

4. List all medications you currently take, including prescription, over-the-counter, and vitamin supplements:

Name of med/supp	Reason for taking	Dose	Frequency	Length of time using

5. Have you noticed any side effects from taking any of these medications/supplements? Yes _____ No _____
 If yes, please explain _____

6. Date of last medical checkup and what the doctor told you: _____

7. **Family health history:** Please circle the conditions mentioned below that are found in your family history. Please indicate who suffers from each condition:

- | | | | |
|--------------|-----------------|----------------------|----------------------------|
| Cancer | Heart disease | Multiple Sclerosis | Allergies |
| Diabetes | Lung disease | Muscular Dystrophy | Chronic fatigue |
| Lupus | Alcoholism | Obesity | Thyroid disease |
| Asthma | Drug abuse | Ulcers | Ulcerative colitis/Crohn's |
| Arthritis | Kidney disease | Liver disease | High blood pressure |
| Psoriasis | Eating disorder | Hormonal disorder | Circulatory problems |
| Osteoporosis | Alzheimer's | Macular Degeneration | Celiac |

8. Are you allergic to any foods or substances? Yes _____ No _____ If yes, please list and describe your symptoms

9. Have you ever had any worm, parasite, bacterial or yeast infections? Yes _____ No _____

10. How many times per day do you have a bowel movement? _____ Per week average _____

11. Do you use laxatives or other medications to promote eliminations? Yes _____ No _____

12. Describe stool quality _____

13. Do you experience any of the following on a regular basis? Yes _____ No _____ If yes, please circle:

- | | | | |
|------------------|-----------------------|----------------------------------|-------------|
| Lack of appetite | Diarrhea | Constipation | Indigestion |
| Gas | Bloating | Nausea | Vomiting |
| Reflux | Abdominal cramps/pain | Difficulty chewing or swallowing | |

14. Females: Age of first menses: _____ Are your menstrual periods normal? Yes ___ No ___ If no, please explain:

15. How would you rate your energy level on a scale of one to five: 1 2 3 4 5

16. How many hours of sleep do you get each night? ____ Do you fall asleep easily and stay asleep all night? _____

17. What is your blood type? O ____ A ____ B ____ AB ____
18. Do you exercise regularly or participate in a sport? Yes ____ No ____ If so, please indicate type of exercise or sport, frequency, and duration _____
19. Do you participate in any other activities or lessons? Yes ____ No ____ If yes, please describe: _____

Eating History

1. Are you on a special diet now or have you been in the past? Yes ____ No ____ If yes, for what reason and with what results? _____
2. Do you sometimes get sleepy, headaches, or other symptoms after eating certain foods? Yes ____ No ____ If yes, please give specifics _____
3. Please list your 10 favorite foods (or the 10 you eat most often) _____
4. Please list the foods you do not eat: _____
5. What do you drink and how much? _____
6. With whom do you usually eat your meals and who prepares them? _____

If you have any recent blood work or medical records pertaining to your current condition(s), please attach these to this questionnaire.