Functional Nutrition Vermont
Paige Kelly, MSACN

Attached you will find a very comprehensive intake. Although it will take you some time to complete the information, your careful consideration and detailed responses to each of the following questions provided will allow me to accurately assess all of the factors presented in your health history. In answering the questions provided as completely as possible, our time together can be utilized more effectively in creating a cohesive nutritional plan for you. None of the information provided is intended to diagnose or treat disease but to evaluate metabolic and homeostatic status and support the excess or insufficient states with food and whole food nutritional supplementation.

These services may include nutrition assessment of eating patterns, suggestions for shifting nutritional choices, nutritional testing, suggestions for physical activity (as set by healthcare provider), therapeutic massage, follow-up appointments, and re-evaluation.

In signing below, I understand the suggestions and advice given will be made in my best interest with information provided but the choices in compliance and final decisions about my health are mine. All printed materials provided are solely for my use.

I hereby agree to the above statements and agree to the above named services. I intend this informed consent form to cover the entire course of care while in this office.

Date:

Print Name:

Patient Guardian:

Patient Signature:

Disclaimer of Liability

Paige Kelly, MSACN is not a physician or psychologist, and the scope of her consultation services does not include treatment or diagnosis of specific illnesses or disorders. If you, the client, suspect you may have an ailment or illness that may require medical attention, then you are encouraged to consult with a licensed physician without delay. Only a licensed physician can prescribe drugs. Any mention of drugs in the course of consultation is only for the purpose of providing a complete history of drugs that the client is taking and not for Paige Kelly, MSACN to judge the appropriateness of the medication. Any change in prescription or dosage is a decision the client makes with his or her physician.

Rather than dealing with treatment of disease, Paige Kelly, MSACN focuses on wellness and prevention of illness through the use of non-toxic, natural nutritional therapies to achieve optimal health. As a certified clinical nutritionist, Paige Kelly, MSACN primarily educates and motivates clients to assume more personal responsibility for their health by adopting a healthy attitude, lifestyle, and diet.

While people generally experience greater health and wellness as a result of embracing a healthier attitude, lifestyle, and diet, Paige Kelly MSACN does not promise or guarantee protection from future illness.

By signing below, you acknowledge that you understand that Paige Kelly, MSACN is a health consultant and NOT a physician, and that you should see a doctor if you think you have a medical condition. Paige Kelly, MSACN will not be held liable for failure to diagnose or treat an illness, nor will she be liable for failure to prevent future illness.

Additionally, you promise to give Paige Kelly, MSACN a complete and accurate account of any medical conditions that you may have and any medications that you are taking.

By signing below, I am stating that I understand and am in agreement with the information presented above.

Print Name: ____

Sign and Date____

ADULT MEDICAL QUESTIONNAIRE

Functional Nutrition. Paige Kelly, MSACN

First Name: __________________Middle Name: ________________Last Name: _____________________

Address:________________________________ City: __________________ State: _______ ZIP: _________

Home Phone: (________) ________-___________ Birth Date: _____/____/____ Age: _________
month day year

Work Phone: (________) ________-___________

Place of Birth:_______________________________
City or town & country if not US

Occupation: ________________________________

Referred by: ________________________________ Height: ___' ____" Weight: _______ Sex: _____

Please (√) the appropriate box(es):

☐ Caucasian ☐ African American ☐ Hispanic/Latino ☐ Asian
☐ Native American ☐ Pacific Islander ☐ Mixed Race ☐ Other

Today's Date ________________________________

Please check (√) any of the following whose care you are under

☐ Medical doctor (MD) ☐ Psychiatrist/Psychologist ☐ Dentist
☐ Osteopath ☐ Physical Therapist ☐ Chiropractor

Other ____

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, accident, physical, etc.):____
____

Describe Your Overall General Health: ____
____
____

ADULT MEDICAL QUESTIONNAIRE

1. Please list current and ongoing symptoms in order of priority and fill in ALL columns as completely as possible:

DESCRIBE MAJOR COMPLAINTS/SYMPTOMS	RATE SYMPTOM SEVERITY ON SCALE FROM 1 TO 10 (10 being the most severe)	EXISTING TREATMENT APPROACH (state 'none' if no current treatment)	CURRENT TREATMENT SUCCESS (if applicable)
Example: Post Nasal Drip	5	Elimination Diet	Moderate
a.			
b.			
c.			
d.			
e.			
f.			
g.			

What is the main reason (from the complaints listed above) that prompted you to seek help?____________________

____

How long does this last? How often do you have this (these) symptom(s)?____________________________________

____

What aggravates this (these) symptom(s)____

____

What makes this (these) symptom(s) better? ____

____

Please describe symptoms if they were not detailed in the major complaint area above_________________________

____

Family History

CONDITION	FAMILY MEMBER	CONDITION	FAMILY MEMBER
☐ Allergies (including food allergies)		☐ Stomach or Duodenal Ulcer	
☐ Fibromyalgia/ Chronic Fatigue		☐ High Cholesterol/ Triglycerides	
☐ Digestive Disease/ Disorder		☐ Multiple Sclerosis (Autoimmune)	
☐ Environmental Sensitivities		☐ Gallbladder Disorders (e.g. gallstones)	
☐ Alzheimer's/Dementia		☐ Asthma	
☐ Anemia		☐ Liver Disease/ Hepatitis	
☐ Anorexia		☐ Diabetes	
☐ Depression		☐ Mental Illness	
☐ Alcoholism/Drug Use		☐ Eating Disorder	
☐ Glaucoma		☐ Migraine Headaches	
☐ Stroke		☐ Cancer or Tumor	
☐ Obesity		☐ Thyroid Disease	
☐ Autoimmune Disorders		☐ Blood Clotting Problems	
☐ Chemical Sensitivities		☐ Autism	
☐ HIV, AIDS		☐ Frequent Infections	

Is there any other family history we should know about (that was not listed above)? ☐ Yes ☐ No
If so, please comment:

____

____

Social History

With whom do you live? Please list all children, parents, relatives, friends, and their ages.
Example: Wendy, age 7, sister

____

____

Do you have any pets or farm animals? ☐ Yes ☐ No
If yes, where do they live? ☐ Indoors ☐ Outdoors ☐ Both Indoors and Outdoors

Have you lived or traveled outside of the United States? ☐ Yes ☐ No
If so, when, and where?

