ASSESSMENT & SYMPTOM FORM **DATE:_____**

Name: Gender (M or F):

Email: Phone:

Address:

City: State: Zip:

Age: Weight: Height:

Occupation:

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

Please list your current and past health conditions (I.e. Type 2 Diabetes, etc.):

Please list any surgeries, including dental: :

What are your most important health concerns or health goals?

Please list any prescription or over-the-counter drugs you take on a regular basis?

Do you exercise 3 or more times per week? _____. Type(s) of exercise: _____

What are your current vitamins and/or supplements?

Family Health History

Yes	No	Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities?
Yes	No	Does anyone in your family experience similar symptoms to yours?
Yes	No	Do you have an immediate family member with a history of cancer?
Yes	No	Do you have an immediate family member with a history of heart disease (heart attack, congestive heart failure, etc.)?
Yes	No	Has an immediate family member ever been diagnosed with bipolar disorder or schizophrenia?
Yes	No	Has an immediate family member had a stroke?
Yes	No	Do you have an immediate family member with an autoimmune disorder?
Yes	No	Do you have an immediate family member with diabetes?

NOTES:

The following questions help identify possible exposures to toxins/chemicals and mold.

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

Do you or have you ever worked where chemicals were common (beauty/nail salon, gold or coal mines, manufacturing, printing office or newspaper office, cleaning services…). List where and dates if possible.

Do you have chemical sensitivities?

Please list your past and present hobbies:

Lead Exposure

Yes	No	Do you get stomach aches in the morning?
Yes	No	Does your current, or past, occupation include soldering or metal salvage?
Yes	No	Have you done any old home repair or sandblasting?
Yes	No	Do you do a lot of painting?
Yes	No	Do you get stomach aches in the morning?
Yes	No	Have you lived in house built before 1978?

General Exposures

Yes	No	Do you primarily eat non-organic fruits and vegetables?
Yes	No	Do you eat at restaurants or fast food once a week or more?
Yes	No	Do you use natural/non-toxic housecleaning supplies?
Yes	No	Have you ever lived near a golf course, freeway or tension wires?
Yes	No	Do you have your house sprayed with pesticides for pest control?
Yes	No	Do you spray herbicide (weed killers) in or around your home?
Yes	No	Do you use conventional insect repellants on your self or family?
Yes	No	Do you use conventional or aerosol sunscreen?
Yes	No	Do you use fragranced body lotions, perfume, or cologne most days?
Yes	No	Do you get your hair colored?
Yes	No	Do you get your nails done? If so, how often? ____
Yes	No	Do you use air freshener in your house, work or car?
Yes	No	Do you drink bottled water - plastic bottles?
Yes	No	Do you drink tap water?
Yes	No	Do you smoke cigarettes? If so, for how long _____
Yes	No	Have you smoked cigarettes within the last 5 years? _____

Have you ever lived in a house that smelled musty, moldy, or had known mold issues? Have you lived in a house that had water damage or a flooded basement? Please list dates if possible.

Current Housing & Mold

How old is the house you are living in? _____ How long have you lived there? _____

Have you noticed any new symptoms since moving in?_____If so, what?_____

Yes	No	Do you see mold growing at home, work or school?
Yes	No	Have you ever had water damage at home, work or school?
Yes	No	Does your home, workplace or school have a damp or mildew smell?
Yes	No	Does spending time in your basement cause or worsen your symptoms?
Yes	No	Does your basement ever get wet?
Yes	No	Do you have a crawl space?
Yes	No	Does anyone in your home have asthma like symptoms?
Yes	No	Does anyone in your family have chronic sinus infections or bronchitis?

Mercury Exposures

Yes	No	Do you have amalgam (silver) fillings in your teeth? If so, How many? ___
Yes	No	Have you had amalgams removed? If Yes, How many_____Date? _____
Yes	No	If you had amalgams removed, was it done by a biological dentist using a safe protocol?
Yes	No	Have you ever worked in a dental office? If so, how long? _____
Yes	No	Have you had any dental crowns? If yes, how many__
Yes	No	Have you had any root canals?
Yes	No	Did you receive yearly flu shots or have you recently received a flu shot?
Yes	No	Have you had more than 4 vaccinations of any kind? How many?_____
Yes	No	Do you eat tuna, shark, swordfish or Atlantic Salmon more than twice a week?
Yes	No	Have you lived in a state that has gold, lithium, or copper mining?

Are there exposures that you feel may be significant? (Water issues in your town/city, exposure to a specific chemical, lead pipes in an old house you lived in or visited frequently, past prescriptions or drugs, etc.)

The questions below provide information about the function of your body systems.

For each question with a 1,2, or 3, 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.

Digestion / Elimination / Bowel Organisms	
1 2 3	Indigestion and/or Heart Burn
1 2 3	Experience excessive gas
1 2 3	Stomach bloating after eating
1 2 3	Stomach burning or sensations that are relieved by eating
Yes No	Do you use antacids or a prescription for acid reflux?
Yes No	Do you alternate between constipation and urgency?
Yes No	Do you have irritated bowels (IBS or IBD)?
Yes No	Do you have or suspect any food allergies or sensitivities? If yes, which foods: _____
1 2 3	Diarrhea, Loose, or Unformed Stool
1 2 3	Constipation (less than one stool movement per day- or straining)
1 2 3	Do you have parts of your stool that float?
1 2 3	Do your stools contain undigested food particles?
1 2 3	Pass mucus in your stool
1 2 3	Do you experience rectal/anal itching?
Yes No	Do you grind or clench your teeth?
Yes No	Have you ever had or suspected food poisoning? Which food(s) did you suspect? _____
Yes No	Have you ever traveled out of the country? Where?_____ _____
Yes No	Have you had a house pet of any kind? List: _____
Yes No	Have you ever had raw fish, (sushi, sashimi, Ahi, ceviche,etc.)?
Yes No	Do you regularly eat pork (chops, sausage, roast, pulled pork, etc.)?
#_____	How many antibiotics have you used in the last 5 years?
Yes No	Have you had a yeast infection?
Yes No	Have you ever taken prednisone / cortisone-type of drug for more than 2 weeks?
Yes No	Are you sensitive to supplements?

Liver / Gallbladder

Yes No	Does you skin peel on your feet or do you have burning feet?
Yes No	Do you get frequent headaches?
Yes No	Do you get migraine headaches?
Yes No	Do greasy foods upset your stomach or digestion?
Yes No	Do you have seasonal allergies or hay fever?
Yes No	Do you have a gallbladder?
Yes No	Have you had a gallbladder attack or gallstones?
Yes No	Do you get rectal/anal burning?
Yes No	Do you have tenderness under your ribs on the right side of your body?
Yes No	Do you use Tylenol (acetaminophen) on a regular basis - at least once per week?
Yes No	Have you had hemorrhoids?
Yes No	Do you get frequent skin rashes/eczema?
1 2 3	Do you have light colored stools?
1 2 3	Do you have nightmares / bad dreams?
Yes No	Have you ever had/have hepatitis A, B, or C?
Yes No	Have you ever had/have herpes?
Yes No	Have you ever had cold sores?
Yes No	Have you ever had mononucleosis / Epstein Barr Virus?
Yes No	Have you ever had anemia (low iron levels)?
Yes No	Have you ever had your vitamin D levels checked? If so, we they low? _____

Thyroid / Pituitary / Adrenals

1 2 3	Intolerance to heat		Yes No	Eyebrows thinning
1 2 3	Inward trembling		Yes No	Sex drive reduced or lacking
1 2 3	Irritable or Moody		Yes No	Excessive sweating or night sweats
1 2 3	Nervousness / Restlessness		1 2 3	Hot Flashes
1 2 3	Eyelids or face twitches		Yes No	Women: hair growth on face
1 2 3	Increased appetite but no weight gain		1 2 3	Dizziness when you stand up
1 2 3	Watery and/or red eyes		1 2 3	Chronically fatigued / no energy
1 2 3	Can’t work under pressure		1 2 3	Tendency to Hives
Yes No	Decreased appetite		Yes No	Low Blood Pressure
Yes No	Increase in weight		1 2 3	Perspiration increase
1 2 3	Feel cold or chilled easily		1 2 3	Swollen Ankles
1 2 3	Fatigue easily		1 2 3	Brown spots / bronzing of skin

1	2	3	Mental sluggishness / brain fog	1	2	3	Arthritic tendencies (stiff / achey)
1	2	3	Dry skin and hair	1	2	3	Muscles are weak or tremble
1	2	3	Hair falls out (excessive)	1	2	3	Sensitive to noise or light

Yes	No	Swelling in lower neck or“lump in throat” feeling when swallowing
Yes	No	Dark circles under eyes even with good sleep
Yes	No	I have experienced long periods of stress - my life is very stressful.
Yes	No	I have had a very stressful event occur in the past 3 years? (Divorce, Death, Moved…)
Yes	No	Have you ever taken birth control pills or injections? For how long? _____

Sleep - Emotions - Memory

1	2	3	Insomnia - most of the night
1	2	3	Do you have a hard time falling asleep?
Yes	No		When you have a hard time falling asleep is it because you find it hard to stop thinking - turn off your brain?
Yes	No		Do you get 6-8 hours of sleep most nights?
Yes	No		Do you take any sleep aids (herbs, supplements, etc.)? What do you take or have tried? _____
1	2	3	Do you feel anxiety, fearful, or nervousness - think about the worst possible outcomes
1	2	3	Do you feel irritated with or around other people - would rather be alone?
1	2	3	Do you get angry easily and then feel bad about not feeling in control of your emotions?
Yes	No		I often have to force myself in order to keep going. Everything is a chore.
Yes	No		Have you ever taken antidepressants or anxiety medications?
Yes	No		Do you have episodes of poor concentration or confusion?
1	2	3	Have you noticed memory issues? If yes, is it with short-term memory or remembering things from long ago? _____
1	2	3	Do you get feelings of being overwhelmed or completely stressed out?
1	2	3	Do you have trouble finding words or notice word reversals when you speak?
Yes	No		Have you ever been in an auto accident, fallen or received a major physical injury?
Yes	No		Do you find excuses to skip social events or to not meet with friends?

