



## INITIAL CONSULTATION CLIENT INTAKE FORM

### I. Personal Information

Name\*

Birth Date

Address\*

City\*

State\*

Zip\*

Occupation

Phone\*

Email\*

Height: \_\_\_\_ Feet \_\_\_\_ Inches

Weight: \_\_\_\_ pounds

Dominant Wrist: \_\_\_\_ inches

Sex:

M  F

Blood Type:

A  B  AB  O

Activity Level:

\_\_\_ Sedentary (little or no exercise, desk job or bed ridden)

\_\_\_ Light Activity (light exercise – sports 1-3 days per week)

\_\_\_ Moderate Activity (moderate ex.: sports 3-5 days/week)

\_\_\_ Very Active (hard exercise – sports 6-7 days per week)

\_\_\_ Extra Active (hard daily exercise – sports and physical job)

Goals:

Look Better

Feel Better

Perform Better

RH Factor:

+  -

### Food Component Reactions Toxins and Junk Food

\_\_\_ Amines

\_\_\_ Salicylates

\_\_\_ Alcohol

\_\_\_ Non-food Items (synthetics)

\_\_\_ Citrus Fruits

\_\_\_ Caffeine

\_\_\_ Soy

\_\_\_ Yeast

\_\_\_ Dairy (casein & lactose)

\_\_\_ Carcinogens & Toxins

\_\_\_ Eggs

\_\_\_ Refined sugars

\_\_\_ Sulfites

\_\_\_ Fluoride/Chlorine

\_\_\_ Glutamates

\_\_\_ Shellfish

\_\_\_ Harmful Fats

\_\_\_ Theobromine

\_\_\_ Gluten & Gliadin

\_\_\_ Pesticides (for organic diets)

\_\_\_ Mercury Contaminated Foods

### Ethnic & Vegetarian Intolerances (check to remove from diet)

\_\_\_ Red Meat

\_\_\_ Dairy Foods

\_\_\_ Eggs and Egg Products

\_\_\_ Fish and Seafood

\_\_\_ Poultry

\_\_\_ Non-Hindu Foods

\_\_\_ Non-Kosher Foods

\_\_\_ Non-Muslim Foods

## INITIAL CONSULTATION QUESTIONNAIRE

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1. What is your main health concern?
2. What drew you to nutritional counseling?
3. What is keeping you from optimal health?
4. In what way could it all be better?
5. What has worked for you in the past?
6. What changed?
7. Do you have any specific cravings?
  - a) When do you crave that?
  - b) How often?
  - c) How does it make you feel?
  - d) Does it make you feel better or worse?
8. In your relationship to food and health, where do you get confused?
9. What is your stress level on a scale of 1-10?
10. How does stress affect your relationship to food?
11. How does it manifest in your body?
12. What do you do to pamper yourself, unwind? How often?
13. Is there anything that you'd like to be doing for yourself that you're not?

**14. What gets in the way of doing these things?**

**15. How would you feel if you were doing this thing on a regular basis?**

**16. Where would like to see your health in 3 months, 6 months, 1 year?**

**17. What nutritional supplements are you currently taking?**

**18. What prescription medications are you currently taking?**

**19. What are your 3 BIGGEST obstacles to being in your peak health?**

**20. What is the ONE thing you could be doing for yourself that you know would have a significant impact on your health and well-being?**

**21. What questions or topics would you MOST like to know more about?**

## Let's Get An Idea of Where You're At and What You've Been Doing:

Nutrition	Your Idea of a "GOOD" Day	Your Idea of a "BAD" Day	A Typical Day
Breakfast			
Snack 1			
Lunch			
Snack 2			
Dinner			
Snack 3/ Dessert			
Water (ounces)			
Total Calories: Even if you have to guess			
Exercise	Your Idea of a "GOOD" Day	Your Idea of a "BAD" Day	A Typical Day
Health & Lifestyle	Your Idea of a "GOOD" Day	Your Idea of a "BAD" Day	A Typical Day
Stress Level (1-10 low to high)			
Sleep (hrs)			
Hours Working (hrs)			
Self Care			
Leisure Activity/Hobby			
Relaxation			