____

____

Have you experienced any major losses in life? ☐ Yes ☐ No
If so, please comment:

____

____

Have you or your family recently experienced any major life changes? ☐ Yes ☐ No
If yes, please comment:

____

____

How important is religion (or spirituality) for you and your family's life?
☐ not at all important ☐ somewhat important ☐ extremely important

Please list all previous
jobs:____

____

How much time have you lost from work or school in the past year?
☐ 0-2 days ☐ 3 –14 days ☐ > 15 days

What type of schooling have you been through or are in the process of going
through?____

____

Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress, illness, and immune system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life, it is very important that you feel safe in telling us about it, so that we can support you and optimize your treatment outcomes.

Please do your best to answer the following questions:

a. Did you feel safe growing up? ☐ Yes ☐ No
b. Have you been involved in abusive relationships in your life? ☐ Yes ☐ No
c. Was alcoholism or substance abuse present in your childhood home? ☐ Yes ☐ No
d. Is alcoholism or substance abuse present now in your relationships? ☐ Yes ☐ No
e. Do you currently feel safe in your home? ☐ Yes ☐ No

Past Medical and Surgical History

Please indicate (√) next to conditions/procedures relevant to you.

(√)	ILLNESSES	WHEN	COMMENTS
	Anemia		
	Arthritis		
	Asthma		
	Bronchitis		
	Cancer		
	Chronic Fatigue Syndrome		
	Crohn's Disease or Ulcerative Colitis		
	Diabetes		
	Emphysema		
	Epilepsy, convulsions, or seizures		
	Gallstones		
	Gout		
	Heart attack/Angina		
	Heart Disease		
	Heart failure		
	Hepatitis		
	Herpes		
	High blood fats (cholesterol, triglycerides)		
	High blood pressure (hypertension)		
	HIV		
	Hypoglycemia		
	Irritable bowel		
	Kidney stones		
	Lyme Disease		
	Mononucleosis		
	Pneumonia		
	Rheumatic fever		
	Sinusitis		
	Sleep apnea		
	Stroke		
	Thyroid disease		
	Other (describe)		
	Back injury		
	Broken (describe)		
	Dislocation		
	Head injury		

ADULT MEDICAL QUESTIONNAIRE

(√)	**ILLNESSES**	**WHEN**	**COMMENTS**
	Neck injury		
	Sprain		
	Other (describe)		
	DIAGNOSTIC STUDIES	**WHEN**	**COMMENTS**
	Barium Enema		
	Blood Work		
	Bone Scan		
	CAT Scan of Abdomen		
	CAT Scan of Brain		
	CAT Scan of Spine		
	Chest X-ray		
	Colonoscopy		
	EKG		
	Liver scan		
	Neck X-ray		
	NMR/MRI		
	Sigmoidoscopy		
	Upper GI Series		
	Other (describe)		

Operations:

	OPERATIONS	**WHEN**	**COMMENTS**
	Appendectomy		
	Dental Surgery		
	Gall Bladder		
	Hernia		
	Hysterectomy		
	Tonsillectomy		
	Other (describe)		

Hospitalizations:

WHERE HOSPITALIZED	**WHEN**	**FOR WHAT REASON**

ADULT MEDICAL QUESTIONNAIRE

Please indicate (√) how often you have taken antibiotics.

	Over 5 Times	**Less Than 5 Times**
Infancy/ Childhood		
Teen		
Adulthood		

Please indicate (√) how often you have taken oral steroids (e.g., Cortisone, Prednisone, etc.).

	Over 5 Times	**Less Than 5 Times**
Infancy/ Childhood		
Teen		
Adulthood		

Please list the medications you are currently taking. Include both prescription and over-the-counter.

Medication Name	**Date started**	**Dosage**	**How Often?**	**Consistently?**
1.			Times/day	
2.			Times/day	
3.			Times/day	
4.			Times/day	
5.			Times/day	
6.			Times/day	
7.			Times/day	
8.			Times/day	

Are you allergic to any medications? ☐ Yes ☐ No
If yes, please list: ______________________________

List all vitamins, minerals, and other nutritional supplements that you are taking. Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible.

Vitamin/Mineral/Herbal Supplement	**Date started**	**Dosage**	**Form of Vitamin/Mineral**	**How Often?**
1.				Time/day
2.				Time/day
3.				Time/day
4.				Time/day
5.				Time/day
6.				Time/day
7.				Time/day
8.				Time/day

Childhood:

	Yes	No	Don't Know	Comment
Were you a full term baby?				
a. A preemie?				
b. Breast fed?				
c. Bottle fed?				
As a child did you eat a lot of sugar and/or candy?				

As a child, were there any foods that you had to avoid because they gave you symptoms? ☐ Yes ☐ No
If yes, please: name the food and symptom (Example: milk – gas and diarrhea)__________________________

____

____

Diet

Indicate (√) the foods/drinks that apply to your current diet.

√	USUAL BREAKFAST	√	USUAL LUNCH	√	USUAL DINNER
	None		None		None
	Bacon/Sausage		Butter		Beans (legumes)
	Bagel		Coffee		Brown rice
	Butter		Eat in a cafeteria		Butter
	Cereal		Eat in restaurant		Carrots
	Coffee		Fish sandwich		Coffee
	Donut		Juice		Fish
	Eggs		Leftovers		Green vegetables
	Fruit		Lettuce		Juice
	Juice		Margarine		Margarine
	Margarine		Mayo		Milk
	Milk		Meat sandwich		Pasta
	Oat bran		Milk		Potato
	Sugar		Salad		Poultry
	Sweet roll		Salad dressing		Red meat
	Sweetener		Soda		Rice
	Tea		Soup		Salad
	Toast		Sugar		Salad dressing
	Water		Sweetener		Soda
	Wheat bran		Tea		Sugar
	Yogurt		Tomato		Sweetener
	Other: (List below)		Water		Tea
			Yogurt		Water
			Other: (List below)		Yellow vegetables
					Other: (List below)

How many glasses of water do you drink during a typical day? ____

ADULT MEDICAL QUESTIONNAIRE

How often do you choose organic fruits and vegetables and grass-fed/cage-free animal products?
____

How many meals do you consume each day? ________ What is the time interval between each meal?________

Indicate when you snack:
Between Meals ☐ Yes ☐ No
Before Bedtime ☐ Yes ☐ No

If yes, what do you normally eat?____
____

How much of the following do you consume each week?

a.	Hard and Sugar Candy (pieces)	
b.	Cheese (oz, where 1 oz = size of a dice)	
c.	Chocolate (oz)	
d.	Cups of coffee containing caffeine	
e.	Cups of decaffeinated coffee or tea	
f.	Cups of hot chocolate	
g.	Cups of tea containing caffeine	
h.	Cups of Diet sodas	
i.	Cups of Sodas with caffeine	
j.	Cups of Sodas without caffeine	
k.	Slices of white bread (or rolls/bagels)	
l.	Ice cream (cups)	
m.	Chips and Crackers (cups)	

Are you on a special diet? ☐ Yes ☐ No
☐ ovo-lacto ☐ vegetarian ☐ other (describe):
☐ dietary restricted ☐ vegan ______________________
☐ diabetic ☐ blood type diet ______________________

Are you injecting insulin? ☐ Yes ☐ No
If yes, how often? ___________ How much? ___________

Is there anything special about your diet that we should know? ☐ Yes ☐ No

If yes, please explain:
____
____

Do you have symptoms **immediately after** eating, such as belching, bloating, sneezing, hives, etc.?
☐ Yes ☐ No
If yes, are these symptoms associated with any particular food or supplement(s)?
☐ Yes ☐ No
If yes, please name the food or supplement and symptom(s). (Example: Milk – gas and diarrhea)____
____

Do you feel you have **delayed** symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? ☐ Yes ☐ No

Do you feel significantly **worse** when you eat a lot of :

- ☐ high fat foods
- ☐ high protein foods
- ☐ high carbohydrate foods (breads, pastas, potatoes)
- ☐ refined sugar (junk food)
- ☐ fried foods
- ☐ 1 or 2 alcoholic drinks
- ☐ other ______________________________

Do you feel significantly **better** when you eat a lot of :

- ☐ high fat foods
- ☐ high protein foods
- ☐ high carbohydrate foods (breads, pastas, potatoes)
- ☐ refined sugar (junk food)
- ☐ fried foods
- ☐ 1 or 2 alcoholic drinks
- other ______________________________

Does skipping a meal greatly affect your symptoms? ☐ Yes ☐ No

Have you ever had a food that you craved or really "binged" on over a period of time? ☐ Yes ☐ No
If yes, what food(s)? ____
____

Do you have an aversion to certain foods? ☐ Yes ☐ No
If yes, what food(s)? ____
____

Do you have trouble eating because of loose, ill fitting, or missing teeth? ☐ Yes ☐ No

Do you prepare the meals eaten in your house? ☐ Yes ☐ No
If no, who does?____

Check All That Describe Your Eating Habits:

- ☐ I eat-out at restaurants _________ times a week.
- ☐ Emotional eating
- ☐ Don't know what to eat
- ☐ Chocolate is my weakness.
- ☐ Hate to exercise
- ☐ Meal Planning
- ☐ Self Esteem
- ☐ Family Influences and Peers
- ☐ Work is my downfall
- ☐ Parties and Social Events
- ☐ Lack of Focus
- ☐ Hunger
- ☐ Habits or Patterns
- ☐ Comfort Foods
- ☐ Snacking, Grazing and Nibbling
- ☐ Too Busy
- ☐ I binge eat ________ times a week, ______ times a month.
- ☐ No time to eat regularly.
- ☐ I love food and it loves me.
- ☐ Loss of Energy at certain times of the day.
- ☐ Don't know how to exercise
- ☐ I don't have the money to eat healthy
- ☐ Picky Eater
- ☐ Negative Self Talk
- ☐ Home is my downfall
- ☐ Medical Reasons
- ☐ Motivation
- ☐ Cravings
- ☐ Tradition and genetics are my challenge.
- ☐ Unconscious Eating
- ☐ Too Tired

Bowl Movements

Please fill in the chart below with information about your bowel movements:

a. Frequency	√	b. Color	√
More than 3x/day		Medium brown consistently	
1-3x/day		Very dark or black	
4-6x/week		Greenish color	
2-3x/week		Blood is visible.	
1 or fewer x/week		Varies a lot.	
		Dark brown consistently	
b. Consistency		Yellow, light brown	
Soft and well formed		Greasy, shiny appearance	
Often float			
Difficult to pass			
Diarrhea			
Thin, long or narrow			
Small and hard			
Loose but not watery			
Contains undigested food			
Alternating between hard and loose/watery			

Indicate **(√)** how often you experience intestinal gas:

- ☐ Daily
- ☐ Occasionally
- ☐ Excessive
- ☐ Present with pain
- ☐ Foul smelling
- ☐ Little odor

Drugs/Alcohol

Have you ever used alcohol? ☐ Yes ☐ No

If yes, how often do you now drink alcohol?
- ☐ No longer drinking alcohol
- ☐ Average 1-3 drinks per week
- ☐ Average 4-6 drinks per week
- ☐ Average 7-10 drinks per week
- ☐ Average >10 drinks per week

c. Have you ever had a problem with alcohol? ☐ Yes ☐ No

d. If yes, please indicate time period (month/year): From _________ To ____________.

Have you ever used recreational drugs? ☐ Yes ☐ No

Have you ever used tobacco? ☐ Yes ☐ No

If yes, number of years as a nicotine user ______ Amount per day ______ Year quit ______

If yes, what type of nicotine have you used?
- ☐ Cigarette
- ☐ Smokeless
- ☐ Cigar
- ☐ Pipe
- ☐ Patch/Gum

Are you exposed to second hand smoke regularly? ☐ Yes ☐ No

Toxin Exposure

Do you have mercury amalgam fillings? ☐ Yes ☐ No
Do you have any artificial joints or implants? ☐ Yes ☐ No
Do you feel worse at certain times of the year? ☐ Yes ☐ No
If yes, when? ☐ spring ☐ fall
☐ summer ☐ winter

Have you, to your knowledge, been exposed to toxic metals in your job or at home? ☐ Yes ☐ No
If yes, which one(s)? ☐ lead ☐ cadmium
☐ arsenic ☐ mercury
☐ aluminum

Do odors affect you? ☐ Yes ☐ No

Social/Mental Status

Please indicate (√) how well things have been going for you:

	VERY WELL	FAIR	POORLY	VERY POORLY	DOES NOT APPLY
a. At school					
b. In your job					
c. In your social life					
d. With close friends					
e. With sex					
f. With your attitude					
g. With your boyfriend/girlfriend					
h. With your children					
i. With your parents					
j. With your spouse					

Have you ever had psychotherapy or counseling? ☐ Yes ☐ No
☐ Currently? ☐ Previously? If previously, from _______ to ________
What kind?
____
Comments:
____
____

Are you currently, or have you ever been, married? ☐ Yes ☐ No
If so, when were you married? ___________ Spouse's occupation ____________________
When were you separated? ___________ Never ______
When were you divorced? ___________ Never ______
When were you remarried? ___________ Never ______

Comments:____
____

What is the attitude of those close to you about your illness?

- ☐ Supportive
- ☐ Non-supportive

Have you ever experienced forgetfulness/slow mental process?________________________________

Have you experienced difficulty concentrating?
____

See Appendix A: Quality of Life Assessment for further evaluation.

Physical Activity

Hobbies and leisure activities:________________________________
____

Do you exercise regularly? ☐ Yes ☐ No

If so, how many times a week?

- ☐ 1x
- ☐ 2x
- ☐ 3x
- ☐ 4x or more

When you exercise, how long is each session?

- ☐ <15 min
- ☐ 16-30 min
- ☐ 31-45 min
- ☐ 45 min

What type of exercise is it?

- ☐ jogging/walking
- ☐ basketball
- ☐ home aerobics
- ☐ tennis
- ☐ water sports
- other ________________________

How long have you been exercising regularly?________________________
How long does it take you to recover after exercise?________________________

Occupational Activity Level (Please "(√)" One:

- ☐ Sedentary: Sitting
- ☐ Light: Standing
- ☐ Moderate: Walking
- ☐ Active: Manual Labor

*****See Appendix B: Physical Activity Questionnaire for further evaluation***

Current Symptoms

Please check if these symptoms either occur presently **or** have occurred in the past 6 months.

GENERAL:	**Mild**	**Mod.**	**Severe**
Cold hands & feet			
Cold intolerance			
Daytime sleepiness			
Difficulty falling asleep			
Early waking			
Fatigue			
Fever			
Flushing			
Heat intolerance			
Night waking			
Nightmares			
Numb fingers and toes			
No dream recall			
Sensitive to minor changes in weather			
Tired, sluggish			
Unintentional weight loss			

HEAD, EYES, NOSE & EARS:	**Mild**	**Mod.**	**Severe**
Burning of eyes			
Conjunctivitis			
Discharge from eyes			
Distorted sense of smell			
Distorted taste			
Ear fullness			
Ear noises			
Ear pain			
Ear ringing/buzzing			
Eye crusting			
Eye pain			
Headache			
Hearing loss			

HEAD, EYES, NOSE & EARS CONT'D:	**Mild**	**Mod.**	**Severe**
Hearing problems			
Lid margin redness			
Migraine			
Nasal congestion or discharge			
Sensitivity to loud noises			
Vision problems			