Is there anything you would like to add about your sleep, emotions, or memory?

Immune Function Insight

Yes No	Do you get sinus infection at least once a year?
Yes No	Do you get bronchitis at least once a year?
Yes No	Do you take antihistamines for allergies?
Yes No	Do you get frequent colds? (More then 1-2 times a year)
Yes No	Do you get the flu or a “bad virus” almost every year?

When you get the flu or a flu-like virus do you usually throw up? _____ Get very bad body/bone aches/but don’t usually throw up? _____ Tend to get both body aches and throw up? _____

Yes No	Have you had any flu vaccines? How many? _____
Yes No	Have you had any COVID-19 virus vaccines? How many? _____
Yes No	Have you had any Human Papillomavirus 9 (HPV) (Gardasil, Cervarix) vaccines?
Yes No	Have you had any HepB (hepatitis B virus) vaccines?
Yes No	Do you have asthma?
Yes No	Have you ever taken medication for acne? _____
Yes No	Do you get warts?
Yes No	Were your tonsils removed? Adenoids? _____
Yes No	Did you get ear infections or strep throat as a child?
Yes No	Have you had strep throat as an adult?
Yes No	Have you noticed any loss of smell or taste - not as good as it once was?
Yes No	Do you get hives or eczema?
Yes No	Do you have fungal issues (think or discolored nails, Athlete’s foot, jock itch, yeast infections)?
Yes No	Do you bouts of joint pain with swelling?
Yes No	Have you ever had cortisone shots? Did they work well? _____

Heart & Kidneys

Yes No	High altitude discomfort	Yes No	Have you ever had kidney stones?
Yes No	Hands and feet go to sleep easily (numbness)?	Yes No	Have you ever had a urinary tract infection (UTI)? How many? _____
Yes No	Experience irregular or a fast heart beats on occasion	1 2 3	Swollen ankles
1 2 3	Shortness of breath	1 2 3	Frequent urination
1 2 3	Toe or muscle cramps	1 2 3	Dark urine
1 2 3	Noises in head or ringing ears	1 2 3	Foamy urine
Yes No	High blood pressure	Yes No	Very light colored urine most of the time?

Yes No	Bruise easily		Yes No	Do you or did you consume beer or soda/pop in a can?	
1 2 3	Dull pain in chest or tension/tightness under the breastbone		Yes No	Did you or do you cook with aluminum foil or use aluminum pots or pans?	
Yes No	Do you consume "energy" drinks? How many per week? _____		Yes No	Do you drink pop/soda? If so how many per week? _____	
Sugar Handling					
1 2 3	Get “shaky” or “lightheaded” if hungry or miss a meal		1 2 3	Can’t think, foggy brain relieved by eating	
1 2 3	Tired after eating		1 2 3	Always thirsty	
1 2 3	Fatigue, eating relieves		1 2 3	Crave candy or chocolate	
1 2 3	Crave bread, pasta, donuts…wheat		Yes No	(Female) Gestational diabetes	
Yes No	Do you order “fancy” coffee drinks? How many per week? _____		Yes No	Was told that the A1C on a blood test was high or that you were prediabetic	

Musculoskeletal					
1 2 3	Joint pain or stiffness		Yes No	Plantar fasciitis	
1 2 3	Stiff or sore feet when getting up in the morning		Yes No	Osteoporosis/Osteopenia	
1 2 3	Muscle weakness - shake easy with exertion		Yes No	Have you used a drug/shot for osteoporosis/osteopenia	
1 2 3	Swelling, inflammation, of knees or hands?		Yes No	Bone spurs	
1 2 3	Restless legs at night		Yes No	Periodontal disease or many cavities	
Women Only			**Men Only**		
Yes No	Excessive bleeding during menstruation		Yes No	Infertility due to slow or low sperm count	
Yes No	Painful or tender breasts		Yes No	Urination difficult or “dribbling”	
Yes No	Premenstrual Tension or PMS		Yes No	Frequent night urination	
Yes No	Menopausal		Yes No	Diminished sex drive or ability	
Yes No	Diminished sex drive		Yes No	High PSA on blood test	

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM.
THANK YOU FOR ALLOWING US TO SERVE YOU.