Master Intake Form and Questionnaire

Please fill out the following questionnaire completely, honestly, and with great attention to detail. The more fully and openly you answer these questions, the more comprehensive picture of your health we will receive. We leave no stone unturned when it comes to your health and wellness. All information is strictly confidential.

1 | Personal Information

Today's Date: _____ How did you hear about us? _____

Name: _____ Gender: ☐ Male ☐ Female Date of birth: _____

Place of birth: _____ Age: _____ Height: _____ Weight: _____

Primary email address: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Are there any restrictions for contacting you? ☐ Yes ☐ No If yes, please list: _____

Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Name: _____

2 | Wellness Overview

What are the top 5 main health complaints you experience regularly?

List in order of severity or disruption of your life.

1. _____
2. _____
3. _____
4. _____
5. _____

Overall, how would you rate your current health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

Is your overall health currently ☐ getting better ☐ getting worse or ☐ staying the same?

What markers do you use as a gauge to determine the level of your health? _____

_____

_____

Do you have any chronic (long-term or recurring) conditions? (for example: chronic inflammation, bad food reactions, kidney stones, skin conditions, abdominal pain or gas) Please list: _____

_____

_____

Do you have any diagnosed diseases, syndromes, or conditions, past or present? Please list: _____

_____

_____

Do you have any genetic or congenital (I was born with it) diseases, syndromes or conditions? Please list:

_____

_____

Have you been diagnosed with high blood pressure? ☐ Yes ☐ No

Have you been diagnosed with low blood pressure? ☐ Yes ☐ No

If known, please list your most recent blood pressure score: _____ / _____

If known, please list your most recent blood scores in the following areas:

Total cholesterol _____

HDL _____

LDL _____

Triglycerides _____

Please list the 5 most significantly stressful events in your life (deaths, divorces, accidents, etc.). Details are not necessary. List approximate dates. If an event continues to affect your life today, please indicate. *This is strictly confidential information*.

1. _____
2. _____
3. _____
4. _____
5. _____

What professionals have you visited so far to improve your health (e.g. traditional medical doctor, alternative medicine doctor, chiropractor, nutritionist, etc)? Please list: _____

_____

Why did you choose to work with me? _____

_____

_____

For our partnership to be considered a success in your own eyes, what do you want to take place? In other words, what are your expectations? _____

_____

_____

How long do you feel it will take to reach your health and wellness goals? _____

_____

_____

How are your major health complaints holding you back in life (family, career, charitable work, overall well-being, etc.)? What's your motivation for improving your health? _____

_____

_____

On a scale of 1 – 10, with 10 being 100% committed, what is your present level of commitment to address the root cause of your main health complaints? _____

On a scale of 1 – 10, with 10 being 100% confident, what is your present level of confidence in yourself to make the necessary changes to meet your health goals using this program? _____

If you are not a "10" in the confidence department, what obstacles do you think might hinder your progress?

_____

_____

Who do you know that will help support you in your health goals? _____

_____

3 | Energy Levels

Check all that describe your energy levels during a typical day:

☐ Normal and consistent ☐ Up and down ☐ Low all the time ☐ Excessive/Hyper ☐ Low after a meal

☐ Tired in the afternoon (after 2pm) ☐ Really "hyped-up" at night/hard to relax ☐ Other _____

4 | Supplements

Use the place below to list any supplements you are currently taking:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____

5 | Prescription Drugs

Use the place below to list any prescription drugs you are currently taking:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____

6 | Water

What type of water comes into your home? ☐ Tap or municipal water ☐ Well water ☐ Other _____

Do you use a filter to purify the water that comes into your home?

☐ Yes ☐ No If yes, list type and/or brand: _____

What type of water do you drink regularly?

☐ Tap or municipal water ☐ Well water ☐ Water ran through filter listed above

☐ Bottled water ☐ Other _____

If bottled water, please list brand: _____

What type of water do you use for cooking?

☐ Tap or municipal water ☐ Well water ☐ Water ran through filter listed above

☐ Bottled water ☐ Other _____

What type of water do you use for bathing or showering?

☐ Tap or municipal water ☐ Well water ☐ Other _____

Do you use anything to filter or negate the chlorine in the water you bathe or shower in (if applicable)?

