



Outline Procedure for New Patients

- Step One:** All new patients are requested to fill out a personal health questionnaire prior to their appointment.
- Step Two:** Your consultation with a doctor to discuss your health problems.
- Step Three:** Diagnostic chiropractic, orthopedic, and neurological examination procedures to determine if Chiropractic care is appropriate for your condition.
- Step Four:** You will be advised if there is the need of any additional procedures such as X-rays, MRI, & CAT Scan.
- Step Five:** If your case requires immediate attention, treatment will be administered.
- Step Six:** You will be advised as to a time you can return for your “Report of Findings” so that the Doctor will inform you as to your examination results and whether or not your case has been accepted. You will be informed of specific recommendations in regards to your condition.
- Step Seven:** If appropriate, your treatment plan will begin following your “Report of Findings.”

Confidential Patient Information

Name _____ SS# _____ Date of Birth _____

Home Phone # _____ Cellular Phone # _____

Address _____ City _____ State ____ Zip _____

E-mail _____ May we send you newsletters and promotions via email? Yes ____ No ____

Marital Status ____ Name of Spouse _____ # of Children _____

Occupation _____ Employer _____ Work Phone _____

In case of emergency, please contact: Name _____ Phone # _____

How were you referred to our office? _____

Purpose of this appointment _____

Is your injury work related, and auto accident or personal injury? [] Yes [] No

If your injury is related to work, an auto accident or any other injury involving a claim, please advise the office staff.

Name of person responsible for payment _____ Insurance Company _____

Group # _____ ID # _____ Phone # _____

Name of the Insured _____ Birth Date of Insured _____ SS# of Insured _____

Financial Policy

I understand that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that **Foothill Chiropractic** will gladly prepare any necessary reports and forms to assist me in making collection from my primary insurance carrier. If I am paying by cash, check or credit card or if I have insurance co-pay and/or deductible, payment is expected at the time of service. If I have insurance, I hereby authorize and direct my insurance carrier to pay benefits, which may be due to me, according to my policy, directly to, and payable to **Foothill Chiropractic** to be applied to my account. I understand and agree that all fees for services rendered on my behalf are my personal responsibility and are due and payable at time of service.

I UNDERSTAND AND AGREE TO ALL OF THE ABOVE. IF MY TREATMENT REQUIRES INSURANCE BILLING, I HEREBY AUTHORIZE AND DIRECT **FOOTHILL CHIROPRACTIC** TO RELEASE ALL MEDICAL INFORMATION NECESSARY TO PROCESS THESE CLAIMS.

Signed _____ Date _____

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (**Relief Care**). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved to avoid future relapses (**Corrective Care**). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible in order to optimize their physical and emotional well-being (**Comprehensive Care**).

Foothill Chiropractic and Wellness Center stresses that it is always **YOUR** choice to choose which form of care you desire. We will honor and support your choice and your Doctor will weigh your needs and desires when recommending your treatment program. Please check the type of care you wish to receive.

Relief Care Corrective Care Comprehensive Care Would like to discuss options with the doctor

Please list your major health concerns in order of severity:

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

Complaint # 1:

When did you first notice this condition? _____

Did it begin Immediately or Gradually? (please describe briefly) _____

What is the exact location of your symptoms? _____

Do your symptoms spread? No Yes Where? _____

How often do you experience these symptoms?
 Constant Frequent (75% of day) Often (50%) Seldom (25%) Rarely (less than 25%)

Is this condition progressively Worsening Improving or Unchanged

What is the intensity of your symptoms? Severe Moderate Mild

Rate your symptoms on a scale of 1-10, considering 1 (minimal) and 10 (severe/excruciating)

Is your pain Deep or Superficial

Please indicate the character of your pain: Dull Sharp Burning Aching Knife-like Throbbing

Are you experiencing any of the following associated symptoms? Pins & Needles Tingling
 Numbness Twitching of muscles If yes, please describe: _____

Complaint # 2:

When did you first notice this condition? _____

Did it begin Immediately or Gradually? (please describe briefly) _____

What is the exact location of your symptoms? _____

Do your symptoms spread? No Yes Where? _____

How often do you experience these symptoms?
 Constant Frequent (75% of day) Often (50%) Seldom (25%) Rarely (less than 25%)

Is this condition progressively Worsening Improving or Unchanged

What is the intensity of your symptoms? Severe Moderate Mild

Rate your symptoms on a scale of 1-10, considering 1 (minimal) and 10 (severe/excruciating)

Is your pain Deep or Superficial

Please indicate the character of your pain: Dull Sharp Burning Aching Knife-like Throbbing

Are you experiencing any of the following associated symptoms? Pins & Needles Tingling
 Numbness Twitching of muscles If yes, please describe: _____

Please indicate what activities provoke (P) or aggravate (A) your condition:
 Sitting ___min Lying Lifting ___lbs. Bowel Movements Hot or Cold
 Standing Pushing Gripping Mental Activities Walking
 Pulling Coughing/Sneezing Bright Lights Other (Please explain)_____

Please indicate what helps you to relieve the pain.
 Lying Walking Rest Medications _____
 Sitting Standing Heat or Cold Other (Please explain)_____

Please list what doctors you have seen for this condition. (Including diagnoses, treatment received, and any changes in your condition)

Past Medical History

Please include any of your previous conditions. If possible include dates, diagnosis, treatment received and any residuals you still suffer from.

Utero, Birth, and Infancy:

Was your mother healthy when you were in utero? Yes No (Please explain _____)

Did she smoke or consume alcohol? No Yes

Where were you born? _____

Were you delivered vaginally or through cesarean section? *Circle one*

Were there any complications during your birth process? No Yes (Please explain) _____

Were you vaccinated? No Yes

Did you have normal neurological, structural, emotional, and social development? Yes No (Please explain) _____

Did you have any of the following:

Injuries, Accidents, Falls or Traumas none _____

Illnesses/Hospitalizations: none _____

Surgeries: none _____

Childhood (ages 2 – 12)

Did you have normal neurological, structural, emotional, social, and academic development?

Yes No _____

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Athletics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dietary Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Overall Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Did you have any of the following:

Injuries, Accidents, Falls or Traumas none _____

Illnesses/Hospitalizations: none _____

Surgeries: none _____

Teens (ages 13-19)

Did you have normal neurological, structural, emotional, social, and academic development?

Yes No _____

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Athletics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dietary Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Overall Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Did you have any of the following:

Injuries, Accidents, Falls or Traumas none _____

Illnesses/Hospitalizations: none _____

Surgeries: none _____

Females only: What age did you start your menses? ____ Regular Irregular

Twenties

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Athletics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dietary Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Overall Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Did you have any of the following:

Motor Vehicle Accidents none _____

Work Injuries none _____

Injuries, Accidents, Falls or Traumas none _____

Illnesses/Hospitalizations: none _____

Surgeries: none _____

Thirties

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dietary Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Overall Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Did you have any of the following:

Motor Vehicle Accidents none _____

Work Injuries none _____

Injuries, Accidents, Falls or Traumas none _____

Illnesses/Hospitalizations: none _____

Surgeries: none _____

Forties

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dietary Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Overall Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Did you have any of the following:

Motor Vehicle Accidents none _____

Work Injuries none _____

Injuries, Accidents, Falls or Traumas none _____

Illnesses/Hospitalizations: none _____

Surgeries: none _____

Females only: Menopausal symptoms none yes _____

Fifties

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dietary Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Overall Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Did you have any of the following:

Motor Vehicle Accidents none _____

Work Injuries none _____

Injuries, Accidents, Falls or Traumas none _____

Illnesses/Hospitalizations: none _____

Surgeries: none _____

Females only: Menopausal symptoms none yes _____

Sixties

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dietary Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Overall Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Did you have any of the following:

Motor Vehicle Accidents none _____

Work Injuries none _____

Injuries, Accidents, Falls or Traumas none _____

Illnesses/Hospitalizations: none _____

Seventies

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dietary Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Overall Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Did you have any of the following:

Motor Vehicle Accidents none _____

Work Injuries none _____
Injuries, Accidents, Falls or Traumas none _____

Illnesses/Hospitalizations: none _____

Eighties

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dietary Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Overall Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Did you have any of the following:

Motor Vehicle Accidents none _____

Work Injuries none _____
Injuries, Accidents, Falls or Traumas none _____

Illnesses/Hospitalizations: none _____

Nineties

Please rate the following abilities and traits:

	Excellent	Good	Average	Below Average	Poor	
Academics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dietary Habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Overall Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Did you have any of the following:

Motor Vehicle Accidents none _____

Work Injuries none _____

Injuries, Accidents, Falls or Traumas none _____

Illnesses/Hospitalizations: none _____

Family History

Mother Alive & Well, age ___ Deceased age ___ from what? _____
Any health conditions _____

Father Alive & Well, age ___ Deceased age ___ from what? _____
Any health conditions _____

Brother Alive & Well, age ___ Deceased age ___ from what? _____
Any health conditions _____

Brother Alive & Well, age ___ Deceased age ___ from what? _____
Any health conditions _____

Sister Alive & Well, age ___ Deceased age ___ from what? _____
Any health conditions _____

Sister Alive & Well, age ___ Deceased age ___ from what? _____
Any health conditions _____

Children: Ages _____ Any health conditions? _____

Maternal Grandmother A&W Deceased age ___ from what? _____
Any health conditions _____

Maternal Grandfather A&W Deceased age ___ from what? _____
Any health conditions _____

Paternal Grandmother A&W Deceased age ___ from what? _____
Any health conditions _____

Paternal Grandfather A&W Deceased age ___ from what? _____
Any health conditions _____

Have any of your family members ever suffered from any of the following conditions?

Diabetes Neurological Disorders _____ Depression/Mental Illness
 Heart Disease Autoimmune Diseases _____ Stroke
 Cancer _____ Other _____

Medications Please list your current medications and the condition they are treating.

Vitamins and Minerals Please list your current supplements and who prescribed them.

Habits

Cigarettes none How many per week? _____ **Cigars** none How many per week? _____
Alcohol none How many drinks per week? _____ Type of alcohol _____
Coffee none How many cups per week? _____
Recreational Drugs none Types _____ Frequency _____ Years of Usage _____
Exercise none Hours/Days per week _____ Types _____
Water none Glasses per day _____
Soft Drinks none Amount per week _____ Types _____
Sleep Average per night _____ Do you have difficulty falling asleep or staying asleep? Yes No
 Hours desired per night? _____
Meals per days _____ What type of foods do you eat? _____
 Do you consider your diet healthy? Yes No _____

DATE OF LAST

Physical Examination: _____ By Whom? _____ Results _____
Blood Work: _____ By Whom? _____ Results _____
Bone Density Study _____ Results _____ **Mammogram** _____ Results _____
Pelvic Exam _____ Results _____ **Self Breast Exam** _____ Regularity _____
PSA level _____ Results _____ **Digital Prostate Examination** _____ Results _____
Chest X-rays _____ Results _____ **EKG** _____ Results _____
Echocardiogram _____ Results _____
Spinal X-rays _____ By Whom? _____ Where are they located? _____
MRI / CAT Scan _____ Re _____ Where are they located? _____
Other tests: _____

CHECK any of the following conditions you have HAD and CIRCLE anything you currently HAVE.

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Infective Diseases _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Anemia | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Fungal Infection _____ |
| <input type="checkbox"/> Tumors | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Herpes _____ |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Parasites | <input type="checkbox"/> Autoimmune Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Venereal Infection | <input type="checkbox"/> _____ |

NERVOUS SYSTEM

- Depression
- Memory loss/Confusion
- Dizziness
- Fainting
- Convulsions
- Numbness
- Weakness
- Poor Balance/Coordination
- Twitches/Tremor
- Cold/Tingling Extremities
- Sleeping Difficulties
- Headaches

C-V

- Chest Pain
- Irregular Heartbeat
- High Blood Pressure
- Shortness of Breath
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- GU**
- Discolored Urine
- Bladder Trouble
- Painful Urination
- Excessive Urination
- Incontinence

EENT

- Vision Problems
- Flashing Lights
- Black Spots
- Blurriness
- Hearing Loss
- Ringing in Ears
- Swallowing Difficulty

GI

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Frequent Diarrhea
- Frequent Constipation
- Hemorrhoids
- Abdominal Cramping
- Black/Bloody Stools
- Heartburn
- Digestive Problems
- Weight Problems
- Gas/Bloating After Meals
- Gall Bladder Problems
- Liver Problems

MUSCULOSKELETAL

- Jaw Pain
- Difficulty Chewing
- Face Pain
- Neck Pain
- Arm/Elbow Pain
- Wrist/Hand Pain
- Mid Back Pain
- Lower Back Pain
- Thigh/Knee Pain
- Ankle/Foot Pain
- Difficulty Walking
- Leg/Arm Fatigue

