**Initial Adult Questionnaire**

|  |
| --- |
| First Name MI |
| Last Name |
| Home Address: |
| Phones: (Home) (Cell) |
| Email: |
| Sex: M F |
| Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ |
| Height: |
| Weight: lbs |
| Current Diagnosis (list all): |
|  |
|  |
|  |
| Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Primary Complaint:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Goals for the visit:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**PAST MEDICAL HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
| CONDITION | PAST TREATMENTS | CURRENT TREATMENTS | APPROXIMATE DATE (S) of TREATMENT |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Please check (X) substances taken now or in the past and mark the appropriate section

|  |  |  |
| --- | --- | --- |
| **Now** | **Past** | **Medications and Supplements** |
|  |  | Multivitamin (Specifiy) |
|  |  | Vitamin A |
|  |  | Vitamin C |
|  |  | Vitamin B3 (Niacin) |
|  |  | Vitamin B6 |
|  |  | 5 HTP |
|  |  | Alpha Keto Glutarate (AKG) |
|  |  | GABA |
|  |  | Glutamine |
|  |  | SAMe |
|  |  | Dimethylglycine (DMG) |
|  |  | TMG |
|  |  | Tryptophan |
|  |  | Tyrosine |
|  |  | Calcium |
|  |  | Magnesium |
|  |  | Manganese |
|  |  | Selenium |
|  |  | Zinc |
|  |  | Human Growth Factor |
|  |  | IV Immune globulin |
|  |  | Oral Immune globulin |
|  |  | Secretin (IV) |
|  |  | Secretin(transdermal/sublingual) |
|  |  | Steroids (oral) |
|  |  | Steroids (topical) |
|  |  | DHA rich oils |
|  |  | EPA rich oils |
|  |  | Omega 6 rich oils |
|  |  | Cod liver oil |
| **Now** | **Past** | **Medications and Supplements** |
|  |  | Steroids (topical) |
|  |  | Folic Acid |
|  |  | DMPS |
|  |  | DMSA (succimer,) |
|  |  | Reduced glutathione(IV) |
|  |  | Reduced glutathione(oral) |
|  |  | Melatonin |
|  |  | Digestive enzymes |
|  |  | Peptidase enzymes |
|  |  | Probiotics |
|  |  | Activated Charcoal |
|  |  | Alka Gold |
|  |  | Antibiotics (specify type and number of times): |
|  |  | Diflucan |
|  |  | Nystatin |
|  |  | Saccharomyces boulardii |
|  |  | Others |
|  |  | Others |
|  |  | Others |
|  |  | Others |
|  |  | Others |
|  |  | Others |
|  |  | Others |
|  |  | Others |
|  |  | Others |
|  |  | Others |
|  |  | Others |
|  |  | Others |

**EARLY HEALTH HISTORY**

Please check if you had any of the following childhood illnesses?

\_\_\_ Frequent Ear, Throat or other Infections

\_\_\_Colic

\_\_\_Reflux

\_\_\_Meningitis

\_\_\_Thrush

\_\_\_Asthma

\_\_\_Chicken Pox

\_\_\_Eczema

\_\_\_Frequent Colds

\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you take \_\_\_\_antibiotics or \_\_\_\_\_steroid medications frequently?

If so please explain the reasons: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY:**

List any allergies, major illnesses, genetic diseases or problems for each family member.

Mother\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Maternal Grandparents\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Paternal Grandparents\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other relatives \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours of SLEEP per night do you average?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any difficulty falling asleep or waking up?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EXERCISE: \_\_\_\_\_\_None Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALCOHOL: \_\_\_\_\_\_\_Never if yes, frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any alcoholics in your family? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

TOBACCO: \_\_\_Never \_\_\_Smoked or \_\_\_Smoking \_\_\_\_ packs/day from age \_\_\_\_\_ to \_\_\_\_\_.

If still smoking, have you ever tried to quit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What methods?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DIETARY/NUTRITIONAL /DIGESTIVE HISTORY**

What are your general EATING HABITS (overeat, undereat, picky, etc)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been on any diets? For which particular reason: weight loss, gain, gastrointestinal problems, and other reasons?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check (X) diet you are following now or in the past and mark the appropriate reaction

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Now | Past | Diets | Very  Good | Good | None | Did not work | Very Bad | Comments |
|  |  | Gluten/ Casein Free |  |  |  |  |  |  |
|  |  | Casein Free |  |  |  |  |  |  |
|  |  | Yeast Free |  |  |  |  |  |  |
|  |  | High Protein/ Low Carb |  |  |  |  |  |  |
|  |  | Low oxalate |  |  |  |  |  |  |
|  |  | Salicylate Free |  |  |  |  |  |  |
|  |  | Low Phenolic |  |  |  |  |  |  |
|  |  | IgG reactive food avoidance |  |  |  |  |  |  |
|  |  | Specific Carbohydrate Diet |  |  |  |  |  |  |
|  |  | Other: |  |  |  |  |  |  |
|  |  | Other: |  |  |  |  |  |  |
|  |  | Other: |  |  |  |  |  |  |

Have you ever had an eating disorder? If yes, which one(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Known food allergies\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suspected food SENSITIVITIES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there foods that you avoid because of how they make you feel? Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food CRAVINGS(e.g. bread, pasta, cheese, salty foods, sodas/coffee/tea with or without caffeine, alcohol, milk) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STOOL pattern (frequency, color, odor, consistency):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you or have you ever had gastrointestinal problems?

Please Describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe your usual food intake for three days using the forms below:

|  |
| --- |
| **DAY 1** |
| Breakfast |
| Morning Snack (s) |
| Lunch |
| Afternoon Snack (s) |
| Dinner |
| Other |

|  |
| --- |
| **DAY 2** |
| Breakfast |
| Morning Snack (s) |
| Lunch |
| Afternoon Snack (s) |
| Dinner |
| Other |

|  |
| --- |
| **DAY 3** |
| Breakfast |
| Morning Snack (s) |
| Lunch |
| Afternoon Snack (s) |
| Dinner |
| Other |

Please check (X) diet you are following now or in the past and mark the appropriate reaction

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Symptoms | Mild | Moderate | Severe | Duration | Unique details |
| Nail biting |  |  |  |  |  |
| Hand/arm biting |  |  |  |  |  |
| Nail/skin picking |  |  |  |  |  |
| Mood swings |  |  |  |  |  |
| Depression |  |  |  |  |  |
| Irritability |  |  |  |  |  |
| Fears/anxieties |  |  |  |  |  |
| Hyperactivity |  |  |  |  |  |
| Inability to concentrate/focus |  |  |  |  |  |
| Fidgety |  |  |  |  |  |
| Impulsive |  |  |  |  |  |
| Panic Attacks |  |  |  |  |  |
| Dizziness |  |  |  |  |  |
| Fainting |  |  |  |  |  |
| Seizures |  |  |  |  |  |
| Poor coordination |  |  |  |  |  |
| Mood swings |  |  |  |  |  |
| Trouble remembering |  |  |  |  |  |
| Low self-esteem |  |  |  |  |  |
| Fatigue |  |  |  |  |  |
| Cold hands/feet |  |  |  |  |  |
| Cold intolerance |  |  |  |  |  |
| Heat intolerance |  |  |  |  |  |
| Recurrent/chronic fever |  |  |  |  |  |
| Flushing |  |  |  |  |  |
| Difficulty falling to sleep |  |  |  |  |  |
| Difficulty staying asleep |  |  |  |  |  |
| Symptoms | Mild | Moderate | Severe | Duration | Unique details |
| Nightmares |  |  |  |  |  |
| Difficulty waking up |  |  |  |  |  |
| Early waking |  |  |  |  |  |
| Daytime sleepiness |  |  |  |  |  |
| Bed wetting |  |  |  |  |  |
| Day time wetting |  |  |  |  |  |
| Numbness/tingling in hands/feet |  |  |  |  |  |
| Headache |  |  |  |  |  |
| Blinking |  |  |  |  |  |
| Tics |  |  |  |  |  |
| Eye discharge |  |  |  |  |  |
| Dark circles/puffiness under eyes |  |  |  |  |  |
| Night-blindness |  |  |  |  |  |
| Congestion |  |  |  |  |  |
| Postnasal drip |  |  |  |  |  |
| Sensitivity to bright lights |  |  |  |  |  |
| Earaches |  |  |  |  |  |
| Ringing in ears |  |  |  |  |  |
| Bad breath |  |  |  |  |  |
| Nose bleeds |  |  |  |  |  |
| Acute sense of smell |  |  |  |  |  |
| Sore throats |  |  |  |  |  |
| Hoarseness |  |  |  |  |  |
| Cough |  |  |  |  |  |
| Wheezing |  |  |  |  |  |
| Seasonal allergy |  |  |  |  |  |
| Geographic tongue (map-like rash) |  |  |  |  |  |
| Swollen gums |  |  |  |  |  |
| Canker sores |  |  |  |  |  |
| Dry lips/mouth |  |  |  |  |  |
| Cracking at corner of lips |  |  |  |  |  |
| Cold scores |  |  |  |  |  |
| Frequent diarrhea |  |  |  |  |  |
| Frequent constipation |  |  |  |  |  |
| Bloating |  |  |  |  |  |
| Passing gas |  |  |  |  |  |
| Belching |  |  |  |  |  |
| Nausea |  |  |  |  |  |
| Vomiting |  |  |  |  |  |
| Reflux |  |  |  |  |  |
| Bad breath |  |  |  |  |  |
| Abdominal pain |  |  |  |  |  |
| Heartburn |  |  |  |  |  |
| Symptoms | Mild | Moderate | Severe | Duration | Unique details |
| Poor appetite |  |  |  |  |  |
| Bad teeth |  |  |  |  |  |
| Gum bleeding |  |  |  |  |  |
| Food Craving |  |  |  |  |  |
| Undigested food in stool |  |  |  |  |  |
| Grinding teeth |  |  |  |  |  |
| Mucous in stools |  |  |  |  |  |
| Blood in stools |  |  |  |  |  |
| Anal itching |  |  |  |  |  |
| Calf cramps |  |  |  |  |  |
| Other muscle cramps/spasms |  |  |  |  |  |
| Tremors |  |  |  |  |  |
| Muscle weakness |  |  |  |  |  |
| Muscle stiffness |  |  |  |  |  |
| Joint pain |  |  |  |  |  |
| Athletes foot |  |  |  |  |  |
| Weakness |  |  |  |  |  |
| Stiffness |  |  |  |  |  |
| Eczema |  |  |  |  |  |
| Psoriasis |  |  |  |  |  |
| Hives |  |  |  |  |  |
| Acne |  |  |  |  |  |
| Other rashes |  |  |  |  |  |
| Easy bruising |  |  |  |  |  |
| Ears get red |  |  |  |  |  |
| Itchy scalp |  |  |  |  |  |
| Itchy skin |  |  |  |  |  |
| Dry skin |  |  |  |  |  |
| Oily skin |  |  |  |  |  |
| Pale skin |  |  |  |  |  |
| Sensitivity to insect bites |  |  |  |  |  |
| Sensitive to texture of clothes |  |  |  |  |  |
| Cracking/peeling hands |  |  |  |  |  |
| Cracking/peeling feet |  |  |  |  |  |
| Strong body odor |  |  |  |  |  |
| Strong urine odor |  |  |  |  |  |
| Strong stool odor |  |  |  |  |  |
| Soft nails |  |  |  |  |  |
| Thickening of nails |  |  |  |  |  |
| Ridges/pitting of nails |  |  |  |  |  |
| White spots/lines on nails |  |  |  |  |  |
| Brittle nails |  |  |  |  |  |
| Fungus on nails |  |  |  |  |  |
| Any OCD (obsessive compulsive) behaviors |  |  |  |  |  |
| Symptoms | Mild | Moderate | Severe | Duration | Unique details |
| Urinary urgency |  |  |  |  |  |
| Urinary leaking |  |  |  |  |  |
| Urinary pain |  |  |  |  |  |
| Urinary hesitancy |  |  |  |  |  |
| Kidney stones |  |  |  |  |  |
| Blood in urine |  |  |  |  |  |
| Other |  |  |  |  |  |
| Other |  |  |  |  |  |
| Other |  |  |  |  |  |
| Other |  |  |  |  |  |
| Other |  |  |  |  |  |
| Other |  |  |  |  |  |
| Other |  |  |  |  |  |

**Tests**

**If you have a copy of any of recent (within past 6 month) tests that are listed below but not limited to the list please send us a copy:**

* Blood Chemistry (Including Liver Function Tests)
* Blood Count (CBC)
* IgG Food Sensitivity Panel
* IgE Environmental Allergy Panel
* Hair Elements
* Urine Toxic Metals and Elements
* Homocysteine
* Folic Acid
* Serum -Methylmalonic Acid
* Immune Profile
* Urine Organic Acids
* Amino Acids
* Plasma or Serum Zinc
* Plasma or Serum Copper
* RBC Elements
* Iron Studies (Ferritin, % Iron Saturation)
* Thyroid Panel (TSH, etc)
* Serum Vitamin Levels (Specify)
* Stool Culture
* Stool Ova and Parasites
* Uric Acid (blood or urine)

List any other history, pertinent thoughts or questions you want to address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_