_____

If you use well water, has the water been tested for safety within the last year? ☐ Yes ☐ No

Do you monitor how much water you drink per day? ☐ Yes ☐ No

If yes, how much water do you drink per day (in ounces)? _____

Are you excessively thirsty? ☐ Yes ☐ No

7 | Diet

Do you think you eat a healthy diet? ☐ Yes ☐ No ☐ Sometimes

Do you typically have a strong craving for any of the following foods? *Check all that apply.*

☐ Candy ☐ Pastries, cookies, donuts ☐ Milk ☐ Ice cream ☐ Coffee ☐ Cokes/Soda ☐ Chocolate

☐ Water ☐ Alcohol ☐ Fruit ☐ Salty foods ☐ Fatty foods ☐ Bread ☐ Other _____

The ingredient list on a package of food is the best indicator of the health and quality of the food – not the savvy marketing on the front of the package or the nutrition facts. Check out the ingredient list of the foods you eat before you answer the following.

Please indicate how many times per week you consume the following foods:

Stimulants		Bad Fats		Refined Carbohydrates		Pasteurized Dairy	
Coffee (including decaf)	_____	Deep fried foods	_____	Bread	_____	Cow's milk	_____
Black or green tea	_____	Fast food	_____	Crackers	_____	Yogurt	_____
Soft drinks/sodas	_____	Roasted nuts	_____	Buns	_____	Ice Cream	_____
Alcohol	_____	Margarine	_____	Bagels	_____	Cottage Cheese	_____
Drinks with artificial sweeteners (diet drinks)	_____	Potato chips or corn chips	_____	Pasta	_____	Imitation cheese (made with oils)	_____
Foods with MSG or artificial flavors	_____	Peanut butter with hydro-genated oils	_____	Muffins	_____	Cheese (made with milk and no oils)	_____
Candy, pastries, sweets	_____	Lunch/Deli meat	_____	Cookies	_____	Sour cream	_____
Chocolate	_____	Hot dogs	_____	Cereal	_____	Cream cheese	_____
Foods with artificial colors	_____	Mayonnaise	_____	Pretzels	_____		
Soy protein /soy protein isolate / whey protein	_____	Salad dressing	_____	Donuts	_____		

3-Day Diet Record

Record below all that you consume for 3 full days.
Be detailed and accurate. Eat your typical diet – don't try to "eat healthy" or overly restrict yourself. List in detail the quantity, preparation and cooking method used (frozen, canned, fried, raw, etc.), any condiments used, as well as the brand of the foods you eat (Kraft, Chef Boyardee, Organic Valley, etc.) and if you know whether the food was grown commercially or locally/organically/without pesticides and herbicides. Also include beverages consumed. It may be easiest to print this record and put it on the refrigerator or take it with you, filling it out at each meal.

Day 1	**Date:**				
Breakfast **Time eaten:**					
Snack #1 **Time eaten:**					
Lunch **Time eaten:**					
Snack #2 **Time eaten:**					
Dinner **Time eaten:**					
Snack #3 **Time eaten:**					
Water consumed (oz.)					
Additional Beverages					

Day 2	**Date:**				
Breakfast **Time eaten:**					
Snack #1 **Time eaten:**					
Lunch **Time eaten:**					
Snack #2 **Time eaten:**					
Dinner **Time eaten:**					
Snack #3 **Time eaten:**					
Water consumed (oz.)					
Additional Beverages					

Day 3	**Date:**				
Breakfast **Time eaten:**					
Snack #1 **Time eaten:**					
Lunch **Time eaten:**					
Snack #2 **Time eaten:**					
Dinner **Time eaten:**					
Snack #3 **Time eaten:**					
Water consumed (oz.)					
Additional Beverages					

8 | Cooking and Eating Habits

How often do you eat out at restaurants? ☐ Once a month ☐ Twice a month ☐ Once a week
☐ 2-4 times a week ☐ More than 5 times a week ☐ I don't eat out

What restaurants do you go to? _____

_____

Do you cook meals at home? ☐ Yes ☐ No If yes, how many times a week? _____

If yes, what types of food do you prepare? *Check all that apply.* ☐ Boxed/pre-packaged ☐ Frozen dinners

☐ Made from scratch with whole foods ☐ Canned foods ☐ Other _____

Do you use a microwave oven to heat foods or beverages? ☐ Yes ☐ No

Do store or heat foods in plastic containers? ☐ Yes ☐ No

What type of cookware do you use? *Check all that apply.*

☐ Stainless steel ☐ Aluminum ☐ Cast iron ☐ Teflon-coated/non-stick ☐ Glass ☐ Ceramic

☐ Enamel ☐ Silicone Other: _____

Do you have a tendency to rush through your meals or eat very quickly? ☐ Yes ☐ No

Do you tend to skip meals? ☐ Yes ☐ No If yes, which meal(s)? _____

Do you tend to ☐ snack throughout the day or ☐ eat "three square meals"?

Do you have irregular eating times (i.e. more than 3 hours' deviation from breakfast at 6am, lunch at 12pm, and dinner at 6pm)? ☐ Yes ☐ No

Do you drink more than 4-6 ounces of liquid with your meals? ☐ Yes ☐ No

Do you take antacids before, during, or after your meal? ☐ Yes ☐ No

Do you get shaky, dizzy, tired and/or irritable when you skip meals? ☐ Yes ☐ No

Check below all that describe your digestion:

☐ No problems that I can tell ☐ Very poor ☐ Heartburn/Acid reflux ☐ Burp/Belch often

☐ Abdominal bloating ☐ Nausea ☐ Sour Stomach ☐ Poor appetite ☐ Pain/burning in the stomach

☐ Lots of gas ☐ Hiccup often ☐ Very sleepy after meals ☐ Meal sits very heavy/feel full for very long time

☐ Headache after eating ☐ Other _____

9 | Blood Sugar Regulation

Have you been diagnosed with pre-diabetes or diabetes? If yes, please explain _____

_____

_____

Please test your blood sugar over the course of 4 days by following the instructions below.

You can purchase an inexpensive glucometer at a discount department store or drug store. You will need at least 16 test strips to do this test. It is suggested that you buy a pack of 50 in case you make a mistake and for retesting later. Be sure your purchase includes a glucometer, lancet (pricks the skin), and test strips.

Take readings over 4 days in a row. Take readings 4 times during each of the 4 days as prescribed below:

1. Upon rising
2. Before lunch
3. Before evening meal
4. Before bed

Record the readings in the chart below.

	Date	**Date**	**Date**	**Date**
Upon rising				
Before lunch				
Before evening meal				
Before bed				

10 | Special Diets

Check any of the following special diets you have followed in the past for at least 6 months. *Check all that apply.*

☐ Low fat ☐ Sodium-restricted ☐ Low carb ☐ Vegetarian ☐ Lacto-Vegetarian ☐ Lacto-Ovo-Vegetarian

☐ Pollo-Vegetarian ☐ Pesco-Vegetarian Vegan ☐ Macrobiotic ☐ Raw Food Diet ☐ Atkins

☐ South Beach Diet ☐ Paleo/Caveman ☐ Metabolic Typing ☐ The Maker's Diet ☐ Ornish Diet

☐ Anti-Candida Diet ☐ Weight Watchers ☐ Nutri-System ☐ Slim-Fast ☐ Diet pills

☐ Other _____ ☐ Other _____ ☐ Other _____

In your eyes, were any of the diets you followed in the past effective? ☐ Yes ☐ No

If yes, which ones and how? _____

_____

Check any special diets that you continue to follow to this day. *Check all that apply.*

☐ Low fat ☐ Sodium-restricted ☐ Low carb ☐ Vegetarian ☐ Lacto-Vegetarian ☐ Lacto-Ovo-Vegetarian

☐ Pollo-Vegetarian ☐ Pesco-Vegetarian Vegan ☐ Macrobiotic ☐ Raw Food Diet ☐ Atkins

☐ South Beach Diet ☐ Paleo/Cavemen ☐ Metabolic Typing ☐ The Maker's Diet ☐ Ornish Diet

☐ Anti-Candida Diet ☐ Weight Watchers ☐ Nutri-System ☐ Slim-Fast ☐ Diet pills

☐ Other _____ ☐ Other _____ ☐ Other _____

Do you have any known or suspected food allergies or food intolerances (i.e. gluten, lactose, etc)? ☐ Yes ☐ No

If yes, please list the food(s) and why you suspect it _____

_____

_____

11 | Elimination

The bowels are a window into gut health. Get into the habit of looking at your stool after each bowel movement before you flush. You may have to observe a few days of bowel movements to gather this information.

