SYMPTOM SURVEY FORM **DATE:**_____

Name:		Sex (M or F):
Address:		
City:	State:	Zip:
Phone/Cell Phone:	Email:	
Age:	Weight:	Height:

Please list your three main physical concerns

1. _____
2. _____
3. _____

What type of work do you do? _____Hours per week _____

Do you have children? How many _____ Any C-sections? _____(females)

Do you have or suspect any food allergies?_____

Where did you grow up? _____ City or Farm/Ranch? _____

Do you exercise 3 or more times per week?_____ Type of exercise:_____

Have you ever taken medication for acne? _____

Have you had any surgeries? _____ If yes, please list them below:

Have you been given a diagnosis/name for your “dis-ease”? If so, please list below:

Are you currently taking any prescription or over-the-counter drugs? If so, please list below:

REMEMBER TO BRING ALL MEDICATIONS & SUPPLEMENTS WITH YOU FOR EACH APPOINTMENT!

For each question, circle the number that best describes your symptoms, **if it does not apply to you just leave the question blank:**

1 = Occasionally
2 = Often - Symptom occurs 2-3 times per week and/or with a frequency that bothers you enough that you would like to do something about it
3 = Frequently—Symptom occurs 4 or more times per week and/or you are aware of the symptom every day, or it occurs with regularity on a monthly or cyclical basis

Some questions require a YES or NO response

Bowel/Digestion		**Liver/Gallbladder**	
Indigestion or Heart Burn	**1 2 3**	Skin peels on feet or you have burning feet.	**Yes No**
Belching and/or Bloating after meals	**1 2 3**	Frequent headaches?	**Yes No**
Do you use antacids or a prescription for acid reflux?	**Yes No**	Use of Tylenol (acetaminophen) on a regular basis - at least once per week.	**Yes No**
Diarrhea (loose, unformed stool)	**1 2 3**	Do you get migraines?	**Yes No**
Alternating constipation/diarrhea	**1 2 3**	Hay fever or seasonal allergies?	**Yes No**
Constipation (less than one stool movement per day- or straining)	**1 2 3**	Greasy foods upset?	**Yes No**
Do you have colitis, or irritable bowels?	**Yes No**	Do you have a gallbladder?	**Yes No**
Bowel movements shortly after eating (within one hour)	**Yes No**	Frequent skin rashes/eczema?	**Yes No**
Pass mucus in your stool	**1 2 3**	Have you had hemorrhoids?	**Yes No**
Rectal/anal itching or burning?	**Yes No**	Do you have tenderness under your ribs on the right side of your body?	**Yes No**
Have you ever had food poisoning?	**Yes No**	Have you ever had a gallbladder attack?	**Yes No**
How many antibiotics have you used in the last 5 years?	**#**	How many flu vaccinations have you received?	**#**
Have you had any yeast infections?	**Yes No**	Do you get cold sores or herpes outbreaks?	**Yes No**

Emotions/Sleep		**Thyroid/Adrenals/Pituitary**	
Insomnia - most of the night?	**1 2 3**	Feel cold or chilled easily	**1 2 3**
Do you have a hard time falling asleep?	**1 2 3**	I am chronically fatigued; a tiredness that is not usually relieved by sleep.	**1 2 3**
When you have a hard time falling asleep do you find it hard to stop thinking - turn off your brain?	**Yes No**	Outer third of your eyebrow is thinning or disappearing	**Yes No**
Do you get 6-8 hours of sleep?	**Yes No**	Feel slow-moving, sluggish	**1 2 3**
Anxiety, Fear or Nervousness?	**1 2 3**	Swelling in lower neck or “lump in throat” feeling when swallowing	**Yes No**
I often have to force myself in order to keep going. Everything is a chore.	**1 2 3**	Dizzy when rising or standing up from a kneeling position	**1 2 3**
Anger, Irritability, Aggressiveness?	**1 2 3**	Dark circles under your eyes?	**Yes No**
Are you currently taking antidepressants or anxiety meds?	**Yes No**	Course or thinning hair?	**Yes No**
Immune		Do you get hot flashes or night sweats?	**Yes No**
Do you get sinus infections on a yearly basis?	**Yes No**	I have experienced long periods of stress - my life is very stressful.	**Yes No**
Do you get the flu every year or two?	**Yes No**	Gag easily?	**Yes No**
Do you have asthma?	**Yes No**	Need coffee or some other stimulant for energy?	**Yes No**
Do you have an autoimmune disease?	**Yes No**	Muscles are weak or tremble.	**Yes No**
Did you get ear infections or strep throat as a child or now?	**Yes No**	Sensitive to noise or light?	**Yes No**
Have you used prednisone?	**Yes No**	Heat intolerance	**1 2 3**
Do you have frequent joint pain or swelling?	**Yes No**	Inward trembling	**1 2 3**
Do you get hives?	**Yes No**	Do you crave salt or salty food?	**Yes No**
Do you get bronchitis?	**Yes No**	Do you get swollen ankles?	**Yes No**
Were your tonsils removed?	**Yes No**	Have you gained weight around the waist?	**Yes No**

Heart/Kidney		**Sugar Handling**	
Have you ever had kidney stones?	**Yes No**	Get “shaky” if hungry	**1 2 3**
Have you had UTI’s	**Yes No**	“Lightheaded” if meals delayed	**1 2 3**
Do you experience “irregular or a fast heart beats on occasion?	**Yes No**	Tired after eating	**1 2 3**
Shortness of breath	**1 2 3**	Fatigue, eating relieves	**1 2 3**
Do you have high blood pressure?	**Yes No**	Crave bread or sweets	**1 2 3**
Nose bleeds	**1 2 3**	Frequent urination	**1 2 3**
Bruise easily?	**Yes No**	Always thirsty	**1 2 3**
High altitude discomfort	**1 2 3**	Can’t think, foggy brain relieved by eating	**1 2 3**
Hands and feet go to sleep easily.	**1 2 3**	**Musculoskeletal**	
Toe or muscle cramps	**1 2 3**	Joint pain or stiffness	**1 2 3**
Noises in head or ringing ears	**1 2 3**	Stiff or sore feet when getting up in the morning	**1 2 3**
Dull pain or tension in chest	**1 2 3**	Osteoporosis/Osteopenia	**Yes No**
History of using margarine or vegetable oil.	**Yes No**	Leg or toe cramps	**1 2 3**
Eat fast food or at a restaurant more than 2 times a week.	**1 2 3**	Bone Spurs	**Yes No**
Do you eat 3-4 servings of vegetables and fruits every day.	**Yes No**	Swelling, inflammation, of knees or hands?	**Yes No**
How many times per week do you eat red meat?	**#**	Restless legs at night	**Yes No**
Do you drink pop/soda? How many per day?	**#**	Muscle weakness - shake easy with exertion	**Yes No**
Have you ever been anemic?	**Yes No**	Have you used a drug/shot for osteoporosis/osteopenia	**Yes No**
Women Only:		**Men Only:**	
Excessive bleeding during menstruation?	**Yes No**	Urination difficult or dribbling?	**Yes No**
Painful breasts/breast tenderness?	**Yes No**	Frequent night urination?	**Yes No**
Premenstrual Tension?	**Yes No**	Diminished sex drive or ability?	**Yes No**