

Family Life:

What is your marital status? M S D W Do you have children? Yes No
Number of children: _____ Ages: _____

Medical Information:

Please list any physicians you see and their specialty:

Diabetes:

Do you have diabetes? Yes No (if no, skip to next section)

If so, are you under the care of a physician? Yes No

If so, which type?

- Type I – insulin dependent (insulin injections only)
- Type II – non-insulin dependent (diabetic pills)
- Type II – insulin dependent (diabetic pills and insulin)

Is your blood sugar level monitored? Yes No

If so, by whom? Myself Physician Other (specify):

Are you taking any medication? Yes No

If so, please list:

Do you tend to be hypoglycemic? Yes No

Cardiovascular Function:

Have you had a cardiovascular event? Yes No (if no, skip to next section)

If so, please specify:

How long ago?

If so, are you under the care of a physician? Yes No

Are you taking any medication? Yes No

If so, please list:

Do you have a history of arrhythmia Yes No

Have you been diagnosed with Congestive Heart Failure (CHF) Yes No

Hypertension:

Do you have high blood pressure? Yes No (if no, skip to next section)

If so, do you have your blood pressure checked? Yes No

If so, are you under the care of a physician? Yes No

Are you taking any medication? Yes No

If so, please list:

Kidney Function:

Have you been diagnosed with kidney disease? Yes No
If so, are you under the care of a physician? Yes No
Are you taking any medication? Yes No
If so, please list:

Have you ever had Kidney Stones? Yes No
Have you ever had Gout? Yes No

Liver Function:

Do you have liver problems? Yes No (if no, skip to next section)
If so, please specify:

If so, are you under the care of a physician? Yes No
Are you taking any medication? Yes No
If so, please list:

Colon Function:

Do you have: Irritable Bowel Colitis Diarrhea Diverticulosis?
 Crohn's disease Constipation
If so, are you under the care of a physician? Yes No
Are you taking any medication? Yes No
If so, please list:

Stomach/Digestive Function:

Do you have: Acid Reflux Gastric Ulcer Heartburn Celiac Disease?
If so, are you under the care of a physician? Yes No
Are you taking any medication? Yes No
If so, please list:

Ovarian/Breast Function:

Check off the situations that apply to you currently:
 Irregular Periods Menopause Fibrocystic Breasts
 Painful Periods Hysterectomy Heavy periods
 Amenorrhea Uterine Fibroma Cancer (uterus, breast)
If so, are you under the care of a physician? Yes No
Are you taking any medication? Yes No
If so, please list:

Please indicate the date of your last menstrual cycle:

Thyroid Function:

Do you have thyroid problems? Yes No (if no, skip to next section)
If so, are you under the care of a physician? Yes No
Are you taking any medication? Yes No
If so, please list: _____

Emotional Evaluation:

Do any of the following apply to you? (if no, skip to next section)
 Depression Anxiety Panic Attacks
 Bulimia (or history of) Anorexia (or history of)
If so, are you under the care of a physician? Yes No
Are you taking any medication? Yes No
If so, please list: _____

Inflammatory Conditions:

Do any of the following apply to you? (if no, skip to next section)
 Migraines Fibromyalgia Rheumatoid Arthritis Lupus
 Osteoarthritis
 Chronic Fatigue Syndrome Psoriasis
 Other autoimmune or inflammatory condition: _____

If so, are you under the care of a physician? Yes No
Are you taking any medication? Yes No
If so, please list: _____

General:

Do you have Parkinson's disease? Yes No
Do you have Cancer? Yes No
Are you in Cancer remission? Yes No
If so, please specify and indicate for how long: _____
If so, are you under the care of a physician? Yes No
Are you taking any medication? Yes No
If so, please list: _____

Are you generally fatigued or have low energy? Yes No

Are you pregnant? Yes No Are you breastfeeding? Yes No

Do you get cold easily? Yes No Do you have cold hands/feet? Yes No

Do you have other health problems? Yes No

If so, please specify: _____
If so, are you under the care of a physician? Yes No
Are you taking any other medications not listed above? Yes No
If so, please list: _____