On average, how often do you have a bowel movement?
☐ 3 times a day ☐ 2 times a day ☐ Once a day ☐ Every other day ☐ 2+ days in between

Color of stool: ☐ Medium brown ☐ Dark brown or black ☐ Tan, grey, or pale
If your stool was a solid piece with the consistency and shape of a banana, how many inches long would it be:
☐ 2-4 inches ☐ 4-6 inches ☐ 6-10 inches ☐ 12 inches or more

Describe your average bowel movement. *Check all that apply.*
☐ Involves lots of pushing and straining ☐ Accompanied by lots of gas ☐ Pain or cramping
☐ Have to wipe excessively to get clean ☐ Usually tends toward constipation ☐ Usually tends toward diarrhea

Describe your average stool. *Check all that apply.*
☐ Sinks to bottom ☐ Floats on top ☐ Stays somewhere in the middle
☐ Contains blood ☐ Very foul/bad smelling ☐ Lots of mucous

Using the Bristol Stool Chart below, indicate the type(s) of stool that most closely resemble your stools over the course of the last month. You can choose more than one type, since the type of stool can change daily. If you have not been observing your stool for the last month, then answer based on a few days of bowel movements.

Bristol Stool Chart

Type 1	 Separate hard lumps, like nuts (hard to pass)	☐
Type 2	 Sausage-shaped but lumpy	☐
Type 3	 Like a sausage but with cracks on the surface	☐
Type 4	 Like a sausage or snake, smooth and soft	☐
Type 5	 Soft blobs with clear-cut edges	☐
Type 6	 Fluffy pieces with ragged edges, a mushy stool	☐
Type 7	 Watery, no solid pieces. **Entirely Liquid**	☐

Types 1-2: Constipation **Types 3-4:** Ideal **Types 5-7:** Diarrhea

Do you have to take a laxative to have a bowel movement? ☐ Yes ☐ No

If yes, what kind(s) or brand name(s) and how often? _____

Have you ever completed a session of colonics (i.e. colonic irrigation/colon hydrotherapy)? ☐ Yes ☐ No

If yes, how many sessions and how long ago? _____

Was your session a positive experience? Please explain. _____

_____

Urination

How many times do you urinate per day? _____

Color of urine: ☐ Clear ☐ Light yellow ☐ Yellow ☐ Bright Yellow (as when taking B-vitamins)

☐ Dark ☐ Other _____

Further describe your urination habits. *Check all that apply.*

☐ Sense of urgency ☐ Too small amount ☐ Too large amount ☐ Burning ☐ Dribbling

☐ More than once a night during sleep ☐ Have had kidney stones ☐ Have had bladder infections

☐ Incontinence ☐ Leaking ☐ Other _____

12 | Women Only

Age when you had your first period _____

Are you perimenopausal (transitioning into menopause)? ☐ Yes ☐ No At what age did this start? _____

Are you menopausal (gone 12 consecutive months without a period)? ☐ Yes ☐ No

If yes, at what age did your periods stop? _____

Check all menopausal symptoms you are experiencing:

☐ Hot flashes ☐ Vaginal dryness or irritation ☐ Loss of libido (sex drive) ☐ Insomnia ☐ Depression

☐ Night sweats ☐ Mood swings ☐ Weepy/Emotionally fragile ☐ Hair loss ☐ Other _____

Are your periods regular, meaning consistently between 27–30 days? ☐ Yes ☐ No
If no, how many days from the beginning of your period to the start of your next period? _____
How many days do you normally bleed? _____

Check all the symptoms you experience around the time of your period:

☐ Cramping ☐ Bloating ☐ Weakness/Fatigue ☐ Heavy flow ☐ Light flow ☐ Spotting between periods

☐ Mood swings ☐ Weepy/Emotionally fragile ☐ Back aches ☐ Bright red blood ☐ Dark clotty blood

☐ Painful or tender breasts ☐ Water retention ☐ Headaches ☐ Food cravings ☐ Abdominal bloating

☐ Constipation and/or diarrhea ☐ Other _____

Do you currently use birth control? ☐ Yes ☐ No If yes, what method? _____

Did you use birth control in the past? ☐ Yes ☐ No If yes, for how long? _____

When did you stop? _____ What method(s) did you use? _____

Are you currently pregnant? ☐ Yes ☐ No

Are you currently breastfeeding? ☐ Yes ☐ No

Pregnancies: Total number: _____ Number of children: _____ Number of miscarriages: _____

Describe any pregnancy or childbirth complications: _____

_____

_____

After having a baby, did your overall health ☐ improve ☐ stay the same ☐ or worsen?

Do you have excess facial or body hair? ☐ Yes ☐ No

Do you have low libido (sex drive)? ☐ Yes ☐ No

Have you had yeast infections in the past? ☐ Yes ☐ No If yes, please explain. _____

Have you had a hysterectomy? ☐ Yes ☐ No If yes, when? _____

List any other past gynecological operations: _____

_____

_____

Describe any other female health issues that you feel might be important: _____

_____

_____

13 | Sleep

What time do you usually go to sleep? _____ What time do you usually wake up? _____

Average number of hours of sleep per night _____

Describe your sleep: ☐ Hard to get to sleep ☐ Wake up multiple times per night ☐ Have bad dreams

☐ I sleep soundly through the night ☐ Night Sweats ☐ Achy legs/Leg cramps

☐ Restless/Tossing and turning ☐ I wake up refreshed and ready to start the day ☐ I wake up tired

☐ I get up during the night to _____ ☐ Other _____

Do you sleep in a completely dark room (very little to no light)? ☐ Yes ☐ No

Do you have a television in your bedroom? ☐ Yes ☐ No

If yes, do you watch the television in your bedroom right before going to bed? ☐ Yes ☐ No

Is there a television, computer, or electrical appliance within 6 feet of your bed? ☐ Yes ☐ No

What type of mattress do you sleep on (i.e. box springs, memory foam, inflatable, water)? _____

Does it take a while for you to "get going" in the morning? ☐ Yes ☐ No

How long does it usually take for you to come out of your sluggishness or sleepiness in the morning? _____

Does this involve a stimulating drink like coffee or tea? ☐ Yes ☐ No ☐ Occasionally

Do you have to take an occasional or daily nap? ☐ Yes ☐ No If yes, how long is your nap? _____

14 | Exercise

What types of exercise do you currently engage in? Below each, type how often and how long each time.

Type of Activity	☐ Slow walking/strolling	☐ Brisk walking	☐ Jogging	☐ Interval Sprinting
How often?				
How long at each instance?				
Type of Activity	☐ Aerobics class	☐ Yoga	☐ Spinning	☐ Zumba
How often?				
How long at each instance?				
Type of Activity	☐ Tony Horton's P90X	☐ Shaun T's Insanity	☐ Bodyweight Calisthenics	☐ Weight-lifting
How often?				
How long at each instance?				
Type of Activity	☐ Pilates	☐ _____	☐ _____	☐ _____
How often?				
How long at each instance?				

How much exercise do you feel you are doing? ☐ Too little ☐ Too much ☐ Just the right amount

Do you feel your exercise program is benefiting you? ☐ Yes ☐ No

Please explain: _____

_____

Do you struggle with losing body fat despite dieting and exercise? ☐ Yes ☐ No

Do you feel an increase in energy and well-being a day or two after your workout? ☐ Yes ☐ No

If you lift weights/do resistance training, generally how long do you take to recover between workouts?

☐ 24 hours ☐ 24-48 hours ☐ More than 48 hours

15 | Sun Exposure

How many hours of natural sunlight from outdoors do you receive per week (include cloudy days)?

In the summer _____ In the winter _____

How many hours of sunlight through a window do you receive daily? _____

How many hours a day do you spend under artificial or fluorescent lights? _____

Do you use full-spectrum lighting in your home or office? ☐ Yes ☐ No

Do you use a tanning bed? ☐ Yes ☐ No How many visits per week? _____ How long do you lay? _____

Type of tanning bed used, if known _____

How well do you tan? ☐ Burn easily and never get tan ☐ Burn first, then burn turns to tan ☐ Tan easily

Do you use sunscreen? ☐ Yes ☐ No If yes, what kind/brands? _____

16 | Personal Care Products / Household Chemicals

Beside each product, type the name brand(s) you use most often. Please take time to complete this list. Go to your kitchen and bathrooms and be certain of the brand – no guessing.

Personal Care	Household Cleaning
Shampoo: _____	Laundry detergent: _____
Hair conditioner: _____	Fabric softener: _____
Bath soap: _____	Fabric softener sheets: _____
Hand soap: _____	Liquid dishwashing soap: _____
Facial cleanser: _____	Automatic dishwasher soap: _____
Deodorant: _____	Tub/Tile cleaner: _____
Toothpaste: _____	Bathroom cleaner: _____
Mouthwash: _____	Toilet cleaner: _____
Hand/Body lotion: _____	Glass cleaner: _____
Facial moisturizer: _____	All-purpose cleaner: _____
Face make-up: _____	Floor cleaner: _____
Eye make-up: _____	Furniture polish: _____
Bronzer/Self-tanner/Sunless tanner: _____	Air freshener: _____
Wet wipe/Baby wipe: _____	Other: _____
Hair spray: _____	Other: _____
Hair gel: _____	Other: _____
Shaving cream: _____	
After shave: _____	
Perfume/Cologne: _____	
Personal lubricant: _____	
Fingernail/Toenail polish: _____	
Hair dye/Hair color: _____	
Hair permanent: _____	
Sun tan lotion/Sunscreen: _____	
Other: _____	
Other: _____	

17 | Chiropractic

Have you ever been to a chiropractor for adjustments? ☐ Yes ☐ No

Why did you start going? _____

Was the treatment effective? ☐ Yes ☐ No Please explain: _____

_____

Do you continue to see a chiropractor for regular adjustments? ☐ Yes ☐ No

If yes, how often to you go? _____

What is your chiropractor's name? _____

18 | Smoking

Do you currently smoke (tobacco)? ☐ Yes ☐ No If yes, how much? _____

How long have you smoked? _____

If you don't smoke currently, did you smoke in the past? ☐ Yes ☐ No

How many years did you smoke? _____ How long ago did you quit smoking? _____

How did you quit smoking (will power, patch, gum, prescription, hypnosis)? _____

19 | Alcohol and Drug Use

This is strictly confidential information.

Do you have a history of alcohol abuse or binge drinking? ☐ Yes ☐ No

If yes, please describe. _____

How many alcoholic beverages do you currently consume per week? ☐ None ☐ 1-2 ☐ 3-4 ☐ 5 or more

Do you currently use recreational drugs? ☐ Yes ☐ No

Check all that apply:

☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Uppers ☐ Downers ☐ Other _____

How often? _____

Have you used recreational drugs in the past? ☐ Yes ☐ No

If yes, for how long? _____

20 | Toxic Exposure

Have you ever had toxic chemicals spill on your body? ☐ Yes ☐ No

If yes, what chemical(s) and how long ago did it happen? _____

Check any of the jobs you have held for at least 2 months:

☐ Farmer ☐ Insect/Pest Exterminator ☐ Factory Maintenance Worker ☐ Janitor ☐ Painter

☐ Golf course/Lawn Maintenance ☐ Dentist ☐ Water Treatment

What vaccinations have you received? ☐ Basic childhood ☐ Flu ☐ Lyme Disease ☐ Hepatitis ☐ HPV

☐ Travel ☐ Other, please list: _____

Have you ever traveled out of the United States (50 states)? ☐ Yes ☐ No

If yes, where and when (approximate dates): _____

_____

Have you ever been administered IV antibiotics? ☐ Yes ☐ No

If yes, approximately how many times and for what reasons: _____

_____

Have you ever taken oral antibiotics? ☐ Yes ☐ No

Have you taken oral antibiotics more than two times in one year? ☐ Yes ☐ No

Have you been exposed to mold ☐ in the home ☐ or at the workplace? ☐ I'm not sure if I've been exposed.

Do you take pain relievers, like Tylenol or Advil? ☐ Yes ☐ No If yes, how often? _____

How often do you have your home treated for insects? _____

Do you have indoor pets? ☐ Yes ☐ No If you have indoor pets, do they sleep in your bed? ☐ Yes ☐ No

What cleanses have you completed sometime in the past? *Check all that apply.*

☐ Fasting from food ☐ Herbal cleanse ☐ Liver Cleanse (pills or powders) ☐ Parasite Cleanse

☐ Juice Cleanse ☐ Master Cleanse/Lemonade Diet ☐ Ionic foot bath

☐ Other _____

Do you use an air purifier in your home? ☐ Yes ☐ No If yes, what kind/brand? _____

