prostate...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Discharge from penis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful testicles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lumps in testicles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impotence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infertility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vasectomy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Condom (Lubricated)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Condom (Dry)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of prostate exam	_____			
I need prostate exam	Yes <input type="checkbox"/>		No <input type="checkbox"/>	
Your initials please: (must)	_____			

**FOR FEMALES**

	Value	P	F	C
My maiden name is	_____			
Hysterectomy Yr	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constant PMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congested breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy menstrual flow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irregular cycle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lumps in breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Menopausal symptom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cervical HPV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uterine fibroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genital herpes Yrs. ___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infertility Yrs. ___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Birth control</b>				
*Oral contraceptive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intrauterine device	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Withdrawal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rhythm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tubal ligation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diaphragm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spermicidal cream	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Condom (Lubricated)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Condom (Dry)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pads	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tampons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of last cycle	_____			
*Pap smear date	_____			
Total of pregnancies	_____			
Total of premature	_____			
Total of Miscarriages	_____			
Total of abortions	_____			
Total of stillbirths	_____			
Date last breast exam	_____			
I need breasts exam	Yes <input type="checkbox"/>		No <input type="checkbox"/>	
Your initials please: (must)	_____			

**HABITS and their frequencies**

	Value	P	F	C
Water, cups per day: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Milk Servings Per day / Wk.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cheese Servings Per day / Wk....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yogurt Servings Per day / Wk....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ice Cream Servings Per day / Wk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eggs # ----- Per day / Wk.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Per day / Wk.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Beer Per day / Wk.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wine R / W Per day / Wk..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whey Protein Shakes Per day / Wk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Butter / Margarine Per day / Wk....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nutella / Peanut Butter Per day / Wk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chocolate Milk Per day / Wk.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar, Sugar Products Per day / Wk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cakes, Cookies, Candies Per day / Wk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eat three meals a day.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eat two meals a day.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eat one meal a day.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cigarettes per day.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Street drugs now / past.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hard drugs now / past.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**YOUR PARENTS**

The following questions pertain to your parents health before and while your mother was pregnant with you. The answer to the following would help determine the strength of your inner constitution.

	Value	Mom	None	Dad
<b>Allergies</b>				
before pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during breast feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Alcoholism</b>				
before pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during breast feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Smoking</b>				
before pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during breast feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Epilepsy</b>				
before pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during breast feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Asthma</b>				
before pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during breast feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Prescribed drugs</b>				
before pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during breast feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Street drugs/narcotics</b>				
before pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during breast feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Communicable diseases</b>				
before pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during pregnancy...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
during breast feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Personal Notes</b>				
No parental history, I was adopted	<input type="checkbox"/>			
Did not have a healthy childhood	<input type="checkbox"/>			

The following section is required to list your medical history, sicknesses, rough times and hospitalizations, I am interested in every medication taken in your life especially antibiotics, cortisone and oral contraceptive pills. You should list the starting year of diseases and the year of their cure such as tonsillitis, problems with your ears, lungs, throat, skin etc. Also list the year of admission to the hospital for whatever reason. **SEE AN EXAMPLE ON PAGE 9.**

Information should be listed from birth until today, chronologically, year after year. You may use additional sheets if needed. **You may choose to fill this sheet with your doctor before your examination.**

Some important notes to consider are

**1- breast feeding at birth, 2- time of food introduction during infancy, 3- smoking and 4- drugs of any kind.**

Duration	Year	Age	Description of incidents
		Birth Day	<input type="checkbox"/> I was not breast fed Or <input type="checkbox"/> I was breast fed for _____ months & started solid food at _____ months.
		1 Yr.	
		2 Yrs.	
		3 Yrs.	
		4 Yrs.	
		5 Yrs.	
		6 Yrs.	
		7 Yrs.	
		8 Yrs.	
		9 Yrs.	
		10 Yrs.	
		11	
		12	
		13	
		14	
		15	
		16	
		17	
		18	
		19	
		20 Yrs.	
		21	
		22	
		23	
		24	
		25	
		26	
		27	
		28	
		29	
		30 Yrs.	
		31	
		32	
		33	
		34	
		35	
		36	
		37	
		38	
		39	
		40 Yrs.	
		41	
		42	
		43	
		44	
		45	
		46	
		47	
		48	
		49	
		50 Yrs.	
		51	
		52	
		53	
		54	
		55	
		56	
		57	
		58	
		59	
		60 Yrs.	
		61	
		62	
		63	

Please add another sheet

# DIET

The next table revolves around your dietary habits. This may be very beneficial in understanding the real causes behind your conditions. Please answer the following questions to the best of your abilities.

