REAL FOOD | REAL SCIENCE | REAL RESULTS

Health Questionnaire for Dietician Consult

Please complete the following form prior to your visit and bring it in with you or email it to us on info@woodhilldieticians.co.za. All this information will be held in the strictest of confidence. The questionnaire below is a comprehensive assessment of your current health and diet issues. Although it may be long and tiring to complete, we ask that you complete it to the best of your ability as we need to have as much detailed information as possible about your current health status and your relationship with food in order to gain a clear idea of what may be causing your weight and health problems, so that we can give you the best possible dietary advice. If you have had laboratory or other medical testing done within the past 12 months, you are encouraged to bring the results/reports with you to your initial appointment.

Personal Information

First Name: Last Name:

Preferred Name:

Date of Birth: Age (years): Gender: Male Female

Home Address:

Phone: Email:

Emergency Contact

Name: Phone

Physician

Name: Phone

Email:

REFERRED BY Name: Phone

Email:

Reason:

Signature:

COMPLAINTS / CONCERNS

What do you hope to **achieve in your visit** with us? _____

_____

If you had a magic wand and could **erase three problems**, what would they be?

1. _____

2. _____

3. _____

When was the **last time you felt well**? _____

What makes you **feel worse**? _____

What makes you **feel better**? _____

Please list current and ongoing problems in order of priority:

Describe the problem	Mild	Moderate	Severe	Prior Treatment / Approaches	Excellent	Good	Fair

Have you experienced any major life changes recently (positively or negatively)? _____

_____

_____

_____

_____

_____

_____

MEDICAL HISTORY

☐ = Past Condition ☐ = Ongoing Condition

DISEASES/ DIAGNOSIS / CONDITIONS *Check appropriate box and provide date of onset*

GASTROINTESTINAL

☐	☐	Irritable Bowel Syndrome
☐	☐	Inflammatory Bowel Syndrome
☐	☐	Chron's
☐	☐	Ulcerative Colitis
☐	☐	Gastritis / Peptic Ulcer Disease
☐	☐	GERD (reflux)
☐	☐	Celiac Disease
☐	☐	Other:

CARDIOVASCULAR

☐	☐	Heart attack
☐	☐	Other Heart Disease
☐	☐	Stroke
☐	☐	Elevated Cholesterol
☐	☐	Arrythmia (irregular heart rate)
☐	☐	Hypertension (high blood pressure)
☐	☐	Rheumatic Fever
☐	☐	Mitral Valve Prolapse
☐	☐	Other:

METABOLIC / ENDOCRINE

☐	☐	Type 1 Diabetes
☐	☐	Type 2 Diabetes
☐	☐	Hypoglycemia
☐	☐	Metabolic Syndrome (Insulin Resistance)
☐	☐	Hypothyroidism (low thyroid)
☐	☐	Hyperthyroidism (overactive thyroid)
☐	☐	Endocrine Problems
☐	☐	Polycystic Ovarian Syndrome (PCOS)
☐	☐	Infertility
☐	☐	Weight Gain
☐	☐	Weight Loss
☐	☐	Frequent Weight Fluctuations
☐	☐	Bulimia
☐	☐	Anorexia
☐	☐	Binge Eating Disorder (non-specific)
☐	☐	Other:

CANCER

☐	☐	Lung Cancer
☐	☐	Breast Cancer
☐	☐	Colon Cancer
☐	☐	Ovarian Cancer
☐	☐	Skin Cancer
☐	☐	Other:

NEUROLOGIC / MOOD

☐	☐	Depression
☐	☐	Anxiety
☐	☐	Bipolar Disorder
☐	☐	Schizophrenia
☐	☐	Headaches
☐	☐	Migraines
☐	☐	ADD/ADHD
☐	☐	Autism
☐	☐	Mild Cognitive Impairment
☐	☐	Memory Problems
☐	☐	Parkinson's Disease
☐	☐	Multiple Sclerosis
☐	☐	ALS
☐	☐	Seizures
☐	☐	Other Neurological Problems

GENITAL AND URINARY SYSTEMS

☐	☐	Kidney Stones
☐	☐	Gout
☐	☐	Interstitial Cystitis
☐	☐	Frequent Urinary Tract Infections
☐	☐	Frequent Yeast Infections
☐	☐	Erectile or Sexual Dysfunction
☐	☐	Other:

MUSCULOSKELETAL / PAIN

☐	☐	Osteoarthritis
☐	☐	Fibromyalgia
☐	☐	Chronic Pain
☐	☐	Other:

INFLAMMATORY / AUTOIMMUNE

☐	☐	Chronic Fatigue Syndrome
☐	☐	Autoimmune Disease
☐	☐	Rheumatoid Arthritis
☐	☐	Lupus SLE
☐	☐	Immune Deficiency Disease
☐	☐	Herpes - Genital
☐	☐	Severe Infectious Disease
☐	☐	Poor Immune Function (frequent infections)
☐	☐	Food Allergies
☐	☐	Environmental Allergies
☐	☐	Multiple Chemical Sensitivities
☐	☐	Latex Allergy
☐	☐	Other:

RESPIRATORY DISEASE

☐	☐	Asthma
☐	☐	Chronic Sinusitis
☐	☐	Bronchitis
☐	☐	Emphysema
☐	☐	Pneumonia
☐	☐	Tuberculosis
☐	☐	Sleep Apnoea
☐	☐	Other:

SKIN DISIEASES

☐	☐	Eczema
☐	☐	Psoriasis
☐	☐	Acne
☐	☐	Melanoma
☐	☐	Skin Cancer
☐	☐	Other:

OTHER

PREVENTATIVE TESTS AND DATE OF LAST TEST

Check box if yes and provide date

- ☐ Full Physician Exam
- ☐ Bone Density
- ☐ Colonoscopy
- ☐ Cardiac Stress Test
- ☐ EBT Heart Scan
- ☐ EKG
- ☐ Hemoccult Test – stool test for blood
- ☐ MRI
- ☐ CT Scan
- ☐ Upper Endoscopy
- ☐ Upper GI Series
- ☐ Ultrasound

SURGERIES

Check box if yes and provide date of surgery

- ☐ Appendectomy
- ☐ Hysterectomy +/- Ovaries
- ☐ Gall Bladder
- ☐ Hernia
- ☐ Tonsillectomy
- ☐ Dental Surgery
- ☐ Joint Replacement – Knee/Hip
- ☐ Heart Surgery – Bypass Valve
- ☐ Angioplasty or Stent
- ☐ Pacemaker
- ☐ Other
- ☐ None

INJURIES

Check box if yes and provide date

- ☐ Back Injury
- ☐ Head Injury
- ☐ Neck Injury
- ☐ Broken Bones
- ☐ Other:

BLOOD TYPE

O A O B O AB O O O Rh+ O Unknown

HOSPITALIZATIONS

Date	Reason

ALLERGIES

Please list all allergies and whether you take any medication for them:

Allergy	Medication

PATIENT BIRTH HISTORY

☐ Term ☐ Premature

Pregnancy Complications: _____

Birth Complications: _____

Method of feeding: ☐ Breast Fed. For How Long? _____ ☐ Bottle Fed

Age at introduction of: Solid Foods: _____ Dairy: _____ Wheat: _____

Did you eat a lot of candy or sugar as child? ☐ Yes ☐ No

GYNECOLOGIC HISTORY *(for women only)*

OBSTETRIC HISTORY *Check box if yes and provide number of:*

☐ Pregnancies ☐ Caesarean ☐ Vaginal deliveries

☐ Miscarriages ☐ Abortion ☐ Living Children

☐ Post-Partum Depression ☐ Toxaemia ☐ Gestational Diabetes ☐ Babies over 4kg

☐ Breastfeeding For how long? _____

MENSTRUAL HISTORY

Age at First Period: _____ Menses Frequency: _____ Length: _____

Pain: OYes ONo **Clotting**: OYes ONo

Has your period ever skipped? _____ For how long? ____

Last Menstrual Period: _____

Use of Hormonal Contraception such as: ☐ Birth Control Pills ☐ Patch ☐ Nuva Ring ☐ Partner Vasectomy

WOMEN'S DISORDERS / HORMONAL IMBALANCES

☐ Fibrocystic Breasts ☐ Endometriosis ☐ Fibroids ☐ Infertility

☐ Painful Periods ☐Heavy Periods ☐ PMS

Last Mammogram: _____ ☐ Breast Biopsy / Date:

Last PAP Test: _____ ☐ Normal ☐ Abnormal

Last Bone Density: _____ Results: ☐ High ☐ Low ☐ Within Normal Ranges

Are you in Menopause: ☐ Yes ☐ No Age at Menopause: _____

Do you experience any of the following symptoms?