Are your eyes sensitive to bright lights? ☐ Yes ☐ No

Are you sensitive to strong odors? (i.e. perfumes, detergents, cigarette smoke, car exhaust)? ☐ Yes ☐ No

Do you suffer from skin rashes or hives, for which the cause is unknown? ☐ Yes ☐ No

21 | Dental Work

Indicate how many of the following you have below:

☐ Amalgams (silver fillings) ☐ Gold crowns or inlays ☐ Stainless steel crowns or inlays

☐ Composites (tooth-colored) ☐ Root canals

Have you ever had a major infection in your mouth? ☐ Yes ☐ No

If yes, please explain: _____

Have you had your wisdom teeth extracted? ☐ Yes ☐ No

Have you had dental surgery (gum surgery, jaw surgery, etc.? ☐ Yes ☐ No

If yes, please explain: _____

Do you need further dental work? ☐ Yes ☐ No

If yes, what? _____

Do you have halitosis (bad breath)? ☐ Yes ☐ No

22 | Electromagnetic Exposure

How many hours do you spend daily (round to the next whole hour):

Watching TV _____ Working on a computer/laptop/tablet PC _____ Talking on a corded phone _____

Talking on a cordless phone _____ Talking on a cell phone _____ Wearing a wired headset _____

Wearing a wireless headset _____ Wearing a hearing aid _____ Wearing a pager _____

Wearing a wrist watch with a battery _____ Riding in a vehicle _____

Working near electrical equipment (machinery, copy machine, etc) _____

Do you carry a cell phone on your hip or in close proximity to your body during most waking hours? ☐ Yes ☐ No

When you sleep, is your head within 6 feet of a plug-in alarm clock (like on a nightstand)? ☐ Yes ☐ No

When you sleep, is your head within 6 feet of a cell phone (like on a nightstand)? ☐ Yes ☐ No

23 | Stress — Mental/Emotional

How would you rate your overall stress level (1-10, with 10 being the highest stress)? _____

What are your main sources of stress? _____

_____

_____

_____

Explain some ways you cope with stress or are attempting to reduce your stress level: _____

_____

_____

_____

Do you tend to worry excessively? ☐ Yes ☐ No

Do you have irrational phobias or fears? ☐ Yes ☐ No

Do you lack motivation or procrastinate often? ☐ Yes ☐ No

Do you have obsessive-compulsive thoughts or behaviors? ☐ Yes ☐ No

Do you often feel irritable or angry for no reason? ☐ Yes ☐ No

Do you suffer from mild depression or apathy? ☐ Yes ☐ No

Do you have low self-esteem or lack confidence? ☐ Yes ☐ No

Do you find it difficult to focus or concentrate on the task at hand? ☐ Yes ☐ No

Do you find it difficult to deal with stressful situations? ☐ Yes ☐ No

Do you find that you cry easily or for no apparent reason? ☐ Yes ☐ No

Do you suffer from anxiety and/or panic attacks? ☐ Yes ☐ No

Do you experience persistent loss of libido (sex drive)? ☐ Yes ☐ No

Check below your most prevalent feelings throughout a typical week:

☐ Happy ☐ Sad ☐ Easy-going ☐ Anxious/Nervous ☐ Depressed ☐ Cry easily/Emotionally fragile

☐ Stressed out ☐ Angry ☐ Frustrated ☐ Fearful ☐ Rushed/behind schedule ☐ Desire to be alone

☐ Indecisive ☐ Restless ☐ Guilty ☐ Feelings of inadequacy ☐ Shy ☐ At peace/peaceful

☐ Hopeful ☐ Hopeless ☐ Get feelings hurt easily ☐ Rejected ☐ Confident ☐ Compassionate

☐ Loved ☐ Secure ☐ Irritable/Grumpy ☐ Thankful/Grateful ☐ Lonely

☐ Lack of purpose ☐ Lack of direction ☐ Other _____

24 | Existential

What are your main goals or highest priorities in life? List the top 3:

1. _____

2. _____

3. _____

Where do you see yourself in 5 years? _____

_____

_____

Do you feel your life has meaning? Please explain: _____

_____

_____

Do you consider yourself a spiritual person? Please explain: _____

_____

_____

Do you consider yourself a religious person? Please explain: _____

_____

_____

Do you believe in a power or being higher than yourself? Please explain: _____

_____

_____

Thank you for taking the time to complete this questionnaire. Better health is ahead of you.