Lake Norman Health & Wellness

19607 West Catawba Ave., Suite 103
Cornelius, NC 28031
Phone 704.987.3993 Fax 704.987.3991
www.drakibagreen.com
www.askdrakiba.com

WELCOME TO OUR PRACTICE

Thank you for choosing Lake Norman Health & Wellness for your health care needs. Our practice is here to provide to you the highest quality of care. To accomplish this goal, it is imperative that you work with your physician and follow the treatment plan designed specifically for you.

OFFICE POLICY

- Please answer all questions asked on the paperwork given to you. Be as specific as possible to ensure Dr. Green has the necessary information to begin his assessment. If something does not pertain to your case please write N/A or No. Anything left blank we will need to contact you for the answer.
- All Paperwork needs to be returned to our office no later than **2** business days prior to your set appointment. If it is not completed prior to your appointment we will need to reschedule.
- All patients will be seen in accordance with their scheduled time. Please **arrive 15 minutes early** for registration, restroom use, etc. If you are late for your appointment it may need to be rescheduled accordingly. We have set this time aside for you, so please arrive promptly in order to get you back to see the doctor on time.
- Please **bring shorts/athletic pants and a T-shirt** as the doctor will perform an examination and may need to get to your arms, knees and/or feet during the exam.
- All cell phones must be turned off while in the office.

Missed appointments

- Unless cancelled at least 24 hours in advance, your missed appointment may be charged at up to the rate of usual office visit. ($450 New Patients)

Addition Office Information

- It is highly recommended that you refer to the following Youtube website where you will find more information about treatments offered in our office; Topics with information posted include Thyroid Dysfunction, IBS, Weight Loss, Peripheral Neuropathy, Fibromyalgia, Celiac Disease, Autoimmune Diseases, Cancer and other Malignancies, Spinal Decompression Therapy, ATM2 Muscle Rehab, Chiropractic care, Migraines, patient testimonials and more….
    - **Youtube.com/drakibagreen or www.DrAkibaGreen.com**

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Vision: A Primary Healthcare Center dedicated to optimizing the health and well-being of our patients.

Mission: Add Value to your life!

Goals:

1. To do the appropriate testing on each patient to find the root cause of their condition.
2. To prevent neurological degeneration. (brain and nerve damage)
3. To return you to the most optimal state of health possible.
4. To enhance, extend, and have maximum positive impact on your life.

CONFIDENTIAL PATIENT INFORMATION Date: ___ / ___ / ___
PLEASE PRINT

Full Name _____ Called Name_____
Address_____City_____State _____Zip_____
SSN _____- _____- _____ Marital Status _____ Sex ____Age _____ DOB _____
Phone _____ Work Phone _____ Cell Phone _____
Email _____ Employer _____
Occupation _____ Spouse Name _____
Emergency Contact _____ Phone _____
How did you hear about our office? _____

What brought you into our office today (chief complaint):

_____

_____

Is your condition due to: ☐ An Auto Accident ☐ A Personal Injury ☐ A Work Injury ☐ Other
Type of Claim: ☐ Cash ☐ Insurance ☐ Personal Injury ☐ Worker's Comp ☐ Medicare ☐ Medicaid

HEALTH CARE AUTHORIZATIONS:

(Please Cross Out Any Permission You Would Like to Revoke)

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.
B. I give permission to Lake Norman Health and Wellness to use my address, phone number, email and clinical records to contact me with birthday cards, holiday related cards, information about treatment alternatives, office seminar dates, patient appreciation dates or other health related information such as newsletters.
C. I give permission to Lake Norman Health and Wellness to use my name and clinical records to display my photos or tests and use my testimonial and experience in an effort to increase the public's awareness of our office.
D. I am aware that other persons in the office may overhear or read some of my protected health information during the course of care. Should I need to speak with a doctor at any time in private, the doctor will provide a room for these conversations.
E. I authorize Lake Norman Health and Wellness to take any x-rays the doctor determines will be beneficial to my case during the course of my care. **I also recognize that if I am a female it is my responsibility to notify the doctor if I am pregnant or it is possible that I am pregnant.**
F. I am giving Lake Norman Health and Wellness permission to use and disclose my protected health information in accordance with the directives listed above.
G. I am giving Lake Norman Health and Wellness permission to contact other health care providers on my behalf to discuss treatment recommendations and co-management of my health care problems.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand I have the following rights and privileges: The right to view the notice prior to signing this consent, the right to object to the use of my health information for directory purposes, and the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

RIGHT TO REVOKE AUTHORIZATION:

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization. You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to Lake Norman Health and Wellness. This AUTHORIZATION is requested by Lake Norman Health and Wellness for its own use/disclosure of PHI.