## II. Body Systems Questionnaire - Please select every symptom that you experience.

- |  |  |
|--|--|
| <input type="checkbox"/> Abdominal pain or discomfort            | <input type="checkbox"/> Infertility   |
| <input type="checkbox"/> Absent-mindedness or forgetfulness      | <input type="checkbox"/> Intestinal gas or bloating  |
| <input type="checkbox"/> Acid indigestion or heartburn           | <input type="checkbox"/> Itchy nose and ears   |
| <input type="checkbox"/> Anxiety, nervousness or tension         | <input type="checkbox"/> Joint pain, arthritis or gout                                     |
| <input type="checkbox"/> Asthma                                  | <input type="checkbox"/> Leg cramps or pains   |
| <input type="checkbox"/> Bad breath or body odor                 | <input type="checkbox"/> Less than 1 bowel elimination per day                             |
| <input type="checkbox"/> Brittle fingernails                     | <input type="checkbox"/> Loose stool or diarrhea   |
| <input type="checkbox"/> Burning or painful urination            | <input type="checkbox"/> Loss of appetite or poor appetite                                 |
| <input type="checkbox"/> Cold hands and feet                     | <input type="checkbox"/> Loss of sexual desire   |
| <input type="checkbox"/> Colitis or other bowel irritations      | <input type="checkbox"/> Menopause problems (females)                                      |
| <input type="checkbox"/> Congested air passages                  | <input type="checkbox"/> Menstrual problems (females)                                      |
| <input type="checkbox"/> Constipation or dry stools              | <input type="checkbox"/> Mental / emotional stress   |
| <input type="checkbox"/> Cravings for fat or high fat diet       | <input type="checkbox"/> Migraine headaches  |
| <input type="checkbox"/> Cravings for sugar                      | <input type="checkbox"/> Muddled thinking, confusion or mental sluggishness                |
| <input type="checkbox"/> Dark circles or puffiness under eyes    | <input type="checkbox"/> Osteoporosis  |
| <input type="checkbox"/> Difficulty getting to sleep             | <input type="checkbox"/> Pale complexion and/or anemia                                     |
| <input type="checkbox"/> Dizziness or light headedness           | <input type="checkbox"/> Prostate problems (males)   |
| <input type="checkbox"/> Dry Skin                                | <input type="checkbox"/> Restless dreams or nightmares                                     |
| <input type="checkbox"/> Excess mucus production                 | <input type="checkbox"/> Scant or excessive urination                                      |
| <input type="checkbox"/> Family history of heart disease         | <input type="checkbox"/> Sinus congestion  |
| <input type="checkbox"/> Fatigue in the afternoons               | <input type="checkbox"/> Sinus headaches   |
| <input type="checkbox"/> Fatigue or low energy levels            | <input type="checkbox"/> Skin problems (acne, rashes, etc.)                                |
| <input type="checkbox"/> Food allergies                          | <input type="checkbox"/> Stiff, aching, or painful muscles                                 |
| <input type="checkbox"/> Food sits heavy on stomach after eating | <input type="checkbox"/> Swollen lymph glands  |
| <input type="checkbox"/> Frequent backache                       | <input type="checkbox"/> Ulcers  |
| <input type="checkbox"/> Frequent cough                          | <input type="checkbox"/> Underweight or unable to gain weight                              |
| <input type="checkbox"/> Frequent infections                     | <input type="checkbox"/> Urinating at night  |
| <input type="checkbox"/> Frequent urinary tract infections       | <input type="checkbox"/> Varicose veins  |
| <input type="checkbox"/> General weakness or chronic illness     | <input type="checkbox"/> Waking up frequently at night                                     |
| <input type="checkbox"/> Hayfever                                | <input type="checkbox"/> Water retention or edema  |
| <input type="checkbox"/> Heart problems                          | <input type="checkbox"/> Weak legs, knees or ankles  |
| <input type="checkbox"/> High blood pressure                     | <input type="checkbox"/> Wheezing or shortness of breath                                   |
| <input type="checkbox"/> High cholesterol                        | <input type="checkbox"/> Wounds won't heal on extremities,<br>i.e. arms, hands, legs, feet |
| <input type="checkbox"/> Impotency (males only)                  |  |

