Confidential **Client Information Sheet** *Confidential*

This consultation is intended to improve the use of bio-identical hormones, prescription, non-prescription medicine and products, non-drug approaches to self-care and/or referral to other health care providers.

Name _____ Date_____

Address _____ Age _____ Gender ☐ Male ☐ Female

City _____ State _____ Zip _____ Birth Date ___/___/___

Day Phone (____) ____-_____ Mobile Phone (____) ____-_____ Night Phone (____) ____-_____

Fax Number (____) ____-_____ E-mail Address _____

Best time to call _____ Best phone number for us to call _____

Would your prefer test results be mailed, faxed or emailed to you? _____

Height _____ Weight _____ Race _____ Marital Status ☐ Married ☐ Single

Occupation _____

Whom may we thank for your referral? _____

Blood Type_____

Do you use tobacco? ☐ Smoke ☐ Chew ☐ Other ☐ None

Do you use alcohol? ☐ None ☐ Occasionally How much? _____

Which do you consume most often? ☐ Home Cooking ☐ Low fat ☐ Fast food

How many servings of fruits and vegetables do you consume each day? ☐ None ☐ 1-3 ☐ 4-6 ☐ 7 Plus

How often do you exercise? ☐ None ☐ Occasional ☐ 2-3 Times a week ☐ 4-5 Times a week

Pregnant? ☐ Yes ☐ No Breast Feeding? ☐ Yes ☐ No

Do you drink filtered or bottled water? ☐Yes ☐ No

Food Allergies _____

Supplement Allergies (Vitamins, minerals, herbs, etc.) _____

_____

Medication Allergies _____

Medication Reactions_____

Medical History

- ❑ Arthritis
- ❑ Bronchitis
- ❑ Asthma
- ❑ Allergies / Hay Fever
- ❑ Emphysema
- ❑ Cancer _____
- ❑ Chronic Tiredness / Fatigue
- ❑ Thyroid dysfunction
- ❑ Digestion problems
- ❑ Glaucoma
- ❑ Angina / Heart Attack
- ❑ Heart Disease _____
- ❑ Pacemaker
- ❑ Defibrillator
- ❑ High Cholesterol
- ❑ High Homocysteine
- ❑ High Blood Pressure
- ❑ Diabetes
- ❑ Hypoglycemia
- ❑ Osteoporosis
- ❑ Hormone Imbalances
- ❑ Prostate
- ❑ Depression
- ❑ Headaches / Migraine
- ❑ Kidney Disease
- ❑ Kidney / Bladder disorders
- ❑ Liver Disease
- ❑ Chronic Infections

Please turn this sheet over and complete the next page

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Other health concerns _____

_____

_____

_____

Health Care Providers

Primary Care Physician _____ Phone (____) ____-_____
Dentist _____ Phone (____) ____-_____
Chiropractor _____ Phone (____) ____-_____
Pharmacy _____ Phone (____) ____-_____

May I contact your health care provider(s) for additional information or to inform them of health concerns that I may have? □ Yes □ No

Today's Health Concern(s)

_____

_____

Current Prescription Medications

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Current Non-Prescription Medications, Vitamins, Minerals, Herbal Supplements, and Self-Care

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Certification Statement of Client: To the best of my knowledge, the information I have entered on this form is correct.

Client Signature _____ Date: ____/____/_____

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DETOXIFICATION QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Rate each of the following symptoms based on your typical health profile for the specified duration:

❒ Past month ❒ Past week ❒ Past 48 hours

Point Scale: **0**—*Never or almost never* have the symptom **1**—*Occasionally* have it, effect is *not severe* **2**—*Occasionally* have it, effect is *severe*
3—*Frequently* have it, effect is *not severe* **4**—*Frequently* have it, effect is *severe*

I. Medical Symptoms Questionnaire (MSQ)

HEAD	_____	Headaches	
	_____	Faintness	
	_____	Dizziness	
	_____	Insomnia	**TOTAL** _____
EYES	_____	Watery or itchy eyes	
	_____	Swollen, reddened or sticky eyelids	
	_____	Bags or dark circles under eyes	
	_____	Blurred or tunnel vision	**TOTAL** _____
EARS	_____	Itchy ears	
	_____	Earaches, ear infections	
	_____	Drainage from ear	
	_____	Ringing in ears, hearing loss	**TOTAL** _____
NOSE	_____	Stuffy nose	
	_____	Sinus problems	
	_____	Hay fever	
	_____	Sneezing attacks	
	_____	Excessive mucus formation	**TOTAL** _____
MOUTH/ THROAT	_____	Chronic coughing	
	_____	Gagging, frequent need to clear throat	
	_____	Sore throat, hoarseness, loss of voice	
	_____	Swollen or discolored tongue, gums, lips	
	_____	Canker sores	**TOTAL** _____
SKIN	_____	Acne	
	_____	Hives, rashes, dry skin	
	_____	Hair loss	
	_____	Flushing, hot flashes	
	_____	Excessive sweating	**TOTAL** _____
HEART	_____	Chest pain	
	_____	Irregular or skipped heartbeat	
	_____	Rapid or pounding heartbeat	**TOTAL** _____
LUNGS	_____	Chest congestion	
	_____	Asthma, bronchitis	
	_____	Shortness of breath	
	_____	Difficulty breathing	**TOTAL** _____
DIGESTIVE TRACT	_____	Nausea, vomiting	
	_____	Diarrhea	
	_____	Constipation	
	_____	Bloated feeling	
	_____	Belching, passing gas	
	_____	Heartburn	
	_____	Intestinal/stomach pain	**TOTAL** _____
JOINTS/ MUSCLE	_____	Pain or aches in joints	
	_____	Arthritis	
	_____	Stiffness or limitation of movement	
	_____	Feeling of weakness or tiredness	
	_____	Pain or aches in muscles	**TOTAL** _____
WEIGHT	_____	Binge eating/drinking	
	_____	Craving certain foods	
	_____	Excessive weight	
	_____	Water retention	
	_____	Underweight	
	_____	Compulsive eating	**TOTAL** _____
ENERGY/ ACTIVITY	_____	Fatigue, sluggishness	
	_____	Apathy, lethargy	
	_____	Hyperactivity	
	_____	Restlessness	**TOTAL** _____
MIND	_____	Poor memory	
	_____	Confusion, poor comprehension	
	_____	Difficulty in making decisions	
	_____	Stuttering or stammering	
	_____	Slurred speech	
	_____	Learning disabilities	
	_____	Poor concentration	
	_____	Poor physical coordination	**TOTAL** _____
EMOTIONS	_____	Mood swings	
	_____	Anxiety, fear, nervousness	
	_____	Anger, irritability, aggressiveness	
	_____	Depression	**TOTAL** _____
OTHER	_____	Frequent illness	
	_____	Frequent or urgent urination	
	_____	Genital itch or discharge	**TOTAL** _____
GRAND TOTAL			**TOTAL** _____

II. Xenobiotic Tolerability Test (XTT)

1. Are you presently using prescription drugs?
❒ Yes (1 pt.)
If yes, how many are you currently taking? ____ (1 pt. each)
❒ No (0 pt.)

2. Are you presently taking one or more of the following over-the counter drugs?
❒ Cimetidine (2 pts.)
❒ Acetaminophen (2 pts.)
❒ Estradiol (2 pts.)

3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them:
❒ Experience side effects, drug(s) is (are) efficacious at lowered dose(s) (3 pts.)
❒ Experience side effects, drug(s) is (are) efficacious at usual dose(s) (2 pts.)
❒ Experience no side effects, drug(s) is (are) usually not efficacious (2 pts.)
❒ Experience *no* side effects, drug(s) is (are) usually efficacious (0 pt.)

4. Do you currently use or within the last 6 months had you regularly used tobacco products?
❒ Yes (2 pts.) ❒ No (0 pt.)

5. Do you have strong negative reactions to caffeine or caffeine containing products?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

6. Do you commonly experience "brain fog," fatigue, or drowsiness?
❒ Yes (1 pt.) ❒ No (0 pt.)

7. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

8. Do you feel ill after you consume even small amounts of alcohol?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

10. Do you have a personal history of
❒ Environmental and/or chemical sensitivities (5 pts.)
❒ Chronic fatigue syndrome (5 pts.)
❒ Multiple chemical sensitivity (5 pts.)
❒ Fibromyalgia (3 pts.)
❒ Parkinson's type symptoms (3 pts.)
❒ Alcohol or chemical dependence (2 pts.)
❒ Asthma (1 pt.)

11. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?
❒ Yes (1 pt.) ❒ No (0 pt.)