Patient Signature: _____ Date: _____

Parent or Guardian: _____ Date: _____

Patient Name: _____

List Alternative Health Practitioners you have seen before (including chiropractors):

1. Name _____ When Visited: _____
2. Name _____ When Visited: _____
3. Name _____ When Visited: _____

List Medical Doctors you have consulted within the past year:

1. Name _____ Reason for Visit?_____
2. Name _____ Reason for Visit?_____
3. Name _____ Reason for Visit?_____

Please list your reasons for visiting our office:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List ***ALL*** medications you take. (Prescriptions and over-the-counter – use additional pages if needed)

Drug name:	Dosage:	How long have you taken this and for what condition?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List ***ALL*** supplements you take. (Use additional pages if needed)

Name of Supplements:	Dosage:	How long have you taken this and for what condition?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List ***ALL*** previous hospitalizations, surgeries, accidents, fractures and illnesses (Use additional pages)

(Example: ***All past*** Auto, Sports, Work, Home related.)

1. Type _____ When _____ Hospitalized? Yes _____ No _____
2. Type _____ When _____ Hospitalized? Yes _____ No _____
3. Type _____ When _____ Hospitalized? Yes _____ No _____
4. Type _____ When _____ Hospitalized? Yes _____ No _____

Patient Name: _____

Check **ALL** "body signals" (symptoms/pains) you may have had or do have now:

___ ADD/ ADHD	___ Depression	___ Hepatitis	___ Miscarriage
___ Alcoholism	___ Diabetes	___ High Blood Pressure	___ Multiple Sclerosis
___ Allergy	___ Diarrhea	___ High Cholesterol	___ Neck Pain
___ Alzheimer's	___ Eczema	___ High Blood Sugar	___ Parkinson's Disease
___ Anemia	___ Emphysema	___ HIV/ AIDS	___ Pneumonia
___ Appendicitis	___ Epilepsy/seizures	___ Irregular menstruation	___ Raynaud's
___ Asthma	___ Fibromyalgia	___ Irritable Bowel	___ Rheumatoid Arthritis
___ Arthritis	___ Gall Bladder	___ Kidney problems	___ Ringing in Ears
___ Back pain	___ Goiter	___ Low Blood Pressure	___ Sinus infections
___ Cancer	___ Gout	___ Low Blood Sugar	___ Stroke
___ Celiac / Gluten Dis.	___ Headaches	___ Lyme Disease	___ Thyroid Problems
___ Chronic Fatigue	___ Heart Attack	___ Lupus	___ Ulcers
___ Constipation	___ Heart Disease	___ Migraine	___ Vertigo/dizziness

Please check all of the following conditions your family has experienced:

Mother:	__Alzheimer's	__Cancer	__ Diabetes	__ Heart Disease	__Parkinson's	__MS	__ Stroke
Father:	__Alzheimer's	__Cancer	__ Diabetes	__ Heart Disease	__Parkinson's	__ MS	__ Stroke
GrandMother (M):	__Alzheimer's	__Cancer	__ Diabetes	__Heart Disease	__Parkinson's	__ MS	__ Stroke
GrandFather (M):	__Alzheimer's	__Cancer	__ Diabetes	__ Heart Disease	__ Parkinson's	__ MS	__ Stroke
GrandMother (P):	__Alzheimer's	__Cancer	__ Diabetes	__ Heart Disease	__ Parkinson's	__ MS	__ Stroke
GrandFather (P):	__Alzheimer's	__Cancer	__ Diabetes	__ Heart Disease	__ Parkinson's	__ MS	__ Stroke
Sisters:	__Alzheimer's	__Cancer	__ Diabetes	__ Heart Disease	__ Parkinson's	__ MS	__ Stroke
Brothers:	__Alzheimer's	__Cancer	__ Diabetes	__ Heart Disease	__ Parkinson's	__ MS	__ Stroke