## Conditions and Complaints

-- **SELECT ONLY THE MOST SIGNIFICANT ISSUES AND HIGHLIGHT THE SINGLE WORST PROBLEM** --

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Acne (vulgaris)                 | <input type="checkbox"/> Depression                   | <input type="checkbox"/> Hyperthyroidism              | <input type="checkbox"/> Obesity                     |
| <input type="checkbox"/> Adrenal Hyper-function          | <input type="checkbox"/> Dermatitis                   | <input type="checkbox"/> Hypochlorhydria              | <input type="checkbox"/> Osteoarthritis              |
| <input type="checkbox"/> Adrenal Hypo-function           | <input type="checkbox"/> Detoxification Support       | <input type="checkbox"/> Hypoglycemia                 | <input type="checkbox"/> Osteoporosis                |
| <input type="checkbox"/> AIDS or HIV                     | <input type="checkbox"/> Diabetes (type I)            | <input type="checkbox"/> Hypotension                  | <input type="checkbox"/> Pain (musculoskeletal)      |
| <input type="checkbox"/> Alcoholism                      | <input type="checkbox"/> Diabetes (type II)           | <input type="checkbox"/> Hypothyroidism               | <input type="checkbox"/> Pancreatitis                |
| <input type="checkbox"/> Alzheimer's Disease             | <input type="checkbox"/> Diarrhea                     | <input type="checkbox"/> Idiopathic Thrombo. Purpura  | <input type="checkbox"/> Panic Disorder              |
| <input type="checkbox"/> Amenorrhea                      | <input type="checkbox"/> Diverticulosis               | <input type="checkbox"/> Ileitis                      | <input type="checkbox"/> Parasthesia                 |
| <input type="checkbox"/> Anemia (macro & microcytic)     | <input type="checkbox"/> Drug Addiction               | <input type="checkbox"/> Ileocecal Valve Dysfunction  | <input type="checkbox"/> Parkinson's Disease         |
| <input type="checkbox"/> Angina Pectoris                 | <input type="checkbox"/> Dry Eyes (Sjögren's synd.)   | <input type="checkbox"/> Immune Deficiency            | <input type="checkbox"/> PCOS                        |
| <input type="checkbox"/> Anxiety                         | <input type="checkbox"/> Dry Skin                     | <input type="checkbox"/> Impotence (male)             | <input type="checkbox"/> Peptic/Duodenal Ulcer       |
| <input type="checkbox"/> Appetite Excessive              | <input type="checkbox"/> Dysmenorrhea                 | <input type="checkbox"/> Incontinence                 | <input type="checkbox"/> Periodontal Disease         |
| <input type="checkbox"/> Appetite Reduced                | <input type="checkbox"/> Dyspepsia (indigestion)      | <input type="checkbox"/> Infection (bacterial)        | <input type="checkbox"/> Phlebitis                   |
| <input type="checkbox"/> Arteriosclerosis                | <input type="checkbox"/> Ear Infections               | <input type="checkbox"/> Infection (parasitic)        | <input type="checkbox"/> Phobias                     |
| <input type="checkbox"/> Asthma                          | <input type="checkbox"/> Eczema                       | <input type="checkbox"/> Infection (prostate)         | <input type="checkbox"/> Pituitary Dysfunction       |
| <input type="checkbox"/> Atherosclerosis                 | <input type="checkbox"/> Edema                        | <input type="checkbox"/> Infection (respiratory)      | <input type="checkbox"/> PMS                         |
| <input type="checkbox"/> Attention Deficit Disorder      | <input type="checkbox"/> Emphysema                    | <input type="checkbox"/> Infection (sinus)            | <input type="checkbox"/> Pneumonia                   |
| <input type="checkbox"/> Autism                          | <input type="checkbox"/> Endometriosis                | <input type="checkbox"/> Infection (urinary)          | <input type="checkbox"/> Polycythemia (secondary)    |