REPRODUCTIVE

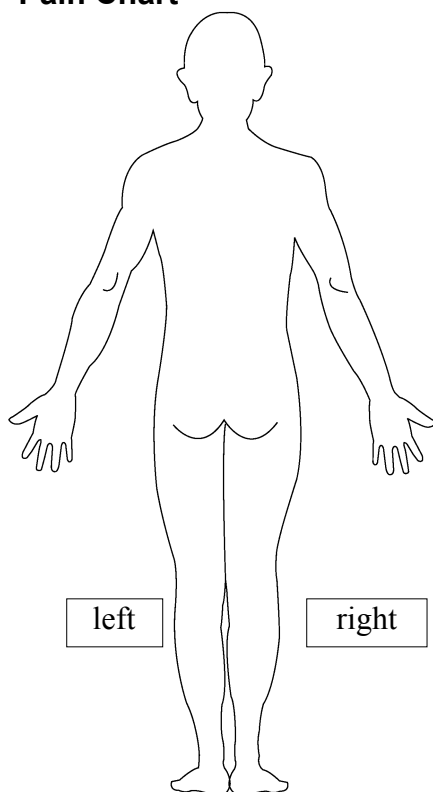
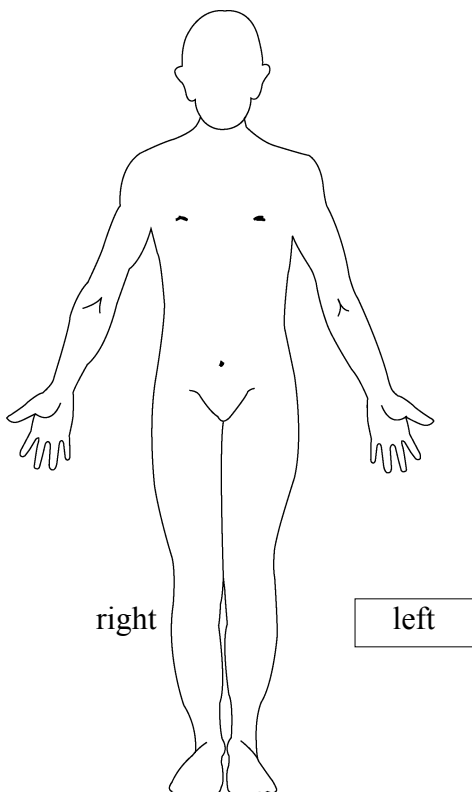
- Erectile Difficulties
- Sexual Dysfunction
- Menstrual Irregularity
- Menstrual Cramping

How often do you have a bowel movement? _____ Are your movements consistent? Yes No
 Do your stools float or sink

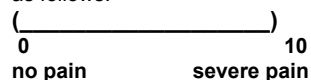
How many times a day do you urinate? _____ Is this consistent? Yes No _____
 Do you experience any urgency, dribbling, incontinence? _____

Show Area(s) of Pain or Unusual Feeling

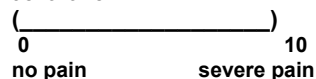
Mark the areas on this body where you feel pain or unusual sensations. Include all affected areas.

Pain Chart**Neck-Shoulder-Arm-Pain**

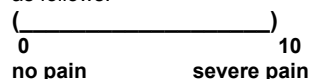
On a scale of zero to 10, I rate my discomfort as follows:

**Mid Back Pain**

On a scale of zero to 10, I rate my discomfort as follows:

**Low Back and Leg Pain**

On a scale of zero to 10, I rate my discomfort as follows:



Metabolic Assessment Form

Please circle the appropriate number between “0” and “3” on all questions below. Use 0 to signify never or the least and 3 to signify the most or always.

Category I

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relief 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
Do you use laxatives frequently	0	1	2	3

Category II

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 movements	0	1	2	3
Sense of fullness during and/or after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested foods found in stools	0	1	2	3

Category III

Stomach pain, burning or aching 1- 4 hours after eating	0	1	2	3
Do you frequently use antacids	0	1	2	3
Feeling hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief from antacids, food, milk, 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 IV

Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness lasts 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage bloated	0	1	2	3
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 V

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 VI

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep yourself going or get started	0	1	2	3
Get lightheaded if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, 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 VII

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 & appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Category VIII

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

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Category IX

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts 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 X

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 gain 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 falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XI

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervousness 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 XII

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

Category XIII

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

Category XIV (Males Only)

Urination difficulty or dribbling	0	1	2	3
Urination frequent	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

Category XV (Males Only)

Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintaining 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
Decrease in 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 XVI (Menstruating Females Only)

Are you a menopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle, greater than 32 days	Yes	No		
Shortened menses, less than every 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 break outs	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XVII (Menopausal Females only)

How many years have you been menopausal?				
Do you ever have uterine bleeding since menopause?	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

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