List any other health conditions that you or your family have had that are not listed: _____

_____

Do you consume any of the following? (Write N/A if it doesn't apply)

Tobacco products (packs/day) ____ How many years? ___ Alcohol drinks/day ___ How many years? ___

Coffee/Tea cups/day ____ Regular or decaf? ___ Soft drinks # day ___ Regular or diet? ___

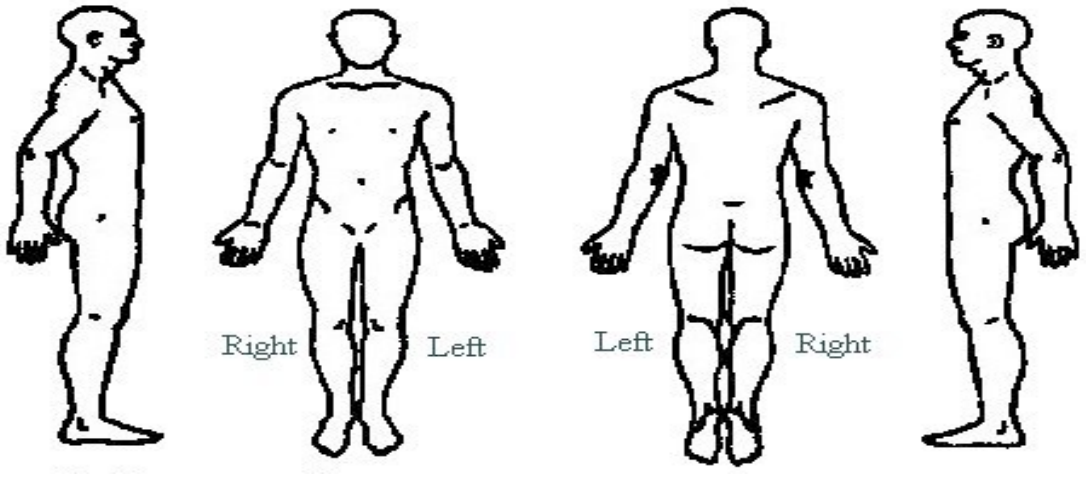
Do you use artificial sweeteners? ___ Yes___ No If yes please list_____

Level of exercise? _____ None _____ Moderate (days per week)_____ Strenuous (days per week)

Have you experienced any unexplained or rapid weight changes in the last six months? __Yes __ No __ lbs

Please mark off the areas of your complaint on the diagram below. Use the following symbols:

P= pain, N= numbness, T= tingling, B= burning, C=cramping



Lake Norman
HEALTH AND WELLNESS
Health Solutions You Can Trust

NEUROLOGICAL ASSESSMENT FORM

NAME: _____ DATE: _____

Are you left or right handed? _____ RIGHT LEFT
Have you had a head injury? _____ YES NO
Do you currently experience or have a past history of vertigo or balance disorders? _____ YES NO
Do you have any ringing or pressure in the ears? _____ YES NO
Do you experience nausea? _____ YES NO
Do you find that your balance is getting worse? _____ YES NO
Do you have difficulties walking down stairs? _____ YES NO
Do you have difficulty with math problems, or remembering numbers? _____ YES NO
Do you find yourself searching for words frequently when you speak? _____ YES NO
Have you noticed your ability to concentrate is getting worse? _____ YES NO
Do you get lost often or have a hard time with directions? _____ YES NO
Do quick flashes of light on TV or loud noises bother you? _____ YES NO
Do you feel like you need to wear sunglasses outside? _____ YES NO
Has your handwriting changed in recent years? _____ YES NO
Do you have a hard time swallowing? _____ YES NO
Do you gag easily? _____ YES NO
Do you experience blurriness in your vision or double vision? ***(<- Circle)*** _____ YES NO
Do you have any changes in smell or smell foul things that are not present? _____ YES NO
Do you have any difficulty with taste or taste things differently than what you are eating? _____ YES NO
Noticed clumsiness in hand coordination? Which hand? Right or left ***(<-Circle)*** _____ YES NO
Do you have difficulty with short-term memory? _____ YES NO
Have you been told or noticed any memory loss of past events? _____ YES NO
Noticed uneven sweating or temperature on one side of your body? _____ YES NO
Do you have any tightness, weakness or instability in your back or neck? ***(Circle)*** _____ YES NO
Do you have tightness, or feelings of weakness in your hands or legs? ***(Circle)*** _____ YES NO
Do you ever have any numbness or tingling in your hands, legs, or face? ***(Circle)*** _____ YES NO
Do you have any difficulty with falling asleep or staying asleep? _____ YES NO
Do you get motion sickness easily (care sick or sea sick)? _____ YES NO
Do you ever experience flashes of light in your visual field? _____ YES NO
Do you ever experience dry eyes or mouth? ***(Circle)*** _____ YES NO
Do you ever experience increase tearing or salivation? ***(Circle)*** _____ YES NO
Do you ever have slurred speech? _____ YES NO
Noticed any drooping of your eyelids or facial muscles? ***(Circle)*** _____ YES NO
Do you ever notice increased heart rate (tachycardia) or pulse during the day? _____ YES NO
Have you ever experienced or been diagnosed with arrhythmia (fluctuating heart rate)? _____ YES NO
Do you experience Déjà vu? _____ YES NO
Does driving cause you fatigue, headaches, or any other symptoms? ***(Circle)*** _____ YES NO
Does working on a computer cause you fatigue, headaches or other symptoms? _____ YES NO
Have you lost your interest in hobbies and functions that you used to enjoy? _____ YES NO
Do you have a hard time motivating yourself to engage in activities? _____ YES NO
Do you ever have fluttering of the eye or noticed you are blinking frequently? _____ YES NO
Do you have difficulty distinguishing right and left? _____ YES NO

Patient Signature: _____ Date: _____

Complaint History

Complaint 1: _____

When did your complaint first begin? _____ Have you ever experienced this complaint before? _____

How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

What aggravates your problem?

□ Nothing □ Coughing □ Reaching □ Standing
□ Sneezing □ Lifting □ Sitting □ Pulling
□ Bending □ Walking □ Straining at Stool □ Turning
□ Other – Describe: _____

What makes your problem better?

□ Nothing □ Stretching □ Heat □ Massage
□ Rest □ Exercise □ Ice □ Adjustments
□ Sitting □ Standing □ Medications □ Sleeping
□ Other – Describe: _____

Describe the type of pain/ symptom you experience? □ Sharp □ Numb □ Dull □ Tingly □ Diffuse □ Sharp with motion

□ Achy □ Shooting with motion □ Burning □ Stabbing with motion □ Shooting □ Electric like with motion □ Stiff □ Other:_____

_____

Does your problem travel into any other part of your body? Where? _____

_____

Have you lost control of any body part (arms, legs, bladder, bowel, etc.)? _____

Rate the severity of your problem on a scale of 0-10 (10 being the worst):

Indicate Pain Level (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Shoot Me Pain)

Complaint 2: _____

When did your complaint first begin? _____ Have you ever experienced this complaint before? _____

How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

What aggravates your problem?

□ Nothing □ Coughing □ Reaching □ Standing
□ Sneezing □ Lifting □ Sitting □ Pulling
□ Bending □ Walking □ Straining at Stool □ Turning
□ Other – Describe: _____

What makes your problem better?

□ Nothing □ Stretching □ Heat □ Massage
□ Rest □ Exercise □ Ice □ Adjustments
□ Sitting □ Standing □ Medications □ Sleeping
□ Other – Describe: _____

Describe the type of pain/ symptom you experience? □ Sharp □ Numb □ Dull □ Tingly □ Diffuse □ Sharp with motion

□ Achy □ Shooting with motion □ Burning □ Stabbing with motion □ Shooting □ Electric like with motion □ Stiff □ Other:_____

_____

Does your problem travel into any other part of your body? Where? _____

_____

Have you lost control of any body part (arms, legs, bladder, bowel, etc.)? _____

Rate the severity of your problem on a scale of 0-10 (10 being the worst):

Indicate Pain Level (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Shoot Me Pain)

Complaint 3: _____

When did your complaint first begin? _____ Have you ever experienced this complaint before? _____

How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

What aggravates your problem?