MUSCULOSKELETAL:	**Mild**	**Mod.**	**Severe**
Abdominal cramps, aches			
Back muscle spasm			
Calf cramps			
Chest tightness			
Foot cramps			
Joint deformity			
Joint pain			
Joint redness			
Joint stiffness			
Muscle pain			
Muscle spasms			
Muscle stiffness			
Muscle twitches: Around eyes			
Arms or legs			
Muscle weakness			
Neck muscle spasm			
Tendonitis			
Tension headache			
Tight sensation in neck			
TMJ problems			

MOOD/NERVES:	**Mild**	**Mod.**	**Severe**
Agoraphobia			

ADULT MEDICAL QUESTIONNAIRE

Anxiety			
Auditory hallucinations			
Black-out			
Depression			
Difficulty: Concentrating			
With balance			
With thinking			
With judgment			
With speech			
With memory			
Dizziness (spinning)			
Fainting			
Fearfulness			
Irritability			
Light-headedness			
Unsteady gait			
Mood swings			
Numbness			
Other Phobias			
Panic attacks			
Paranoia			
Restless, agitated, angry			
Seizures			
Suicidal thoughts			
Tingling			
Tremor/trembling			
Visual hallucinations			

EATING:	**Mild**	**Mod.**	**Severe**
Binge eating			
Bulimia			
Can't gain weight			
Can't lose weight			
Carbohydrate craving			
Carbohydrate intolerance			

EATING CONT'D:	**Mild**	**Mod.**	**Severe**
Feeling hungry an hour or two after eating			
Poor appetite			
Sense of fullness during and after meals			
Salt craving			

DIGESTION:	**Mild**	**Mod.**	**Severe**
Anal spasms			
Bad teeth			
Bleeding gums			
Bloating of: Lower abdomen			
Whole abdomen			
Blood in stools			
Burping			
Canker sores			
Cold sores			
Constipation			
Cracking at corner of lips			
Dentures w/poor chewing			
Diarrhea			
Difficulty swallowing			
Dry mouth			
Farting			
Bowl Pain			
Fissures			
Foods "repeat" (reflux)			
Heartburn			
Hemorrhoids			
Indigestion			
Intolerance to: Lactose			
All milk products			
Intolerance to: Gluten (wheat)			
Corn			
Eggs			
Fatty foods			
Yeast			

DIGESTION CONT'D:	**Mild**	**Mod.**	**Severe**
Liver disease/jaundice (yellow eyes or skin)			

Lower abdominal pain			
Mucus in stools			
Nausea			
Periodontal disease			
Smooth tongue			
Sore tongue			
Sores in corner of mouth			
Strong stool odor			
Undigested food in stools			
Upper abdominal pain			
Vomiting			

GENERAL SKIN PROBLEMS:	**Mild**	**Mod.**	**Severe**
Acne on back			
Acne on chest			
Acne on face			
Acne on shoulders			
Athlete's foot			
Blotchy skin			
Bruising easily			
Bumps on back of upper arms			
Cellulite			
Dark circles under eyes			
Ears get red			
Easy bruising			
Skin in general			
Throat			
Scalp			
Eczema			
Elasticity lost			
Herpes - genital			
Hives			
Jock itch			
Lackluster skin			
Moles w color/size change			

GENERAL SKIN PROBLEMS CONT'D:	**Mild**	**Mod.**	**Severe**
Oily skin			
Pale skin			
Patchy dullness			
Psoriasis			
Puffy face, hands, and feet			
Rash			
Red face			
Open sores on feet and legs			
Sensitive to bites			
Sensitive to poison ivy/oak			
Shingles			
Skin cancer			
Skin darkening			
Strong body odor			
Swollen eyelids			
Thick calluses			
Vitiligo			

SKIN, ITCHING:	**Mild**	**Mod.**	**Severe**
Anus			
Arms			
Ear canals			
Eyes			
Feet			
Hands			
Legs			
Nipples			
Nose			
Penis			
Roof of mouth			

SKIN, DRYNESS OF:	**Mild**	**Mod.**	**Severe**
Eyes			
Feet			
Any cracking?			
Any peeling?			

SKIN, DRYNESS OF CONT'D:	**Mild**	**Mod.**	**Severe**
Hair			

Unmanageable?			
Hands			
Any cracking?			
Any peeling?			
Mouth/throat			
Scalp			
Any dandruff?			
Skin in general			

HAIR:	**Mild**	**Mod.**	**Severe**
Loss of chest and armpit hair			
Loss of eyebrow hair (lateral 1/3)			
Loss of lower leg hair			

LYMPH NODES:	**Mild**	**Mod.**	**Severe**
Enlarged/neck			
Tender/neck			
Other enlarged/tender lymph nodes			

NAILS:	**Mild**	**Mod.**	**Severe**
Bitten			
Brittle			
Curve up			
Discolorations			
Frayed			
Fungus - fingers			
Fungus - toes			
Pitting			
Ragged cuticles			
Ridges			
Soft			
Thickening of: Finger nails			

NAILS CONT'D:	**Mild**	**Mod.**	**Severe**
Toenails			
White spots/lines			

RESPIRATORY:	**Mild**	**Mod.**	**Severe**
Bad breath			
Bad odor in nose			
Chest pain			
Cough - dry			
Cough - productive			
Difficulty breathing			
Hay fever : Spring			
Summer			
Fall			
Change of season			
Hoarseness			
Nasal stuffiness			
Nose bleeds			
Post nasal drip			
Sinus fullness			
Sinus infection			
Snoring			
Sore throat			
Wheezing			
Winter stuffiness			

CARDIOVASCULAR:	**Mild**	**Mod.**	**Severe**
Angina/chest pain			
Breathlessness			
Heart attack			
Heart burn			
Heart murmur			
High blood pressure			
Irregular pulse			
Mitral valve prolapse			
Phlebitis			
Pounding heart			

CARDIOVASCULAR CONT'D:	**Mild**	**Mod.**	**Severe**
Swollen ankles/feet			

Varicose veins			
Slow heartbeat			

URINARY:	Mild	Mod.	Severe
Bed wetting			
Dark Urine			
Hesitancy			
Increased frequency			
Infection			
Kidney disease			
Kidney stone			
Leaking/incontinence			
Pain/burning			
Prostate enlargement			
Prostate infection			
Urgency			

MALE REPRODUCTIVE:	Mild	Mod.	Severe
Discharge from penis			
Ejaculation problem			
Genital pain			
Impotence			
Infection			
Lumps in testicles			
Poor libido (sex drive)			

FEMALE REPRODUCTIVE:	Mild	Mod.	Severe
Breast cysts			
Breast lumps			
Breast tenderness			
Ovarian cyst			
Poor libido (sex drive)			
Endometriosis			
Fibroids			
Infertility			
Vaginal discharge			
Vaginal odor			
Vaginal itch			
Vaginal pain			
Premenstrual: Bloating			
Breast tenderness			
Carbohydrate craving			
Chocolate craving			
Constipation			
Decreased sleep			
Diarrhea			
Fatigue			
Increased sleep			
Irritability			
Menstrual: Cramps			
Heavy periods			
Irregular periods			
No periods			
Scanty periods			
Spotting between			

For Women Only (questions 50-58):

2. Have you ever been pregnant? (If no, skip to question 53.) ☐ Yes ☐ No

   Number of miscarriages _____ Number of abortions _____ Number of preemies _____

   Number of term births _____ Birth weight of largest baby _____ Smallest baby _____

   Did you develop toxemia (high blood pressure)? ☐ Yes ☐ No

   Have you had other problems with pregnancy? ☐ Yes ☐ No

   If so, please comment: ____
   ____

3. Age at first period ___________ Date of last Pap Smear _________ Date of last Mammogram___________

   Pap Smear: ☐ Normal ☐ Abnormal
   Mammogram: ☐ Normal ☐ Abnormal

   In the second half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)? ☐ Yes ☐ No ☐ Not applicable

4. Have you ever used birth control pills? ☐ Yes ☐ No If yes, when ________

5. Are you taking the pill now? ☐ Yes ☐ No

6. Did taking the pill agree with you? ☐ Yes ☐ No ☐ Not applicable

7. Do you currently use contraception? ☐ Yes ☐ No
   If yes, what type of contraception do you use? ______________________________

8. Are you in menopause? ☐ Yes ☐ No If yes, age at last period______
   Do you take: ☐ Estrogen ☐ Ogen ☐ Estrace ☐ Premarin
   ☐ Progesterone ☐ Provera Other (specify) ______________________

How long have you been on hormone replacement therapy (if applicable)? ________________

Do you have any other concerns or questions that have not been addressed in this form? Anything I need to know about your case history that was not covered on this form?

____
____

____ Date________________
Patient Signature

Systems Survey Form | Restricted to Professional Use

NAME: AGE: HEALTH CARE PROFESSIONAL: DATE:

INSTRUCTIONS: Circle the number that applies to you. **If a symptom does not apply, don't circle anything** for that symptom.

Circle the corresponding number.	
1	MILD symptom (occurs rarely)
2	MODERATE symptom (occurs several times a month)
3	SEVERE symptom (occurs almost constantly)

GROUP 1

1. 1 2 3 Acid foods upset
2. 1 2 3 Get chilled often
3. 1 2 3 "Lump" in throat
4. 1 2 3 Dry mouth, eyes, nose
5. 1 2 3 Pulse speeds after meal
6. 1 2 3 Keyed up, fail to calm
7. 1 2 3 Gag occasionally
8. 1 2 3 Unable to relax, startle easily
9. 1 2 3 Extremities cold, clammy
10. 1 2 3 Strong light irritates
11. 1 2 3 Occasionally weak urine flow
12. 1 2 3 Heart pounds after retiring
13. 1 2 3 "Nervous" stomach
14. 1 2 3 Appetite reduced occasionally
15. 1 2 3 Cold sweats often
16. 1 2 3 Get heated easily
17. 1 2 3 Nerve discomfort
18. 1 2 3 Staring, blink little
19. 1 2 3 Sour stomach frequent

___ 1 ___ 2 ___ 3 TOTAL

GROUP 2

20. 1 2 3 Joint stiffness after arising
21. 1 2 3 Muscle, leg, toe cramps at night
22. 1 2 3 "Butterfly" stomach, cramps
23. 1 2 3 Eyes or nose watery
24. 1 2 3 Eyes blink often
25. 1 2 3 Eyelids swollen, puffy
26. 1 2 3 Indigestion soon after meals
27. 1 2 3 Always seem hungry, feel "lightheaded" often
28. 1 2 3 Digestion rapid
29. 1 2 3 Vomit occasionally
30. 1 2 3 Hoarseness frequent
31. 1 2 3 Uneven breathing
32. 1 2 3 Pulse slow
33. 1 2 3 Gagging reflex slow
34. 1 2 3 Difficulty swallowing
35. 1 2 3 Temporary constipation or diarrhea
36. 1 2 3 "Slow starter"
37. 1 2 3 Get "chilled"
38. 1 2 3 Perspire easily
39. 1 2 3 Sensitive to cold
40. 1 2 3 Upper respiratory challenges

___ 1 ___ 2 ___ 3 TOTAL

GROUP 3

41. 1 2 3 Eat when nervous
42. 1 2 3 Excessive appetite
43. 1 2 3 Hungry between meals
44. 1 2 3 Irritable before meals
45. 1 2 3 Get "shaky" if hungry
46. 1 2 3 Fatigue, eating relieves
47. 1 2 3 "Lightheaded" if meals delayed
48. 1 2 3 Heart palpitates if meals missed or delayed
49. 1 2 3 Fatigue in afternoon
50. 1 2 3 Overeating sweets upsets
51. 1 2 3 Awaken after few hours sleep, hard to get back to sleep
52. 1 2 3 Crave candy or coffee in afternoon
53. 1 2 3 Moods of "blues" or melancholy
54. 1 2 3 Craving for sweets or snacks

___ 1 ___ 2 ___ 3 TOTAL

GROUP 4

55. 1 2 3 Hands and feet go to sleep easily, numbness
56. 1 2 3 Sigh frequently, "air hunger"
57. 1 2 3 Aware of "breathing heavily"
58. 1 2 3 High-altitude discomfort
59. 1 2 3 Open windows in closed room
60. 1 2 3 Immune system challenges
61. 1 2 3 Afternoon "yawner"
62. 1 2 3 Get "drowsy" often
63. 1 2 3 Swollen ankles worse at night
64. 1 2 3 Muscle cramps, worse during exercise; get "charley horse"
65. 1 2 3 Difficulty catching breath, especially during exercise
66. 1 2 3 Tightness or pressure in chest, worse on exertion
67. 1 2 3 Skin discolors easily after impact
68. 1 2 3 Tendency to anemia
69. 1 2 3 Noises in head or "ringing in ears"
70. 1 2 3 Fatigue upon exertion

___ 1 ___ 2 ___ 3 TOTAL

GROUP 5

71. 1 2 3 Dizziness
72. 1 2 3 Dry skin
73. 1 2 3 Burning feet
74. 1 2 3 Blurred vision
75. 1 2 3 Itching skin and feet
76. 1 2 3 Hair loss
77. 1 2 3 Occasional skin rashes
78. 1 2 3 Bitter, metallic taste in mouth in morning
79. 1 2 3 Occasional constipation
80. 1 2 3 Worrier, feels insecure
81. 1 2 3 Nausea occasionally after eating
82. 1 2 3 Greasy foods upset
83. 1 2 3 Stools light-colored
84. 1 2 3 Skin peels on foot soles
85. 1 2 3 Discomfort between shoulder blades
86. 1 2 3 Occasional laxative use
87. 1 2 3 Stools alternate from soft to watery
88. 1 2 3 Sneezing attacks
89. 1 2 3 Dreaming, nightmare-type bad dreams
90. 1 2 3 Bad breath (halitosis)
91. 1 2 3 Milk products cause upset
92. 1 2 3 Sensitive to hot weather
93. 1 2 3 Burning or itching anus
94. 1 2 3 Crave sweets

___ 1 ___ 2 ___ 3 TOTAL

GROUP 6

95. 1 2 3 Loss of taste for meat
96. 1 2 3 Lower bowel gas several hours after eating
97. 1 2 3 Burning stomach sensations, eating relieves
98. 1 2 3 Coated tongue
99. 1 2 3 Pass large amounts of foul-smelling gas
100. 1 2 3 Indigestion ½-1 hour after eating; may be up to 3-4 hours after
101. 1 2 3 Watery or loose stool
102. 1 2 3 Gas shortly after eating
103. 1 2 3 Stomach "bloating"

___ 1 ___ 2 ___ 3 TOTAL

GROUP 7A

104. 1 2 3 Difficulty sleeping
105. 1 2 3 On edge
106. 1 2 3 Can't gain weight
107. 1 2 3 Intolerance to heat
108. 1 2 3 Highly emotional
109. 1 2 3 Flush easily
110. 1 2 3 Night sweats
111. 1 2 3 Thin, moist skin
112. 1 2 3 Inward trembling
113. 1 2 3 Heart races
114. 1 2 3 Increased appetite without weight gain
115. 1 2 3 Pulse fast at rest
116. 1 2 3 Eyelids and face twitch
117. 1 2 3 Irritable and restless
118. 1 2 3 Can't work under pressure

___ 1 ___ 2 ___ 3 TOTAL

GROUP 7B

119. 1 2 3 Increase in weight
120. 1 2 3 Decrease in appetite
121. 1 2 3 Fatigue easily
122. 1 2 3 Ringing in ears
123. 1 2 3 Sleepy during day
124. 1 2 3 Sensitive to cold
125. 1 2 3 Dry or scaly skin
126. 1 2 3 Temporary constipation
127. 1 2 3 Mental sluggishness
128. 1 2 3 Hair coarse, falls out
129. 1 2 3 Tension in head upon arising wears off during day
130. 1 2 3 Slow pulse below 65
131. 1 2 3 Changing urinary function
132. 1 2 3 Sounds appear diminished
133. 1 2 3 Reduced initiative

____ ____ ____ TOTAL
1 2 3

GROUP 7C

134. 1 2 3 Failing memory with age
135. 1 2 3 Increased sex drive
136. 1 2 3 Episodes of tension in head
137. 1 2 3 Decreased sugar tolerance

____ ____ ____ TOTAL
1 2 3

GROUP 7D

138. 1 2 3 Abnormal thirst
139. 1 2 3 Bloating of abdomen
140. 1 2 3 Weight gain around hips or waist
141. 1 2 3 Sex drive reduced or lacking
142. 1 2 3 Tendency for stomach issues
143. 1 2 3 Immune system challenges
144. 1 2 3 Menstrual disorders

____ ____ ____ TOTAL
1 2 3

GROUP 7E

145. 1 2 3 Dizziness
146. 1 2 3 Headaches
147. 1 2 3 Hot flashes
148. 1 2 3 Hair growth on face or body (female)
149. 1 2 3 Sugar in urine (not diabetes)
150. 1 2 3 Masculine tendencies (female)

____ ____ ____ TOTAL
1 2 3

GROUP 7F

151. 1 2 3 Weakness, dizziness
152. 1 2 3 Tired throughout day
153. 1 2 3 Nails weak, ridged
154. 1 2 3 Sensitive skin
155. 1 2 3 Stiff joints
156. 1 2 3 Perspiration increase
157. 1 2 3 Bowel discomfort
158. 1 2 3 Poor circulation
159. 1 2 3 Swollen ankles
160. 1 2 3 Crave salt
161. 1 2 3 Areas of skin darkening
162. 1 2 3 Upper respiratory sensitivity
163. 1 2 3 Tiredness
164. 1 2 3 Breathing challenges

____ ____ ____ TOTAL
1 2 3

GROUP 8

165. 1 2 3 Muscle weakness
166. 1 2 3 Lack of stamina
167. 1 2 3 Drowsiness after eating
168. 1 2 3 Muscular soreness
169. 1 2 3 Heart races
170. 1 2 3 Hyperirritable
171. 1 2 3 Feeling of a band around head
172. 1 2 3 Melancholia (feeling of sadness)
173. 1 2 3 Swelling of ankles
174. 1 2 3 Change in urinary function
175. 1 2 3 Tendency to consume sweets/carbohydrates
176. 1 2 3 Muscle spasms
177. 1 2 3 Blurred vision
178. 1 2 3 Involuntary muscle action
179. 1 2 3 Numbness
180. 1 2 3 Night sweats
181. 1 2 3 Rapid digestion
182. 1 2 3 Sensitivity to noise
183. 1 2 3 Redness of palms of hands and bottom of feet
184. 1 2 3 Visible veins on chest and abdomen
185. 1 2 3 Hemorrhoids
186. 1 2 3 Apprehension (feeling that something bad is going to happen)
187. 1 2 3 Nervousness causing loss of appetite
188. 1 2 3 Nervousness with indigestion
189. 1 2 3 Gastritis
190. 1 2 3 Forgetfulness
191. 1 2 3 Thinning hair

____ ____ ____ TOTAL
1 2 3

FEMALE ONLY

192. 1 2 3 Very easily fatigued
193. 1 2 3 Premenstrual tension
194. 1 2 3 Menses more painful than usual
195. 1 2 3 Depressed feelings before menstruation
196. 1 2 3 Painful breasts during menses
197. 1 2 3 Menstruate too frequently
198. 1 2 3 Hysterectomy/ovaries removed
199. 1 2 3 Menopausal hot flashes
200. 1 2 3 Menses scanty or missed
201. 1 2 3 Acne, worse at menses

____ ____ ____ TOTAL
1 2 3

MALE ONLY

202. 1 2 3 Less involved in exercise/social activities
203. 1 2 3 Difficult to postpone urination
204. 1 2 3 Weak urinary stream
205. 1 2 3 Feeling of "blues" or melancholy
206. 1 2 3 Feeling of incomplete bowel evacuation
207. 1 2 3 Lack of energy
208. 1 2 3 Muscles in arms and legs seem softer/smaller
209. 1 2 3 Tire too easily
210. 1 2 3 Avoid activity
211. 1 2 3 Leg nervousness at night
212. 1 2 3 Diminished sex drive

____ ____ ____ TOTAL
1 2 3

IMPORTANT | Please list below the five main physical complaints you have in order of their importance.

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

Digestion	Large Intestine (Palpate)	Adrenals	Pass/Fail Zinc Taste Test
________ Hydrochloric Acid Point	________ Ascending	Pass/Fail Pupil Dilation Exam	Pass/Fail Cuff Test
________ Enzyme Point	________ Transverse	Postural Hypotension	________ Cuff Pressure
________ Murphy's Sign	________ Descending	________ Supine	________ pH of Saliva
		________ Standing	________ Pulse

BARNES THYROID TEST

The test is conducted by the patient in the morning before leaving bed, with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test such as getting up for any reason, shaking down the thermometer, etc. It is important that the test, be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.

PRE-MENSES FEMALES AND MENOPAUSAL FEMALES (any two days during the month)
FEMALES HAVING MENSTRUAL CYCLES (the second and third days of flow or any five days in a row)
MALES (any two days during the month)

Day 1 ________ Day 2 ________ Day 3 ________ Day 4 ________ Day 5 ________

RESTRICTIONS ON USE

The systems survey is to be used only by trained health care professionals. If you are a patient, you should not use the systems survey. If you are not a trained health care practitioner, you should not use the systems survey. Health care practitioners should only use the systems survey to provide services that are within the scope of their license or professional training. The systems survey is intended to be used as a helpful tool for health care practitioners in collecting information concerning the health and wellness of patients.

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Name: Date:

Diet History 3-5 days. Please record all foods, snacks, and drinks inclusive of water consumed.

Date:	Breakfast	Lunch	Dinner	Snacks/Drinks