☐ Hot Flashes ☐ Mood Swings ☐ Concentration / Memory Problems ☐ Vaginal Dryness ☐ Decreased Libido ☐Heavy Bleeding

☐ Joint Pains ☐ Headaches ☐Weight Gain ☐ Loss of Control of Urine ☐ Palpitations

☐ Use of hormone replacement therapy: For how long? ____

MEN'S HISTORY *(for men only)*

Have you had a PSA done? ☐ Yes ☐ No

PSA Level: ☐ 0-2 ☐ 2-4 ☐ 4-10 ☐ >10

☐ Prostate Enlargement ☐ Prostate infection ☐ Change in Libido ☐ Impotence

☐ Difficulty Obtaining an Erection ☐Difficulty Maintaining an Erection

☐ Nocturia (urination at night). How many times at night? _____

☐ Urgency / Hesitancy / Change in Urinary Stream ☐ Loss of Control of Urine

GI HISTORY

Foreign Travel? ☐ Yes ☐ No Where? _____

Wilderness Camping? ☐ Yes ☐ No Where? _____

Have you ever had severe: ☐ Gastroenteritis ☐ Diarrhea

Do you feel like you digest your food well? ☐ Yes ☐ No

Do you feel bloated after meals? ☐ Yes ☐ No

Please indicate what your recent bowel movements are:

Frequency: ☐ More than 3 times per day ☐ 1-3 times per day ☐ 4-6 times per week ☐ 2-3 times per week ☐ 1 or fewer times per week

Consistency: ☐ Soft and well formed ☐ Often float ☐ Difficult to pass ☐ Diarrhoea ☐ Thin, long or narrow ☐ Small and hard ☐ Loose but not watery ☐ Alternating between hard and loose or watery stools

Frequency: ☐ Medium brown consistently ☐ Very dark or black ☐ Greenish colour ☐ Blood is visible ☐ Varies a lot ☐Dark brown consistently ☐ Yellow, light brown ☐ Greasy, shiny appearance

Intestinal Gas: ☐ Daily ☐ Occasionally ☐ Excessive ☐ Present with Pain ☐ Foul Smelling ☐ Little Odor

DENTAL HISTORY

DENTAL SURGERY

☐ Silver Mercury Fillings: How Many? _____

☐ Gold Fillings ☐ Root Canals ☐Implants ☐Tooth Pain ☐ Bleeding Gums

☐ Gingivitis ☐Problems with Chewing

Do you floss regular? ☐ Yes ☐ No

MEDICATIONS

MEDICATION (Prescription or Non-Prescription) **/ NUTRITIONAL SUPPLEMENTS** (Vitamins, Minerals, Herbs, Homeopathy)

Medication	Dose	Frequency	Start Date	Reason for Use

Have your medication or supplements ever caused you unusual side effects or problems ☐ No ☐ Yes, please explain:

_____

_____

Have you had prolonged or regular use of **NSAIDS** e.g. Diclofenac, Ibuprofen, Aspirin? ☐ Yes ☐ No

Have you had prolonged or regular use of **Paracetamol** e.g. Panado? ☐ Yes ☐ No

Have you had prolonged or regular use of **Acid Blocking Drugs** e.g. Nexium, Zantac, etc.? ☐ Yes ☐ No

Frequent antibiotics > 3 times/year ☐ Yes ☐ No

Long term antibiotics ☐ Yes ☐ No

Use of **steroids** (prednisone, nasal allergy inhalers) in the past ☐ Yes ☐ No

Use of **oral contraceptives** ☐ Yes ☐ No

FAMILY HISTORY AND GENETICS

Have you ever done any **genetic testing**? ☐ DNALysis ☐ Geneway ☐ 3x4 ☐ Other

What is your **genetic background** (Genetic deposition & disease)?

☐ African ☐ European ☐ Native American ☐ Mediterranean ☐ Asian ☐ Ashkenazi ☐ Middle Eastern

☐ Other: _____

FAMILY MEDICAL HISTORY

Describe any medical conditions in your family	Mother	Father	Grand-mother	Grand-father	Sisters/ Brothers	Children	Aunts / Uncles	Other

NUTRITIONAL AND LIFESTYLE BACKGROUND

NUTRITIONAL HISTORY

Have you ever had a **nutritional consultation**? ☐ Yes ☐ No

Have you **made any changes** in your eating habits because of your health? ☐ No ☐ Yes, what changes have you made:

_____

Do you currently follow a special diet or nutritional program? ☐ No ☐ Yes, what does it involve?

_____

Height (metres): _____ **Current Weight:** _____

Usual Weight Range: _____ Desired Weight Range: _____

Highest Adult Weight: _____ Lowest Adult Weight: _____

Weight Fluctuations (>5kg): ☐ Yes ☐ No Body Fat %: _____

How often do you weight yourself? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Have you ever had your metabolism (resting metabolic rate) checked? ☐ Yes, what was it: _____ ☐ No

Do you **avoid any particular foods**? ☐ No ☐ Yes, type and reason:

_____

_____

If you could **only eat a few foods a week**, what would they be? Which foods can't you live without?

_____

Do you have any **symptoms immediately after eating** e.g. belching, bloating, sneezing, hives, etc?

_____

Do you feel you have **delayed symptoms** after eating certain foods (symptoms may not be evident for 24 hours or more) e.g. fatigue, muscle aches, sinus congestion, etc. ☐ No ☐ Yes, Please explain:

_____

Does **skipping a meal** greatly affect your symptoms? ☐ Feel much better ☐ Feel much worse

Have you ever had a food that you craved or really **"binged"** on over a period of time? *Food craving may be an indicator that you may be allergic or sensitive to that food.* ☐ No ☐ Yes, please explain:

_____

Do you **grocery shop**? ☐ Yes ☐ No, who does the shopping? _____

How many meals do you **eat out** per week? ☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ >5 meals per week

Check all the factors that apply to your current lifestyle and eating habits:

☐ Fast eater
☐ Erratic eating pattern
☐ Eat too much
☐ Late night eating
☐ Dislike healthy food
☐ Time constraints
☐ Eat more than 50% meals away from home
☐ Travel frequently
☐ Non-availability of healthy foods
☐ Do not plan meals or menus
☐ Reliance on convenience items
☐ Poor snack choices
☐ Significant other or family members don't like healthy foods
☐ Significant other or family members have special dietary needs or food preferences
☐ Love to eat
☐ Eat because I have to
☐ Have a negative relationship to food
☐ Struggle with eating issues
☐ Emotional eater (eat when sad, lonely, depressed, bored)
☐ Eat too much under stress
☐ Eat too little under stress
☐ Don't care to cook
☐ Eating in the middle of the night
☐ Confused about nutrition advice

The most **important thing** I should change about my diet to improve my health is:

_____

_____

SMOKING

Currently Smoking? ☐ No ☐ Yes: How many years _____ and Amount per day: _____ Attempts to quit: _____

Previously Smoking? ☐ No ☐ Yes: How many years _____ and Amount per day: _____

Second Hand Smoke Exposure? _____

ALCOHOL INTAKE

How **many drinks** currently per week? ***1 drink*** *= 150ml wine, 360ml beer, 45ml beer*

☐ None *(Skip to Other Substances)* ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ > 10

Previous alcohol intake? ☐ Yes *(☐ Mild ☐ Moderate ☐ High)* ☐ None

Have you ever **been told** you should cut down your alcohol intake? ☐ Yes ☐ No

Do you get annoyed when people ask you about your drinking? ☐ Yes ☐ No

Do you ever feel guilty about your alcohol consumption? ☐ Yes ☐ No

Do you ever take an eye-opener? ☐ Yes ☐ No

Do you notice a **tolerance to alcohol** (can you "hold" more than others)? ☐ Yes ☐ No

Have you ever been unable to remember what you did during a drinking episode? ☐ Yes ☐ No

Do you get into arguments or physical fights when you have been drinking? ☐ Yes ☐ No

Have you ever been arrested or hospitalized because of drinking? ☐ Yes ☐ No

Have you ever thought about getting help to control or stop your drinking? ☐ Yes ☐ No

OTHER SUBSTANCES

Caffeine Intake: ☐ No ☐ Yes: **Coffee** cups/day: ☐ 1 ☐ 2-4 ☐ > 4 | **Tea** cups/day: ☐ 1 ☐ 2-4 ☐ > 4

Caffeinated Sodas or Diet Sodas Intake: ☐ No ☐ Yes

360ml can/bottle ☐ 1 ☐ 2-4 ☐ > 4 per day

List favourite type (Ex. Diet Coke, Pepsi, etc.): _____

Are you currently using any **recreational drugs**? ☐ No ☐ Yes, type: _____

Have you ever used IV or inhaled recreational drugs? ☐ Yes ☐ No

EXERCISE

Activity	Type	Frequency per Week	Duration in Minutes
Stretching			
Cardio / Aerobics			
Strength			
Other (yoga, pilates, gyrotonics, etc.)			
Sport or Leisure Activities (golf, tennis, etc.)			
Other:			

Do you do any **competitive sport**, or participate on a provincial or national level? _____

Rate your levels of **motivation** for including exercise in your life? ☐ Low ☐ Medium ☐ High

List **problems that limit activity**: _____

Do you feel unusually **fatigued after exercise**? ☐ No ☐ Yes, please describe: _____

Do you usually **sweat** when exercising? ☐ Yes ☐ No

PSYCHOSOCIAL

Do you feel significantly less vital than you did a year ago? ☐ Yes ☐ No

Are you happy? ☐ Yes ☐ No

Do you feel your life has meaning and purpose? ☐ Yes ☐ No

Do you believe stress is presently reducing the quality of your life? ☐ Yes ☐ No

Do you like the work you do? ☐ Yes ☐ No

Have you ever experienced major losses in your life? ☐ Yes ☐ No

Do you spend the majority of your time and money to fulfil responsibilities and obligations? ☐ Yes ☐ No

Would you describe your experience as a child in your family as happy and secure? ☐ Yes ☐ No

STRESS / COPING

Have you ever sought counselling? ☐ Yes ☐ No

Are you **currently in therapy**? ☐ No ☐ Yes, describe:

_____

Do you feel you have an **excessive amount of stress** in your life? ☐ Yes ☐ No

Do you feel you can **easily handle the stress** in your life? ☐ Yes ☐ No

Daily Stressors: *Rate on scale of 1-10*

Work _____ Family _____ Social _____ Finances_____ Health_____ Other_____

Do you **practice meditation or relaxation techniques**? ☐ Yes, how often? _____ ☐ No

Check all that apply: ☐ Yoga ☐ Meditation ☐ Imagery ☐ Breathing ☐ Tai Chi ☐ Prayer ☐ Other: _____

Have you ever been abused, a victim of a crime, or experienced a significant trauma? ☐ Yes ☐ No

Do you experience any of the following?

☐ Excessive Fatigue	☐ Dry & Thin Skin	☐ Nervous or Irritability	☐ Low Body Temperature
☐ Inability to concentrate	☐ Mental Depression	☐ Food Allergies & Sensitivities	☐ Craving for Sweets
☐ Headaches	☐ Alcohol Intolerance	☐ Poor Memory	☐ Heart Palpitations
☐ Chronic Pain	☐ Chronic Inflammation	☐Premenstrual Tension	

WORK ENVIRONMENT / EMPLOYMENT

What **type** of work do you do? _____

What **position** do you hold? _____

Do you work night shifts? ☐ Yes ☐ No

Do you stay **far away** from work / have to drive in traffic? _____

What are your normal working hours? _____

SLEEP / REST

Average **number of hours** you sleep per night: ☐ >10 ☐ 8-10 ☐ 6-8 ☐ < 6

Do you have trouble **falling asleep**? ☐ Yes ☐ No

Do you feel **rested** upon awakening? ☐ Yes ☐ No

Do you have problems with **insomnia**? ☐ Yes ☐ No

Do you **snore**? ☐ Yes ☐ No

Do you use **sleeping aids**? ☐ Yes, Explain: _____ ☐ No

ROLES AND RELATIONSHIPS

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Long Term Partnership ☐ Widow

List Children:

Child's Name	Age	Gender

Who is **living in the household**? Number: _____ Names: _____

Their Employment / Occupations: _____

Resources for **emotional support**? *Check all that apply:* ☐ Spouse ☐ Family ☐ Friends ☐ Religious / Spiritual ☐ Pets

☐ Other: _____

ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

Do you have known **adverse food reactions or sensitivities**? ☐ No ☐ Yes, describe symptoms: _____

_____

Do you have any **food allergies or sensitivities**? ☐ No ☐ Yes, list all: _____

Do you have an **adverse reaction to caffeine**? ☐ No ☐ Yes

When you drink caffeine do you feel: ☐ Irritable or Wired ☐ Aches & Pains

Do you **adversely react to** *(Check all that apply):*

☐ Monosodium glutamate (MSG) ☐ Aspartame (Sweeteners) ☐ Caffeine ☐ Bananas ☐ Garlic ☐ Onion

☐ Cheese ☐ Citrus Foods ☐ Chocolate ☐ Alcohol ☐ Red Wine

☐ Sulphite Containing Foods (wine, dried fruit, salad bars) ☐ Preservatives (ex. sodium benzoate)

☐ Other:_____

Which of these significantly affect you? *Check all that apply:*

☐ Cigarette Smoke ☐ Perfumes/Colognes ☐ Auto Exhaust Fumes ☐ Other: _____

In your work or home environment, are **you exposed to:** ☐ Chemicals ☐ Electromagnetic Radiation ☐ Mold

Have you ever turned **yellow** (jaundiced)? ☐ Yes ☐ No

Have you ever been told you have **Gilbert's syndrome or a liver disorder**? ☐ No ☐ Yes

Do you have a known history of **significant exposure to any harmful chemicals** such as the following:

☐ Herbicides ☐ Insecticides (frequent visits of exterminator) ☐ Pesticides ☐ Organic Solvents

☐ Heavy Metals ☐ Other_____

Chemical Name, Date, Length of Exposure: _____

Do you **dry clean your clothes** frequently? ☐ Yes ☐ No

Do you or have **you lived or worked in a damp or mouldy environment** or had other mold exposures? ☐ Yes ☐ No

Do you have **any pets or farm animals**? ☐ Yes ☐ No

SYMPTOM REVIEW

*Please check all current symptoms occurring or present in the **past 6 months***

GENERAL
- ☐ Cold Hands & Feet
- ☐ Cold Intolerance
- ☐ Low Body Temperature
- ☐ Low Blood Pressure
- ☐ Daytime Sleepiness
- ☐ Difficulty Falling Asleep
- ☐ Early Waking
- ☐ Fatigue
- ☐ Fever
- ☐ Flushing
- ☐ Heat Intolerance
- ☐ Night Waking
- ☐ Nightmares
- ☐ No Dream Recall

MUSCULOSKELETAL
- ☐ Back Muscle Spasm
- ☐ Calf Cramps
- ☐ Chest Tightness
- ☐ Foot Cramps
- ☐ Joint Deformity
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Stiffness
- ☐ Muscle Pain
- ☐ Muscle Spasms
- ☐ Muscle Stiffness
- Muscle Twitches
  - ☐ Around the Eye
  - ☐ Arms/Legs
- ☐ Muscle Weakness
- ☐ Neck Muscle Spasm
- ☐ Tendonitis
- ☐ Tension Headaches
- ☐ TMJ Problems
- ☐ Delayed Onset Muscle Pain

SKIN PROBLEMS
- ☐ Acne on Back, Chest, Shoulders
- ☐ Acne on Face
- ☐ Ahtlete's Foot
- ☐ Bumps on Back of Upper Arms
- ☐ Cellulite
- ☐ Dark Circle Under Eyes
- ☐ Dryness of Eyes
- ☐ Dryness of Feet e.g Cracking
- ☐ Ears Get Red
- ☐ Easy Bruising
- ☐ Lack of Sweating
- ☐ Eczema
- ☐ Hives
- ☐ Itching Skin
- ☐ Jock Itch
- ☐ Lackluster Skin
- ☐ Moles Change: Colour/Size
- ☐ Oily Skin
- ☐ Pale Skin
- ☐ Patchy Dullness
- ☐ Rash, Red Face
- ☐ Sensitivity to Poison Ivy/Oak
- ☐ Shingles
- ☐ Skin Darkening
- ☐ Strong Body Odor
- ☐ Hair Loss
- ☐ Vitiligo

HEADS, EYES & EARS
- ☐ Conjunctivitis
- ☐ Distorted Sense of Smell
- ☐ Distorted Taste
- ☐ Ear Fullness
- ☐ Ear Pain
- ☐ Ear Ringing / Buzzing
- ☐ Lid Margin Redness
- ☐ Eye Crusting
- ☐ Eye Pain
- ☐ Hearing Loss
- ☐ Hearing Problems
- ☐ Headache
- ☐ Migraine
- ☐ Sensitivity to Loud Noises
- ☐ Vision Problems (other than glasses)
- ☐ Macular Degeneration
- ☐ Vitreous Detachment
- ☐ Retinal Detachment

MOOD AND NERVES
- ☐ Agoraphobia
- ☐ Anxiety
- ☐ Auditory Hallucinations
- ☐ Black-out
- ☐ Depression
- ☐ Difficulty Concentrating
- ☐ Difficulty with Balance
- ☐ Difficulty Judgement
- ☐ Difficulty with Speech
- ☐ Difficulty with Memory
- ☐ Dizziness (spinning)
- ☐ Fainting
- ☐ Fearfulness
- ☐ Irritability
- ☐ Light-headedness
- ☐ Numbness
- ☐ Other Phobias
- ☐ Panic Attacks
- ☐ Paranoia
- ☐ Seizures
- ☐ Suicidal Thoughts
- ☐ Tingling
- ☐ Tremor / Trembling
- ☐ Visual Hallucinations

LYMPH NODES
- ☐ Enlarged inneck
- ☐ Tender in neck
- ☐ Other Enlarged / Tender
- ☐ Lymph Nodes

RESPIRATORY
- ☐ Bad Breath
- ☐ Bad Odor in Nose
- ☐ Cough – Dry
- ☐ Cough – Productive
- ☐ Hoarseness
- ☐ Sore Throat
- ☐ Hay Fever
- ☐ Nasal Stuffiness
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Fullness
- ☐ Sinus Infection
- ☐ Snoring or Wheezing

DIGESTION
- ☐ Anal Spasms
- ☐ Bad Breath
- ☐ Bleeding of Gums
- ☐ Bloating of Lower Abdomen
- ☐ Bloating of Whole Abdomen
- ☐ Bloating After Meals
- ☐ Blood in Stools
- ☐ Burping
- ☐ Canker Sores
- ☐ Cold Sores
- ☐ Constipation
- ☐ Cracking at Corner of Lips
- ☐ Cramps
- ☐ Dentures with Poor Chewing
- ☐ Diarrhea
- ☐ Alternating Diarrhoea and Constipation
- ☐ Difficulty Swallowing
- ☐ Dry Mouth
- ☐ Excess Flatulence / Gas
- ☐ Foods "Repeat" (Reflux)
- ☐ Gas
- ☐ Heartburn
- ☐ Haemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Upper Abdominal Pain
- ☐ Vomiting

Intolerance to:

- ☐ *Lactose*
- ☐ *All Dairy Products*
- ☐ *Wheat*
- ☐ *Gluten (Wheat, Rye, Barley)*
- ☐ *Corn*
- ☐ *Eggs*
- ☐ *Fatty Foods*
- ☐ *Yeast*

- ☐ Jaundice (Yellow Eyes /Skin)
- ☐ Abnormal Liver Function Test
- ☐ Lower abdominal Pain
- ☐ Mucus in Stools
- ☐ Peridontal Disease
- ☐ Sore Tongue
- ☐ Strong Stool Odor
- ☐ Undigested Food in Stools

EATING
- ☐ Binge eating
- ☐ Bulimia
- ☐ Can't Gain Weight
- ☐ Can't Lose Weight
- ☐ Can't Maintain Healthy weight
- ☐ Frequent Dieting
- ☐ Poor Appetite
- ☐ Salt Cravings
- ☐ Carbohydrate Craving (bread, pasta)
- ☐ Sweet Cravings (candy, cookies, cakes)
- ☐ Chocolate Cravings
- ☐ Caffeine Dependency

MALE REPRODUCTIVE
- ☐ Genital Pain, Poor Libido, Discharge
- ☐ Impotence, Ejaculation Problems
- ☐ Prostate or Urinary Infections
- ☐ Lumps in Testicles

NAILS

- ☐ Bitten
- ☐ Brittle
- ☐ Curve Up
- ☐ Frayed
- ☐ Fungus -Fingers
- ☐ Fungus - Toes
- ☐ Pitting
- ☐ Ragged Cuticles
- ☐ Ridges
- ☐ Soft
- ☐ Thickening of Nails
- ☐ White Spots / Lines

CARDIOVASCULAR

- ☐ Angina / Chest Pain
- ☐ Breathlessness
- ☐ Heart Murmur
- ☐ Irregular Pulse
- ☐ Palpitations
- ☐ Phlebitis
- ☐ Swollen Ankles / Feet
- ☐ Varicose Veins

URINARY

- ☐ Bed Wetting
- ☐ Hesitancy (trouble getting started)
- ☐ Infection
- ☐ Kidney Disease
- ☐ Leaking / Incontinence
- ☐ Pain / Burning
- ☐ Prostate Infection
- ☐ Urgency

FEMALE REPRODUCTIVE

- ☐ Breast Cysts
- ☐ Breast Lumps
- ☐ Breast Tenderness
- ☐ Ovarian Cysts
- ☐ Poor Libido (Sex Drive)
- ☐ Vaginal Discharge
- ☐ Vaginal Itch
- ☐ Vaginal Pain with Sex
- ☐ **Premenstrual:**
- ☐ Bloating Breast Tenderness
- ☐ Carbohydrate Craving
- ☐ Chocolate Craving
- ☐ Constipation
- ☐ Decreased Sleep
- ☐ Diarrhoea
- ☐ Fatigue
- ☐ Increased Sleep
- ☐ Irritability
- ☐ **Menstrual:**
- ☐ Cramps
- ☐ Heavy Periods
- ☐ Irregular Periods
- ☐ No Periods
- ☐ Scanty Periods
- ☐ Spotting Between

OTHER

READINESS ASSESSMENT

In order to improve your health, how willing are you to:

Significantly modify your diet . . . . . ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Take several nutritional supplements each day. . . . . ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Keep a record of everything you eat each day . . . . . ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Modify your lifestyle (e.g., work demands, sleep habits). . . . . ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Practice a relaxation technique . . . . . ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Engage in regular exercise . . . . . ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Have periodic lab tests to assess your progress . . . . . ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Any comments:

How confident are you of your ability to organize and follow through on the above health related activities?

☐ 5 (very confident) ☐ 4 ☐ 3 ☐ 2 ☐ 1 (not confident at all).

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities?

At the present time, how supportive do you think the people in your household will be to your implementing the above changes?

☐ 5 (very supportive) ☐ 4 ☐ 3 ☐ 2 ☐ 1 (not supportive at all)

Comment:

How much on-going support and contact (e.g., telephone consults, e-mail correspondence) from our professional staff would be helpful to you as you implement your personal health program?

☐ 5 (very frequent contact) ☐ 4 ☐ 3 ☐ 2 ☐ 1 (very infrequent contact)

Comment:

3-DAY DIET DIARY INSTRUCTIONS

It is important to keep an **accurate record** of your **usual food and beverage intake** as a part of your treatment plan.

Please complete this Diet Diary for **3 consecutive days** including **one weekend day**.

Do not change your eating behaviour at this time, as the purpose of this food record is to analyse your present eating habits.

Record information as soon as possible after the food has been consumed

Describe the food or beverage as accurately as possible e.g., milk – what kind? (full cream, low fat, fat free, 2%, lactose free); toast (whole wheat, white, buttered); chicken (fried, baked, breaded); coffee (decaffeinated with sugar and ½ & ½). Use brands as far as possible.

Record the amount of each food or beverage consumed using standard measurements such as 90 grams, ½ cup, 1 teaspoon, etc.

Include any added items. For example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.

Record all beverages, including water, coffee, tea, sports drinks, sodas/diet sodas, etc.

Include any additional comments about your eating habits on this form (ex. craving sweet, skipped meal and why, when the meal was at a restaurant, etc).

Please note all bowel movements and their consistency (regular, loose, firm, etc.)

DIET DIARY

DATE: _____ **DAY 2:** _____

Time	Food / Beverage / Amount	Comments

Bowel Movement: _____

Stress/ Mood / Emotions: _____

Other Comments: _____

DATE: _____ **DAY 2:** _____

Time	Food / Beverage / Amount	Comments

Bowel Movement: _____

Stress/ Mood / Emotions: _____

Other Comments: _____

DATE: _____ **DAY 3:** _____

Time	Food / Beverage / Amount	Comments

Bowel Movement: _____

Stress/ Mood / Emotions: _____

Other Comments: _____

MSQ - MEDICAL SYMPTOM/TOXICITY QUESTIONNAIRE

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are completing this after your first time, then record your symptoms for the ***last 48 hours ONLY***

Point Scale
0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

DIGESTIVE TRACT
- Nausea or Vomiting
- Diarrhoea
- Constipation
- Bloated feeling
- Belching or passing gas
- Heartburn
- Intestinal / Stomach Pain

TOTAL _____

EARS
- Itchy Ears
- Earaches, ear infections
- Drainage from ear
- Ringing in ears, hearing loss

TOTAL _____

EMOTIONS
- Mood Swings
- Anxiety, fear or nervousness
- Anger, irritability or aggressiveness
- Depression

TOTAL _____

ENERGY / ACTIVITY
- Fatigue, sluggishness
- Apathy, lethargy
- Hyperactivity
- Restlessness

TOTAL _____

EYES
- Watery or itchy ears
- Swollen, reddened or sticky eyelids
- Bags or dark circles under eyes
- Blurred or tunnel vision

TOTAL _____

HEAD
- Headaches
- Faintness
- Dizziness
- Insomnia

TOTAL _____

HEART
- Irregular or skipped heartbeat
- Rapid or pounding heartbeat
- Chest pain

TOTAL _____

JOINT/MUSCLES
- Pain or aches in joints
- Arthritis
- Stiffness or limitation of movement
- Pain or aches in muscles
- Feeling of weakness or tiredness

TOTAL _____

LUNGS
- Chest congestion
- Asthma, bronchitis
- Shortness of breath
- Difficult breathing

TOTAL _____

MIND
- Poor memory
- Confusion, poor comprehension
- Poor concentration
- Poor physical coordination
- Difficulty in making decisions
- Stuttering or stammering
- Slurred speech
- Learning disabilities

TOTAL _____

MOUTH / THROAT
- Chronic Cough
- Gagging, frequent need to clear throat
- Sore throat, hoarseness, loss of voice
- Swollen/discoloured tongue, gums, lips
- Canker sores

TOTAL _____

NOSE
- Stuffy Nose
- Sinus problems
- Hay fever
- Sneezing attacks
- Excessive mucus formation

TOTAL _____

SKIN
- Acne
- Hives, rashes or dry skin
- Hair loss
- Flushing or hot flushes
- Excessive sweating

TOTAL _____

WEIGHT
- Binge eating / drinking
- Craving certain foods
- Excessive weight
- Compulsive eating
- Water retention
- Underweight

TOTAL _____

OTHER
- Frequent illness
- Frequent or urgent urination
- Genital itch or discharge

TOTAL _____

GRAND TOTAL _____