| <input type="checkbox"/> Bell's Palsy                    | <input type="checkbox"/> Enuresis (bed wetting)       | <input type="checkbox"/> Infection (viral)            | <input type="checkbox"/> Pregnancy (gen. support)    |
| <input type="checkbox"/> Benign Prostatic Hyperplasia    | <input type="checkbox"/> Epilepsy (seizure disorders) | <input type="checkbox"/> Infection (yeast/fungal)     | <input type="checkbox"/> Pregnancy & Yeast Infec.    |
| <input type="checkbox"/> Biliary Insufficiency           | <input type="checkbox"/> Epstein Barr Virus (EBV)     | <input type="checkbox"/> Infertility (female)         | <input type="checkbox"/> Psoriasis                   |
| <input type="checkbox"/> Biliary Stasis                  | <input type="checkbox"/> Fever                        | <input type="checkbox"/> Infertility (male)           | <input type="checkbox"/> Purpura Simplex             |
| <input type="checkbox"/> Bipolar Disorder                | <input type="checkbox"/> Fibrocystic Breast Disease   | <input type="checkbox"/> Inflammation (general)       | <input type="checkbox"/> Radiation Therapy Support   |
| <input type="checkbox"/> Bleeding Gums                   | <input type="checkbox"/> Fibromyalgia                 | <input type="checkbox"/> Inflammation (vascular)      | <input type="checkbox"/> Raynaud's Disease           |
| <input type="checkbox"/> Body Odor                       | <input type="checkbox"/> Flatulence                   | <input type="checkbox"/> Influenza (flu)              | <input type="checkbox"/> Reduced Circulation         |
| <input type="checkbox"/> Bone Spurs                      | <input type="checkbox"/> Fractures                    | <input type="checkbox"/> Insomnia                     | <input type="checkbox"/> Rhinovirus (common cold)    |
| <input type="checkbox"/> Bradycardia                     | <input type="checkbox"/> Gallbladder Dysfunction      | <input type="checkbox"/> Interstitial Cystitis        | <input type="checkbox"/> Rheumatoid Arthritis        |
| <input type="checkbox"/> Bronchitis                      | <input type="checkbox"/> Gallstones                   | <input type="checkbox"/> Irritable Bowel Syndrome     | <input type="checkbox"/> Rhinovirus (comm.cold)      |
| <input type="checkbox"/> Bruxism                         | <input type="checkbox"/> GERD                         | <input type="checkbox"/> Joint Pain                   | <input type="checkbox"/> Schizophrenia               |
| <input type="checkbox"/> Burning Feet                    | <input type="checkbox"/> Glaucoma                     | <input type="checkbox"/> Kidney Stones                | <input type="checkbox"/> Sciatica                    |
| <input type="checkbox"/> Burns (1st, 2nd, 3rd degree)    | <input type="checkbox"/> Goiter                       | <input type="checkbox"/> Lactose Intolerance          | <input type="checkbox"/> Scleroderma                 |
| <input type="checkbox"/> Bursitis                        | <input type="checkbox"/> Gout                         | <input type="checkbox"/> Liver-Colon Detoxification   | <input type="checkbox"/> Seborrhea                   |
| <input type="checkbox"/> Cancer (prevention)             | <input type="checkbox"/> Grave's Disease              | <input type="checkbox"/> Low Cholesterol (HDL)        | <input type="checkbox"/> Sex Drive Diminished (F)    |
| <input type="checkbox"/> Canker Sores                    | <input type="checkbox"/> Halitosis                    | <input type="checkbox"/> Lung Problems (non-specific) | <input type="checkbox"/> Sex Drive Diminished (M)    |
| <input type="checkbox"/> Cardiac Arrhythmia              | <input type="checkbox"/> Hashimoto's Disease          | <input type="checkbox"/> Lupus                        | <input type="checkbox"/> Skin Rashes                 |
| <input type="checkbox"/> Cataracts                       | <input type="checkbox"/> Headaches (non-migraine)     | <input type="checkbox"/> Lyme Disease                 | <input type="checkbox"/> Sperm Count Reduced         |
| <input type="checkbox"/> Celiac Disease (sprue)          | <input type="checkbox"/> Heal Spurs                   | <input type="checkbox"/> Macular Degeneration         | <input type="checkbox"/> Stroke (recovery support)   |
| <input type="checkbox"/> Chemotherapy Support            | <input type="checkbox"/> Heavy Metal Toxicity         | <input type="checkbox"/> Manic Depression             | <input type="checkbox"/> Sulfite Allergy-Sensitivity |
| <input type="checkbox"/> Cervical Dysplasia              | <input type="checkbox"/> Hemachromatosis              | <input type="checkbox"/> Measles                      | <input type="checkbox"/> Surgery Support (pre/ post) |
| <input type="checkbox"/> Chicken Pox                     | <input type="checkbox"/> Hemophilia                   | <input type="checkbox"/> Meniere's Disease            | <input type="checkbox"/> Tachycardia                 |
| <input type="checkbox"/> Cholesterol Decreased (total)   | <input type="checkbox"/> Hemorrhoids                  | <input type="checkbox"/> Menorrhagia                  | <input type="checkbox"/> Tendonitis                  |
| <input type="checkbox"/> Cholesterol Elevated (total)    | <input type="checkbox"/> Hepatic Cirrhosis            | <input type="checkbox"/> Menstrual Cramps             | <input type="checkbox"/> Thrombophlebitis            |
| <input type="checkbox"/> Chronic Fatigue Syndrome        | <input type="checkbox"/> Hepatic Disease Support      | <input type="checkbox"/> Metabolic Syndrome           | <input type="checkbox"/> Tinea (ringworm)            |
| <input type="checkbox"/> Colic (mother's & child's diet) | <input type="checkbox"/> Hepatitis                    | <input type="checkbox"/> Migraine Headache            | <input type="checkbox"/> Tinnitus                    |
| <input type="checkbox"/> Congestive Heart Failure        | <input type="checkbox"/> Herpes Simplex (HSV-1)       | <input type="checkbox"/> Mitral Valve Prolapse        | <input type="checkbox"/> Trigeminal Neuralgia        |
| <input type="checkbox"/> Constipation                    | <input type="checkbox"/> Herpes Zoster (HSV-2)        | <input type="checkbox"/> Mononucleosis                | <input type="checkbox"/> Tuberculosis (TB)           |
| <input type="checkbox"/> COPD                            | <input type="checkbox"/> Hiatal Hernia                | <input type="checkbox"/> Mucous (allergy related)     | <input type="checkbox"/> Ulcerative Colitis          |
| <input type="checkbox"/> Copper toxicity                 | <input type="checkbox"/> High Cholesterol (LDL)       | <input type="checkbox"/> Mucous (respiratory/sinus)   | <input type="checkbox"/> Urticaria (hives)           |
| <input type="checkbox"/> Coronary Artery Disease         | <input type="checkbox"/> High Triglycerides           | <input type="checkbox"/> Multiple Sclerosis (MS)      | <input type="checkbox"/> Uterine Fibroids            |
| <input type="checkbox"/> Crohn's Disease                 | <input type="checkbox"/> Homocysteine Elevated        | <input type="checkbox"/> Mumps                        | <input type="checkbox"/> Varicose Veins              |
| <input type="checkbox"/> Cystic Fibrosis                 | <input type="checkbox"/> Hot Flashes (menopausal)     | <input type="checkbox"/> Muscular Dystrophy           | <input type="checkbox"/> Vertigo                     |
| <input type="checkbox"/> Cytomegalovirus (CMV)           | <input type="checkbox"/> Hyperglycemia                | <input type="checkbox"/> Myasthenia Gravis            | <input type="checkbox"/> Vitiligo                    |
| <input type="checkbox"/> Degenerative Joint Disease      | <input type="checkbox"/> Hyperkinesia                 | <input type="checkbox"/> Nausea                       | <input type="checkbox"/> Wilson's Syndrome           |
| <input type="checkbox"/> Dental Caries (cavities)        | <input type="checkbox"/> Hypertension                 | <input type="checkbox"/> Nausea (during pregnancy)    | <input type="checkbox"/> Xerophthalmia               |

