Questionnaire

	Date:				
Name:	Date of birth:	Age:			
	City:	State/Zip			
Contact Telephone:	E-mail:				
Occupation:					
🗆 Fulltime 🗆 Par	rt time 🗆 Unemployed 🗆 Self-emplo	by ed \square At home			
Employer					
Sex: F M Height:	Weight:3 years age	0			
Living situation: \Box Alone \Box Pa	rtner Spouse Friends Parents	\Box Children \Box Pets			
Current diagnosis/main	symptoms I would like to add	dress:			
Family Doctor:	nily Doctor: Tel:				
Last physical exam:					
Medical History: list all surge	eries &dates:				
Allergies:					
Family History: major health	issues in the family (mother, father	, siblings):			
What treatments have you at	tomated any iously (conventioned	l/altomativa)?			
what treatments have you at	ttempted previously (conventiona				
Medications currently taking	g and for what condition:				
NT1	4-1-1				
Natural supplements currently	taking:				

My health goals:

Check how do you feel during a typical day: $(1 = \text{worst}, 10 = \text{best})$, you can check a range $(e.g.4 - 6)$												
□ 1			□ 4	□ 5		□ 7		□ 9	□ 10			
How many hours of sleep do you get each night?Do you wake up rested?												
Are you on any special diet?												
Do you know your blood type? $\Box A \Box B \Box AB \Box O$ Don't know \Box												
Do you use artificial sweeteners? \Box YES \Box NO Do you use margarine? \Box YES \Box NO												
Do you buy organic food? □ YES □ NO How many times a week do you eat fish?												
What type of cooking oil do you use at home?												
How many hours per week do you work out?												
How many hours do you watch TV in a week?												
Favorite recreational activities:												
How many hours of sleep do you get each night?Do you wake up rested?												
Level of stress : 1-10 (10 = highest)												
Coffee		c	ups/day	у			Alcoho	ol		_drinks/ week		
Typical	l breakfas	st:										
Typical breakfast: Typical lunch:												
Drinks	during th	e day:										
Snacks	during th	ne day:										
ΤΟΧΙΟ	C EXPOS	SURE:										
Do you drink - 🗆 tap water 🗆 bottled water 🗆 purified water?												
Have you recently remodeled your house?												
Do you work with X-rays, computers or other sources of radiation?												
Do you have mold in your house?												
Do you smoke?How often have you taken anti-biotics?												
Reactions to vaccinations?												
Dental	problems	?		n	umber o	f fillings		root	canals			
Dental problems?number of fillingsroot canals Recreational drugs?												
Exposure to fumes/chemicals/pesticides?												

Current symptoms most or some of the time:

- □ Frequent gas/bloating \Box Pain under the ribcage \Box left \Box right □ Frequent indigestion □ Frequent heartburn/use of antacids □ Constipation □ Unusual stool consistency or color Diarrhea □ Intolerance to fatty foods □ Stomach pain after eating □ Gallbladder attacks/GB removed □ Nausea/Vomiting □ White/yellow coated tongue □ Fatty foods cause problem \square Food reactions – which ones if □ Loss of appetite known: □ Blurred vision □ Sugar cravings □ Irritable if meals missed □ Fatigue after meals □ Frequent urination □ Eating relieves fatigue □ Nervous, agitated □ Increased thirst □ Headaches (afternoons, or stress related) \Box Crave salt □ Cannot fall or stay asleep □ Perspire easily □ Slow starter in the morning □ Wake up tired □ Dizzy if stand up quickly □ Weight gain under stress □ Tired/sluggish □ Thinning of hair □ Feel cold (hands, feet, all over) □ Heart palpitations \square Needs a lot of sleep □ Inward trembling □ Nervous/emotional □ Gain weight even on low calorie diet □ Depression/mental sluggishness 🗆 Insomnia \Box Outer third of eyebrows thins □ Night sweats □ Intolerance to smells, chemicals, cosmetics □ Muscle cramping □ Skin outbreaks/acne □ Osteoporosis □ Foul smelling sweat □ Joint pain, where? □ Edema/swollen ankles or wrists \Box Frequent cold sores □ Bumpy skin on arms \Box Ringing in the ears \Box Get sick often □ Gets boils/sties □ Frequent urination □ Sinus/nasal congestion □ Chest pain □ Painful urination \Box Chronic cough
- □ Asthma
- □ Shallow breathing
- \Box Sensitive to smog
- \Box Sore throat
- □ Bleeding gums

MEN:

- □ Decreased libido/problem with erection
- \square Pain inside of legs
- □ Legs twitching at night
- □ Inability to concentrate
- □ Muscle soreness
- Decreased physical stamina

- \square Nosebleeds
- \Box Tendency to anemia
- □ Bruise easily
- □ Shortness of breath
- □ Numbness in extremities
- □ Weakness/fatigue
- WOMEN:
- □ Irregular, too short or too long menstrual cycle
- □ Painful period/cramping
- $\square PMS$
- □ Heavy bleeding
- \square Mood swings
- □ Hot flashes/night sweats

- □ Strong smelling urine □ Lower back pain □ Dark circles under eyes □ Frequent infections?
- Where?