12. Do you have an adverse or allergic reaction when you consume sulfite containing foods such as wine, dried fruit, salad bar vegetables, etc?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

GRAND TOTAL: _____

III. Alkalizing Assessment

1. Do you have a history or currently have kidney dysfunction?
❒ Yes ❒ No

2. Have you ever been diagnosed with a condition known as hyperkalemia?
❒ Yes ❒ No

3. Are you currently on diuretics or blood pressure medication?
❒ Yes ❒ No

Note: Prescribe non-alkalizing nutrients if patient answered yes to any part of this section.

For Practitioner Use Only:

OVERALL SCORE TABULATION

See doctor brochure for protocol suggestions.

MSQ SCORE _____ (High >50; moderate 15-49: Low <14)
XTT SCORE _____ (High >10; moderate 5-9: Low <4)
URINARY pH _____

Note: Patients with high MSQ but low XTT may be exhibiting pathology that is not related to toxic load. Other mechanisms should be considered such as inflammation/immune/allergic gastrointestinal dysfuntion, oxidative stress, hormonal/neuro-transmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.

HEALTH APPRAISAL QUESTIONNAIRE

Name _____ **Date** _____

DIRECTIONS

This questionnaire asks you to assess how you have been feeling **during the last four months**. This information will help you keep track of how your physical, mental and emotional states respond to changes you make in your eating habits, priorities, supplement program, social and family life, level of physical activity and time spent on personal growth. All information is held in strict confidence. Take all the time you need to complete this questionnaire.

For each question, circle the number that best describes your symptoms:

0 = No or Rarely—You have never experienced the symptom or the symptom is familiar to you but you perceive it as insignificant (monthly or less)

1 = Occasionally—Symptom comes and goes and is linked in your mind to stress, diet, fatigue or some identifiable trigger

4 = 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

8 = 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: 0 = NO 8 = YES

PART I

	No/Rarely	Occasionally	Often	Frequently
SECTION A				
1. Indigestion, food repeats on you after you eat	0	1	4	8
2. Excessive burping, belching and/or bloating following meals	0	1	4	8
3. Stomach spasms and cramping during or after eating	0	1	4	8
4. A sensation that food just sits in your stomach creating uncomfortable fullness, pressure and bloating during or after a meal	0	1	4	8
5. Bad taste in your mouth	0	1	4	8
6. Small amounts of food fill you up immediately	0	1	4	8
7. Skip meals or eat erratically because you have no appetite	0	1	4	8
Total points				
SECTION B				
1. Strong emotions, or the thought or smell of food aggravates your stomach or makes it hurt	0	1	4	8
2. Feel hungry an hour or two after eating a good-sized meal	0	1	4	8
3. Stomach pain, burning and/or aching over a period of 1-4 hours after eating	0	1	4	8
4. Stomach pain, burning and/or aching relieved by eating food; drinking carbonated beverages, cream or milk; or taking antacids	0	1	4	8
5. Burning sensation in the lower part of your chest, especially when lying down or bending forward	0	1	4	8
6. Digestive problems that subside with rest and relaxation	(0)No			(8)Yes
7. Eating spicy and fatty (fried) foods, chocolate, coffee, alcohol, citrus or hot peppers causes your stomach to burn or ache	0	1	4	8
8. Feel a sense of nausea when you eat	0	1	4	8
9. Difficulty or pain when swallowing food or beverage	0	1	4	8
Total points				
SECTION C				
1. When massaging under your rib cage *on your left side*, there is pain, tenderness or soreness	0	1	4	8
2. Indigestion, fullness or tension in your abdomen is delayed, occurring 2-4 hours after eating a meal	0	1	4	8
3. Lower abdominal discomfort is relieved with the passage of gas or with a bowel movement	0	1	4	8
4. Specific foods/beverages aggravate indigestion	0	1	4	8
5. The consistency or form of your stool changes (e.g., from narrow to loose) within the course of a day	0	1	4	8

	No/Rarely	Occasionally	Often	Frequently
SECTION C *(cont.)*				
6. Stool odor is embarrassing	0	1	4	8
7. Undigested food in your stool	0	1	4	8
8. Three or more large bowel movements daily	0	1	4	8
9. Diarrhea (frequent loose, watery stool)	0	1	4	8
10. Bowel movement shortly after eating (within 1 hour)	0	1	4	8
Total points				
SECTION D				
1. Discomfort, pain or cramps in your colon (lower abdominal area)	0	1	4	8
2. Emotional stress and/or eating raw fruits and vegetables causes abdominal bloating, pain, cramps or gas	0	1	4	8
3. Generally constipated (or straining during bowel movements)	0	1	4	8
4. Stool is small, hard and dry	0	1	4	8
5. Pass mucus in your stool	0	1	4	8
6. Alternate between constipation and diarrhea	0	1	4	8
7. Rectal pain, itching or cramping	0	1	4	8
8. No urge to have a bowel movement	(0)No			(8)Yes
9. An almost continual need to have a bowel movement	(0)No			(8)Yes
Total points				

PART II

1. When massaging under your rib cage *on your right side*, there is pain, tenderness or soreness	0	1	4	8
2. Abdominal pain worsens with deep breathing	0	1	4	8
3. Pain at night that may move to your back or right shoulder	0	1	4	8
4. Bitter fluid repeats after eating	0	1	4	8
5. Feel abdominal discomfort or nausea when eating rich, fatty or fried foods	0	1	4	8
6. Throbbing temples and/or dull pain in forehead associated with overeating	0	1	4	8
7. Unexplained itchy skin that's worse at night	0	1	4	8
8. Stool color alternates from clay colored to normal brown	0	1	4	8
9. General feeling of poor health	0	1	4	8

PART II

	No/Rarely	Occasionally	Often	Frequently
10. Aching muscles not due to exercise	0	1	4	8
11. Retain fluid and feel swollen around the abdominal area	0	1	4	8
12. Reddened skin, especially palms	0	1	4	8
13. Very strong body odor	0	1	4	8
14. Are you embarrassed by your breath?	0	1	4	8
15. Bruise easily	(0)No			(8)Yes
16. Yellowish cast to eyes	(0)No			(8)Yes

Total points ____

PART III

SECTION A

1. Feel cold or chilled—hands, feet or all over—for no apparent reason	0	1	4	8
2. Your upper eyelids look swollen	0	1	4	8
3. Muscles are weak, cramp and/or tremble	0	1	4	8
4. Are you forgetful?	0	1	4	8
5. Do you feel like your heart beats slowly?	0	1	4	8
6. Reaction time seems slowed down	0	1	4	8
7. In general, are you disinterested in sex because your desire is low?	0	1	4	8
8. Feel slow-moving, sluggish	0	1	4	8
9. Constipation	0	1	4	8
10. Dryness, discoloration of skin and/or hair	(0)No			(8)Yes
11. Have you noticed recently that your voice is deepening?	(0)No			(8)Yes
12. Thick, brittle nails	(0)No			(8)Yes
13. Weight gain for no apparent reason	(0)No			(8)Yes
14. Outer third of your eyebrow is thinning or disappearing	(0)No			(8)Yes
15. Swelling of the neck	(0)No			(8)Yes

Total points ____

SECTION B

1. Lingering mild fatigue after exertion or stress	0	1	4	8
2. Do you find that you get tired and exhaust easily?	0	1	4	8
3. Craving for salty foods	0	1	4	8
4. Sensitive to minor changes in weather and surroundings	0	1	4	8
5. Dizzy when rising or standing up from a kneeling position	0	1	4	8
6. Dark bluish or black circles under your eyes	0	1	4	8
7. Have bouts of nausea with or without vomiting	0	1	4	8
8. Catch colds or infections easily	(0)No			(8)Yes
9. Wounds heal slowly	(0)No			(8)Yes
10. Your body or parts of your body feel tender, sore, sensitive to the touch, hot and/or painful	0	1	4	8
11. Feel puffy and swollen all over your body	0	1	4	8
12. Skin is gradually tanning without exposure to sun or the ingestion of high levels of carotene-rich foods (e.g., daily carrot juice intake) or supplements	(0)No			(8)Yes

Total points ____

PART IV

	No/Rarely	Occasionally	Often	Frequently

SECTION A

When you miss meals or go without food for extended periods of time, do you experience any of the following symptoms?

1. A sense of weakness	0	1	4	8
2. A sudden sense of anxiety when you get hungry	0	1	4	8
3. Tingling sensation in your hands	0	1	4	8
4. A sensation of your heart beating too quickly or forcefully	0	1	4	8
5. Shaky, jittery, hands trembling	0	1	4	8
6. Sudden profuse sweating and/or your skin feels clammy	0	1	4	8
7. Nightmares possibly associated with going to bed on an empty stomach	0	1	4	8
8. Wake up at night feeling restless	0	1	4	8
9. Agitation, easily upset, nervous	0	1	4	8
10. Poor memory, forgetful	0	1	4	8
11. Confused or disoriented	0	1	4	8
12. Dizzy, faint	0	1	4	8
13. Cold or numb	0	1	4	8
14. Mild headaches or head pounding	0	1	4	8
15. Blurred vision or double vision	0	1	4	8
16. Feel clumsy and uncoordinated	0	1	4	8

Total points ____

SECTION B

1. Frequent urination during the day and night	0	1	4	8
2. Unusual thirst—feeling like you can't drink enough water	0	1	4	8
3. Unusual hunger—eating all the time	0	1	4	8
4. Vision blurs	0	1	4	8
5. Feel itchy all over	0	1	4	8
6. Tingling or numbness in your feet	0	1	4	8
7. Sense of drowsiness, lethargy during the day not associated with missing meals or not sleeping	0	1	4	8
8. Eating starchy foods, even if they are healthy and unprocessed (like rice, corn, beans, whole wheat or oats), causes you to gain weight or prevents you from losing weight	(0)No			(8)Yes
9. Sores heal slowly	(0)No			(8)Yes
10. Loss of hair on your legs	(0)No			(8)Yes

Total points ____

PART V

SECTION A

1. Feel jittery	0	1	4	8
2. First effort of the day causes pain, pressure, tightness or heaviness around the chest	0	1	4	8
3. Exhaustion with minor exertion	0	1	4	8
4. Heavy sweating (no exertion, no hot flashes)	0	1	4	8
5. Difficulty catching breath, especially during exercise	0	1	4	8
6. Heart pounding, sensation of heart beating too quickly, too slowly or irregularly	0	1	4	8
7. Swelling in feet, ankles and/or legs comes and goes for no apparent reason	0	1	4	8

Total points ____

ELIMINATION ASSESSMENT BRIEF

Name: _____ Date: _____

Colon / Bowels:

1. My bowels move: _____ times per day; _____ times per week (on the average).

2. Laxative use: _____ times per day; _____ times per week; _____ times per month; ____ never.

Please circle your answer to question number 3 according to the following scale:
1 = never 2 = infrequent 3 = frequently 4 = constantly

3. My stools are:

1 2 3 4	Large (3 fingers wide and 6" plus in length)
1 2 3 4	Soft and well-formed (smooth texture)
1 2 3 4	Medium (2 fingers wide and 4-6 plus in length and well-formed)
1 2 3 4	Thin, long or narrow stools
1 2 3 4	Often float
1 2 3 4	Small and hard
1 2 3 4	Large and hard
1 2 3 4	Difficult to pass
1 2 3 4	Loose, but not watery
1 2 3 4	Diarrhea
1 2 3 4	Alternates between hard (constipated) and loose and watery (diarrhea-like)

Stool odor:

1 2 3 4	Offensive usually
1 2 3 4	Offensive occasionally
1 2 3 4	Little odor usually

Stool color is:

1 2 3 4	Medium brown (peanut butter color), consistently
1 2 3 4	Dark brown, consistently
1 2 3 4	Very dark
1 2 3 4	Black
1 2 3 4	Yellow
1 2 3 4	Light brown
1 2 3 4	Clay or putty colored
1 2 3 4	Greenish color
1 2 3 4	Greasy, shiny appearance
1 2 3 4	Blood is visible in them
1 2 3 4	Have mucus in them
1 2 3 4	Varies a lot

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ELIMINATION ASSESSMENT BRIEF

Intestinal gas:	1	2	3	4	Daily
	1	2	3	4	Occasionally
	1	2	3	4	Excessive
	1	2	3	4	Present with pain
	1	2	3	4	Foul smelling
	1	2	3	4	Little odor

4. Do you have trouble initiating your bowel movement, yet the stool is not too large or too hard? (Y/N)_____

5. Does abdominal discomfort or cramping ever accompany bowel movements? (Y/N) ____
How often? _____

6. Have you ever been diagnosed as having a dental, gum, mouth, stomach, liver, gallbladder, pancreas, intestinal or bowel disorder or disease? (Y/N) ____
If yes, please explain.

7. Have you had or do you have hemorrhoids or varicose veins? (Y/N) ____
Please explain.

8. Do you make a conscious effort to eat a high fiber diet? (Y/N) ____
What do you eat?

9. Do you usually pay attention when nature calls? (Y/N) ____

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