## Basic Metabolic Typing Assessment

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1. Do you have an appetite for breakfast?
  - a. Usually
  - b. No
2. Does a muffin or plain toast give you enough energy to last until lunch?
  - a. Never/Sometimes
  - b. Usually
3. Do you feel energetic after a breakfast of bacon and eggs?
  - a. Yes
  - b. No
4. Does one cup of coffee make you feel jittery and irritable?
  - a. Yes
  - b. Not Usually
5. Do you crave more bread or pasta 2 hours after having had some?
  - a. Yes
  - b. Not usually
6. Which desserts do you prefer?
  - a. Cheesecake, creamy pastries, ice cream, chocolate mousse
  - b. Fruit pies, cakes, cookies.
  - c. Don't like dessert
7. In which group is your FAVORITE comfort food?
  - a. Salty chips, cheese, peanuts, bread, ice cream, cheesecake
  - b. Soft drinks, popcorn, fruit
  - c. None of the above
8. Does heavy food (meat or cheese) before bed disturb your sleep?
  - a. No
  - b. Yes
9. Do sweets before bed disturb your sleep?
  - a. No
  - b. Yes
10. Do you ever need to get up to eat at night?
  - a. Yes
  - b. Never
11. Which foods cause you to gain weight?
  - a. Bread and pasta
  - b. Meat and fatty food
  - c. Don't know
12. Do you often get real stomach hunger pangs?
  - a. yes
  - b. No
13. Do you find red meat hard to digest?
  - a. No
  - b. Yes or sometimes
14. How much do you like sour foods (vinegar, lemon juice)?
  - a. A lot
  - b. Average or not at all
15. How much do you like mustard?

- a. Average or not at all
  - b. A lot
16. How much do you like salt?
- a. A lot
  - b. Average or not at all
17. How much do you like potatoes?
- a. A lot
  - b. Average
18. Do you have a tendency to be:
- a. Too warm
  - b. Too chilly
  - c. Neither/Both
19. Even when you're not sick, do you get a dry cough or sneezing at night or after eating?
- a. Often
  - b. No
20. Does your skin crack on your fingertips or heels?
- a. Yes
  - b. No
21. Do you have a problem with dandruff?
- a. yes
  - b. No
22. Are your ears?
- a. Redder in color than your face
  - b. Lighter in color than your face
  - c. The same color
23. Do you have?
- a. Watery eyes
  - b. Dry eyes and nose
  - c. Neither
24. Do you have?
- a. Too much saliva?
  - b. A dry mouth?
  - c. Neither
25. Do you have chronically itchy skin?
- a. Yes
  - b. No
26. Do you react badly to insect bites?
- a. Yes, welts and swelling
  - b. Mild reactions only
27. Do you frequently and easily get Goosebumps?
- a. No
  - b. Yes
28. Are your pupils?
- a. Smaller than the iris
  - b. Larger than the iris
  - c. Average. The same size
29. Are you?
- a. Blood Type O or B
  - b. Blood Type A or AB
30. Do you have apple-shaped weight gain? (Women only.)
- a. Yes
  - b. No



# History & Symptoms Questionnaire:

**Questionnaire Answer Key** Follow the instructions of each section. At the end, total up your scores for each section and enter below.

Section 1:      Section 2:      Section 3:      Section 4:  
 Section 5:      Section 6:      Section 7:      Section 8:

This questionnaire is a quick way to identify many root causes of clinical conditions. As a nutritionist, I use this as a springboard into developing an individualized action plan. It also helps prioritize health issues, so that I can work effectively with each client. **For each section, highlight the number on the left for answers that apply to you, add the total and place it in the total score line provided for that section. When you finish all sections, record your totals in the answer key above:**

**Section 1. Score** \_\_\_\_\_

4 Sensitivity to emotional (or physical) pain; cry easily 4 Eat as a reward for pleasure, comfort, numbness 4 Worry, anxiety, phobia or panic 4 Difficulty getting to sleep or staying asleep 3 Difficulty with focus, attention deficits 2 Low energy, drive and arousal 4 Obsessive thinking or behavior	4 Inability to relax after tension, stress 3 Depression, negativity 4 Low self esteem, lack of confidence 4 More mood and eating problems in winter or end of day 3 Irritability, anger 4 Use alcohol or drugs to improve mood
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**Section 2. Score** \_\_\_\_\_

4 Increased cravings for and focus on food; overeating 4 Regain weight after dieting, more than was lost 3 Increased moodiness, irritability, anxiety, or depression 3 Less energy and endurance 3 Usually eat less than 2,100 calories/day 3 Skip meals, especially breakfast 3 Eat mostly low-fat carbs like bagels and pasta 2 Constantly think about weight	2 Use aspartame daily 2 Take Prozac or similar serotonin-boosting drugs 2 Have become vegetarian 3 Decreased self-esteem 4 Have become bulimic or anorectic
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**Section 3. Total Score** \_\_\_\_\_