□ Nothing □ Coughing □ Reaching □ Standing
□ Sneezing □ Lifting □ Sitting □ Pulling
□ Bending □ Walking □ Straining at Stool □ Turning
□ Other – Describe: _____

What makes your problem better?

□ Nothing □ Stretching □ Heat □ Massage
□ Rest □ Exercise □ Ice □ Adjustments
□ Sitting □ Standing □ Medications □ Sleeping
□ Other – Describe: _____

Describe the type of pain/ symptom you experience? □ Sharp □ Numb □ Dull □ Tingly □ Diffuse □ Sharp with motion

□ Achy □ Shooting with motion □ Burning □ Stabbing with motion □ Shooting □ Electric like with motion □ Stiff □ Other:_____

_____

Does your problem travel into any other part of your body? Where? _____

_____

Have you lost control of any body part (arms, legs, bladder, bowel, etc.)? _____

Rate the severity of your problem on a scale of 0-10 (10 being the worst):

Indicate Pain Level (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Shoot Me Pain)

Complaint 4: _____

When did your complaint first begin? _____ Have you ever experienced this complaint before? _____

How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

What aggravates your problem?

□ Nothing □ Coughing □ Reaching □ Standing
□ Sneezing □ Lifting □ Sitting □ Pulling
□ Bending □ Walking □ Straining at Stool □ Turning
□ Other – Describe: _____

What makes your problem better?

□ Nothing □ Stretching □ Heat □ Massage
□ Rest □ Exercise □ Ice □ Adjustments
□ Sitting □ Standing □ Medications □ Sleeping
□ Other – Describe: _____

Describe the type of pain/ symptom you experience? □ Sharp □ Numb □ Dull □ Tingly □ Diffuse □ Sharp with motion

□ Achy □ Shooting with motion □ Burning □ Stabbing with motion □ Shooting □ Electric like with motion □ Stiff □ Other:_____

_____

Does your problem travel into any other part of your body? Where? _____

_____

Have you lost control of any body part (arms, legs, bladder, bowel, etc.)? _____

Rate the severity of your problem on a scale of 0-10 (10 being the worst):

Indicate Pain Level (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Shoot Me Pain)

NEW PATIENT QUESTIONNAIRE

Name: _____ Date: _____

Please describe any problem you are currently experiencing or have experienced in the past to help us get a better understanding of your health history. For example, if you now, or as a child, frequently were ill with ear infections please write that in the ears/nose/throat section below. Again please be as detailed as possible as this form is VERY IMPORTANT to us. We need to know as much about you as possible in order to properly evaluate and treat your condition.

1. WHOLE BODY

HEAD: (concussions, stroke, headaches, dizziness, etc.)

EARS/NOSE/THROAT: (ear infections, inner ear problems, nose bleeds, frequent strep infections, difficulty swallowing, loss of hearing, smelling or taste etc.)

EYES: (corrective lenses, dryness, double/blurry vision, etc.)

THYROID: (hyper/hypothyroidism? Medication for this?)

ARMS/LEGS: (pain, skin disorders, abnormal weakness, loss of limbs/fingers/toes-briefly explain how loss occurred, etc.)

ABDOMINAL/REPRODUCTIVE AREA: (nausea, ulcers, kidney stones, ovarian cancer, prostate problems, diabetes, bladder control, any cancers, etc.)

LUNG/HEART: (difficulties breathing, asthma, heart attacks, angina, stroke, rapid/slow heart rate, pacemaker, etc.)

BLOOD: (anemia, etc.)

THE FOLLOWING QUESTIONS HAVE TO DO WITH BRAIN FUNCTION:

Are you sensitive to light or have blurring vision?

Have you experienced an increase in sweating?

Do you have trouble sleeping, continuously waking up during the night or trouble getting to sleep?

Have you experienced an increase in pulse or heart rate, or experienced heart palpitations?

Do you have a history of urinary tract infections?

Have you experienced visual changes before migraine headaches?

Do you have, or have you had bedsores or lesions?

Do you fatigue easily?

Do you have cold hands or feet?

Do you experience frequent urination or are you unable to control urinary or bowel movements?

Do you have episodes of fainting or hypoxia?

For the next several questions please answer briefly and give the dates each began to the best of your knowledge and if you can think of what contributed to it.

1. Any history of fainting/loss of consciousness?

2. Noticeable changes in your handwriting?

3. Changes in sexual function?

4. Are you more irritable or angry?

5. Episodes of depression or anxiety?

6. Problems with equilibrium, loss of balance, tripping, dropping things, etc?

7. Difficulty scanning pages while reading a book?

8. Difficulty adding or subtracting?

9. Difficulty moving your eyes? Or double vision?

10. Difficulty expressing what you would like to say?

11. Any changes in speech?

12. Any changes in sensation?

13. Any changes in memory?

14. Any changes in hearing?

15. Excess dryness or wetness of the eyes or nose?

2. FULL DESCRIPTION (DETAILED) OF WORK ACTIVITIES

What do you do? What are your duties?

How many hours per week do you work?

Do you do a lot of lifting or twisting at work?

3. LIFESTYLE

Hobbies/Activities/Exercise.

Diet (List briefly the types of foods you generally eat.)

Rate your salt/sugar/fat consumption. (Mark each: **L**ow/**M**oderate/**H**igh)

Salt	L	M	H
Sugar	L	M	H
Fat	L	M	H

History of diets? Any changes?

Are you satisfied with your weight?

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Name: _____ Date: _____

Please take several minutes to answer these questions so Dr. Green can help you get better faster. (**Please circle as many that apply**)

1. How have you taken care of your health in the past?

a. Medications
b. Emergency Room
c. Routine Medical
d. Exercise
e. Nutrition/Diet
f. Holistic Care
g. Vitamins
h. Chiropractic
i. Other (please specify): _____

2. How did the previous method(s) work out for you?

a. Bad results
b. Some results
c. Great results
d. Nothing changed
e. Did not get worse
f. Did not work very long
g. Still trying
h. Confused

3. How have others been affected by your health condition?

a. No one is affected
b. Haven't noticed any problem
c. They tell me to do something
d. People avoid me

4. What are you afraid this might be (or beginning) to affect (or will affect)?

a. Job
b. Kids
c. Future ability
d. Marriage
e. Self-esteem
f. Sleep
g. Time
h. Finances
i. Freedom

5. Are there health conditions you are afraid this might turn into?

a. Family health problems
b. Heart disease
c. Cancer
d. Diabetes
e. Arthritis
f. Fibromyalgia
g. Depression
h. Chronic Fatigue
i. Need surgery

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How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

_____

_____

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples

_____

_____

What are you most concerned with regarding your problem? _____

_____

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific _____

_____

What would be different/better without this problem? Please be specific _____

_____

What do you desire most to get from working with us?_____

_____

On a scale of 1 to 10 (with 10 being the best) what is your level of commitment to regaining your health?

_____

_____

Metabolic Assessment Form

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

PART I

Please list your 5 major health concerns in order of importance:

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

PART II **Please circle the appropriate number on all questions below.**
0 as the least/never to 3 as the most/always.

Category I				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3
Category II				
Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3
Category III				
Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc.	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3
Category IV				
Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movement	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3
Category V				
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3
Category VI				
Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3

Category VI (continued)				
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucous like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3
Category VII				
Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?	Yes		No	
Category VIII				
Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3
Category IX				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory/forgetful	0	1	2	3
Blurred vision	0	1	2	3
Category X				
Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XI

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIII

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XIV

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XV

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVI

Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XVII

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting" - type headaches	0	1	2	3

Category XVIII *(Males Only)*

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XIX *(Males Only)*

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XX *(Menstruating Females Only)*

Perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle (greater than 32 days)	Yes	No		
Shortened menstrual cycle (less than 24 days)	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XXI *(Menopausal Females Only)*

How many years have you been menopausal?	_____ years			
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times do you eat raw nuts or seeds per week? _____

Rate your stress level on a scale of 1-10 during the average week: _____

How many times do you eat fish per week? _____

How many times do you work out per week? _____

List the three worst foods you eat during the average week: _____ _____ _____

List the three healthiest foods you eat during the average week: _____ _____ _____

PART IV

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions: