Name: ______________________________

Date of Birth: ___________________ **Date:** ________________

If you have significant health problems, how many years would you consider yourself in relatively poor health? _____________

Estimate of how many mainstream practitioners you've seen. _____

Estimate of how many alternative practitioners you've seen. _____

To you knowledge, have you ever lived in house with mold or water damage? (Yes or No) _____

Diet (circle the one that is closest to yours)

1. "Clean diet" – mostly organic, mostly plants
2. Good diet – variety of meats, vegetables, and fruits prepared from scratch, largely or completely nonorganic
3. Regular American – "meat and potatoes" kind of food
4. "On the go" – mostly processed, pre-prepared, fast food restaurants, and/or purchased "heat and eat" foods
5. Irregular / mixed – no consistent pattern of the above

Smoking history? Yes or No (Circle one) If yes, how many years have you smoked? _____

Level of physical activity/exercise (Circle the one that most reflects a typical week)

1. Daily
2. 3-5 times per week
3. 1-2 times per week
4. Inconsistently or 0 times per week

Please rate these from 0-10. (O means it is not an issue for you and 10 is a prominent issue for you with major impact on your quality of life.)

fatigue ______	depression ______
tender lumps/bumps ______	nervousness/anxiety ______
irritability ______	trouble sleeping ______
impaired memory, confused easily ______	impaired concentration, brain fog ______
sugar craving ______	prone to low blood sugar ______
salt cravings ______	excessive sweating ______
palpitations ______	headaches ______
dizziness ______	blurry vision ______
nasal congestion ______	ringing in the ears ______
leg cramps ______	gas and bloating ______
constipation, hard stools ______	diarrhea, loose stools ______
gastrointestinal symptoms within 5-10 minutes of eating ______	frequent urination out of proportion to fluid to fluid intake ______
difficulty with weight loss ______	unexplained itching ______
rashes ______	painful intercourse ______
testicular/pelvic pain ______	menstrual irregularities ______
loss of libido or interest in sexual activity ______	hair loss or thinning ______
muscle pain ______	joint pain ______
unexplained muscle twitching ______	muscle cramps ______
numbness, tingling, burning ______	frequent swollen glands ______
tick exposure ______	shortness of breath ______
prone to electric shocks ______	prone to bleeding/bruising ______
sensitive to medications and prone to side effects ______	hypersensitive to sounds/noise ______
hypersensitive to smells ______	hypersensitive to light ______
frequent colds and infections ______	