## What do you eat during breakfast?

- 1-
- 2-
- 3-
- 4-
- 5-

## What do you eat during lunch?

- 1-
- 2-
- 3-
- 4-
- 5-

## What do you eat during dinner?

- 1-
- 2-
- 3-
- 4-
- 5-

## What do you eat or during snacks?

### Mid-Day:

### Afternoon:

### Before bed time:

## FOODS THAT YOU CRAVE?

### I crave:

- Chocolate
- Crunchy foods such as chips & crackers
- Caffeine such as coffee, tea, & energy drinks
- Cola, Pop, Soda
- Sugary foods and Desserts
- Hard Candy or Gum
- Protein
- Dairy
- Salty foods
- Fast foods
- Wine with meals
- Beer with meals

## TYPE OF FOOD THAT YOU CONSUME?

- I have a strict dietary plan that I follow
- Most of my meals are home cooked whole foods
- I eat out less often today than I did 5 years ago
- I avoid refined grains, breads & pastas
- I avoid deep fried foods
- I eat sugary foods & dessert less than 3 times wk.
- I avoid diet foods
- I avoid Colas, Pops, Sodas
- I eat gluten free food
- I avoid foods that I have allergies to \_\_\_\_\_.
- I buy frozen or canned fruits and vegetables

## WHEN DO YOU CONSUME FRUITS / VEGETABLES?

### I consume:

- NO** servings of fruit and vegetables at all
- Fruits &/or vegetables during breakfast
- Fruits &/or vegetables during lunch
- Fruits &/or vegetables during dinner
- Fruits &/or vegetables for snacks
- I make time to eat fruits &/or vegetables daily
- I prepare **fresh** fruits & vegetables
- I prepare **canned** or **frozen** fruits & vegetables

## WHAT FRUITS & VEGETABLES DO YOU CONSUME?

### I consume:

- A wide variety of **organic** fruits
- A wide variety of **regular** fruits
- A wide variety of **organic** vegetables
- A wide variety of **regular** vegetables
- A wide variety of vegetables
- A wide range of green leafy vegetables
- A wide color range of fruits & vegetables
- Broccoli, cauliflower, kale & Brussels sprouts
- I add Lemon / Lime juice to my salad

## THE FOLLOWING BEST DESCRIBE YOUR DIGESTION?

- I am often bloated
- I have low energy after eating
- I am often constipated
- I have foggy brain after eating
- I have general digestive upset after eating
- I have excess mucus after eating
- I often have gas or flatulence
- I often have acid reflux &/or heartburn
- Going to the bathroom is often difficult
- I run to the bathroom immediately after food
- My stool varies in size & consistency

## DO YOU CONSUME THE FOLLOWING IN MY FOOD ?

### I must add the following to my food

- Vinegar
- Balsamic Vinegar
- Apple Cider
- Cheese
- Butter
- Mayonnaise
- I am hungry & often don't know why
- White sugar
- Salt
- MSG

## THE FOLLOWING YOU DO NOT UNDERSTAND WHY ?

### I always feel like

- Eating often eat when I feel guilt or depressed
- Eating & not knowing why
- Eat to reward myself
- I often eat when I am low energy especially in the
- I am hungry & often don't know why



The following section is required to list your medical history, sicknesses, rough times and hospitalizations, I am interested in every medication taken in your life especially antibiotics, cortisone and oral contraceptive pills. You should list the starting year of diseases and the year of their cure such as tonsillitis, problems with your ears, lungs, throat, skin etc. Also list the year of admission to the hospital for whatever reason. Information should be listed from birth until today, chronologically, year after year. You may use additional sheets if needed. **You may choose to fill this sheet with your doctor before your examination.**

Some important notes to consider are

- 1- breast feeding at birth, 2- time of food introduction during infancy, 3- smoking and 4- drugs of any kind.**

Duration	Year	Age	Description of incidents
	1951	Birth	Was not breast fed, used formula
		1	Repeated ear infections
		2	
		3	1 <sup>st</sup> set of tubes in the ears
		4	
		5	
	1957	6	2 <sup>nd</sup> set of tubes in ears plus antibiotics
		7	
	1959	8	Asthmatic symptoms, inhalers were prescribed and used daily
		9	
		10	
	1962	11	3 <sup>rd</sup> set of tubes in the ears
		12	
		13	
		14	
		15	
<b>These lines are extended to indicate duration of diseases or medication use</b>			
		17	
		18	
	1970	19	Asthma symptoms disappeared
	1971	20	Motor vehicle accident, hospitalized for a broken leg
		21	
		22	
		23	
	1974	24	Smoking 1 pack a day
	1975	25	Marriage
	1976	26	Repeated Candida infection and discharge, prescribed anti fungal
		27	
	1979	28	1 <sup>st</sup> child birth, normal delivery, epidural
		29	
		30	
		31	
		32	
		33	
	1985	34	2 <sup>nd</sup> child birth, C section
		35	
		36	
		37	
	1989	38	Candida cleared
		39	
	1991	40	Stopped smoking, saddened and depressed by father's death, caused diabetes and hypertension
	1992	41	Migraine, daily used Advil
	1993	42	Constipation, bowel movement every 3 days, used OTC laxatives
		43	
		44	
		45	
		46	
		47	
<b>This line indicates that constipation is still a problem medicated with laxatives</b>			
		48	
		49	
		50	
		51	
		52	
		53	
		54	
		55	
	2007	56	Today, still have constipation, migraine plus was diagnosed with hypercholesterolemia and hypertension,
		57	
		58	
		59	
		60	
		61	
		62	

**Please be as specific as possible since the medical history may hold the key to your complete recovery.**

**These lines are extended to indicate duration of diseases or medication use**

**This line indicates that constipation is still a problem medicated with laxatives**

**Thank you for completing the form**