4 Crave a lift from sweets or alcohol, but experience a drop in mood afterwards 4 Family history of diabetes, hypoglycemia, or alcoholism 3 Nervous, jittery, irritable, headachy or weak, on and off during the day. May be calmer after meals 3 Frequent infections, allergies or asthma, especially when weather changes 3 Mental confusion, decreased memory, hard to focus or get organized 4 Frequent thirst 3 Night sweats (not menopausal)	5 Light-headed, especially on standing up 4 Crave salty foods or licorice 4 Often feel stressed, overwhelmed and exhausted 4 Dark circles under eyes or eyes sensitive to bright light 4 More awake at night
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**Section 4. Total Score \_\_\_\_\_**

4 Low energy  
 4 Easily chilled (especially hands and feet)  
 4 Other family members have thyroid problems  
 4 Can gain weight without overeating; hard to lose excess weight  
 3 Have to force yourself to do even moderate exercise  
 4 Find it hard to get going in the morning

3 High cholesterol  
 3 Low blood pressure  
 4 Weight gain began near the start of menses, a pregnancy, or menopause  
 3 Chronic headaches  
 3 Use food, caffeine, tobacco and /or other stimulants to get going

**Section 5. Total Score \_\_\_\_\_**

4 Premenstrual mood swings  
 4 Premenstrual or menopausal food cravings  
 4 Irregular periods or migraines  
 4 History of fibroids  
 3 Experienced miscarriage, abortion or infertility

4 Use(d) birth control pills or other hormone medication  
 3 Uncomfortable periods – cramps, lengthy or heavy bleeding, or sore breasts  
 4 Peri- or postmenopausal discomfort (hot flashes, weight gains, sweats, insomnia or mental dullness)  
 3 Skin eruptions with period

**Section 6. Total Score \_\_\_\_\_**

3 Crave milk, ice cream, yogurt, cheese, or doughy foods and eat them frequently  
 3 Experience bloating after meals  
 4 Gas, frequent belching  
 3 Digestive discomfort of any kind  
 3 Chronic constipation and/or diarrhea  
 4 Respiratory problems, such as asthma, postnasal drip, congestion  
 3 Low energy or drowsiness, especially after meals  
 4 Allergic to milk products or other common foods

3 Under-eat or often prefer beverages to solid foods  
 3 Avoid food or throw up food because bloating after eating makes you feel fat or tired  
 4 Can't gain weight  
 3 Hyperactivity or manic depression  
 3 Severe headaches or migraine  
 4 Food allergies in family

**Section 7. Total Score \_\_\_\_\_**

3 Crave milk, ice cream, yogurt, cheese, or doughy foods and eat them frequently  
 3 Experience bloating after meals  
 4 Gas, frequent belching  
 3 Digestive discomfort of any kind  
 3 Chronic constipation and/or diarrhea  
 4 Respiratory problems, such as asthma, postnasal drip, congestion  
 3 Low energy or drowsiness, especially after meals  
 4 Allergic to milk products or other common foods  
 3 Stool unusual in color, shape or consistency

4 Often bloated abdominal distention  
 3 Foggy-headed  
 2 Depressed  
 4 Yeast Infections  
 4 Used antibiotics extensively (at any time in life)  
 4 Used cortisone or birth control pills for more than one year  
 4 Have chronic fungus on nails or skin or athlete's foot  
 3 Recurring sinus or ear infections as an adult or child  
 3 Achy muscles and joints  
 4 Rashes

**Section 8. Total Score \_\_\_\_\_**

3 Crave milk, ice cream, yogurt, cheese, or doughy foods and eat them frequently  
 3 Experience bloating after meals  
 4 Crave chips, cheese, and other rich foods more than, or in addition to sweets and starches  
 4 Have ancestry that includes Irish, Scottish, Welsh, Scandinavian or coastal Native American  
 3 Alcoholism and depression in the family history  
 3 High cholesterol, low HDL levels  
 4 Feel heavy, uncomfortable, and "clogged up" after eating fatty foods

4 Often bloated abdominal distention  
 3 Foggy-headed  
 2 Depressed  
 4 History of hepatitis or other liver or gallbladder problems  
 4 Light colored stools  
 4 Hard or foul-smelling stool  
 4 Pain on right side under rib cage

# Comments: