

# OMEGA

Rhinebeck, New York

You are registered for course # 1405-951, "Detox & Weight Loss Cleanse" with Tom Francescotti on May 23 - 28, 2010. Faculty asked that we send the following note and attached Detox FAQs.

Dear Participant:

I would like to take this opportunity to thank you for joining me on this journey with your health. Taking time to cleanse your body and spirit can be one of the most rewarding experiences for your health and well-being. My hope is that you will reach a higher level of wellness, happiness, and freedom. In order to best guide you, please fill out the attached Patient Health Profile as completely as possible

Prior to the start of workshop (as soon as possible), please mail the Patient Health Profile to:

Dr. Thomas J. Francescotti  
Rhinebeck Cooperative Health Center  
6384 Mill Street  
Rhinebeck, NY 12572

I look forward to helping you successfully achieve your personal health goals!

Sincerely,

Dr. Tom Francescotti

Awakening the Best in the Human Spirit

## Detox Program FAQ

### **Should I stop taking my prescription medications during program?**

You should not stop any medications unless you are told to do so by your healthcare provider. You can still take part in this program, just please indicate all current medications on Dr. Tom's "patient health profile."

### **Should I alter my diet in anyway prior to my arrival at Omega?**

If you normally consume significant amounts of caffeinated beverages, simple sugars, and alcohol you might experience withdrawal headaches if you discontinue them all at once. I recommend that you gradually decrease these items in your diet before your arrival at Omega. Ideally these items will be out of your diet at least one week prior to the workshop to enhance your cleansing process. Do the best you can with this. There is no judgment. I will be work with you wherever you are at in your healing and cleansing process.

### **Should I continue with my regular vitamins?**

The program contains many vitamins and other nutrients to help meet your daily requirements. You may suspend natural supplements during the detox if you wish. Please ask your current health care practitioner if you have any specific questions, especially if they were prescribed to you for a particular condition.

### **Will I be fasting during this program?**

No. This is not a fast, nor is it a colon cleanse, which are very harsh on your system. You will be eating plenty of food and the shakes are pleasant tasting. You may feel a slight withdrawal in the first few days if you are giving up a lot of caffeine or a lot of sugar. The "medical shakes" will assist you with hunger and any withdrawal symptoms that you may have.

### **Can I do this program if I have hypoglycemia?**

Yes. Since this is not a fast or juice fast, you will be consuming adequate amounts of food to help regulate your blood sugar. Dr. Tom may also tailor the program to fit your needs as well.

### **Will I lose Weight?**

This detox program is not designed to be a weight loss program. However, many people lose weight during the course of their detox program. Some of the reasons for this weight loss include: lower than usual caloric intake due to having shakes, taking sugar out the diet, decreased consumption of allergenic foods such as wheat and dairy, and the release of toxins from fat stores.

# Patient Health Profile

This form is confidential. This information cannot and will not be given to anyone outside this clinic without your written permission.

Please answer all questions honestly and with the intent of providing as thorough a picture as possible of your health history.

Successful health care and preventative medicine are only possible when the physician has a complete understanding of the patient physically, mentally, emotionally, and spiritually.

The nature of your responses to the following questions will go a long way in assisting my understanding of your truest desires. *Your time, thoughtfulness and honesty are greatly appreciated!*

Name: \_\_\_\_\_ Sex: M F SS#: \_\_\_\_\_

Race or ethnic background: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Blood Type: \_\_\_\_\_ Ht \_\_\_\_\_ Wt \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Email Address: \_\_\_\_\_ Website: \_\_\_\_\_

Occupation \_\_\_\_\_ Hours per week \_\_\_\_\_ Retired \_\_\_\_\_

Employer \_\_\_\_\_

Person to notify in case of emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

Who can we thank for referring you? \_\_\_\_\_

Has any other family member already been a patient at the clinic? \_\_\_\_\_

\_\_\_\_ Married \_\_\_\_ Partnership \_\_\_\_ Separated \_\_\_\_ Divorced \_\_\_\_ Widowed \_\_\_\_ Single

Live with: \_\_\_\_ Spouse \_\_\_\_ Partner \_\_\_\_ Parents \_\_\_\_ Children \_\_\_\_ Friends \_\_\_\_ Alone

Do you have any children? Yes No How many? \_\_\_\_\_ Their names/ages: \_\_\_\_\_

What other health care practitioners are you currently seeing? \_\_\_\_\_

Have you ever consulted a Naturopathic Physician before? Yes No

Who? \_\_\_\_\_

Date of last complete physical exam: \_\_\_\_\_ Date of last blood tests: \_\_\_\_\_

For women: Date of last Pap Smear: \_\_\_\_\_ Results: normal abnormal don't know

Are you willing to change your living habits to improve your health? Yes No

What goals do you have for your visit today? \_\_\_\_\_

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

Please list up to 8 major health concerns in order of their importance:

- |          |          |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

How did these conditions develop? Are there traumatic events that you can identify as having caused or clearly aggravated your health problems. What happened in your life around this time? *If you prefer, list these in order of occurrence on a separate page.*

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

**MEDICATIONS:** List all the drugs(prescription/non-prescription) including dosages.

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

Are you allergic to any drugs, foods, chemicals, animals, environmental substances?  Yes  No

If yes, please list: \_\_\_\_\_

What happens when you have an "allergy attack"? \_\_\_\_\_

What prior types of allergy testing have you had?:  None  Blood IgG/IgE food/inhalant  
 Electroacupuncture  Kinesiology("muscle testing")  Food Intolerance testing  Scratch

**CURRENT SUPPLEMENTS:** List all vitamins, minerals, herbs, homeopathics, with dosages

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

For doctors use only:

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

## PAST MEDICAL HISTORY

### Your Prenatal/birth/feeding history:

Any known problems/birth trauma during your mother's pregnancy with you: \_\_\_\_\_

C-section? \_\_\_\_\_ Umbilical cord problems? \_\_\_\_\_ forceps used? \_\_\_\_\_ Antibiotics? \_\_\_\_\_

Breast fed? \_\_\_\_\_ how long? \_\_\_\_\_ Formula (kind): \_\_\_\_\_ how long? \_\_\_\_\_

Age solid foods began: \_\_\_\_\_ What foods were eaten in your first year of life? \_\_\_\_\_

### What childhood illnesses have you had?

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Rubella (German 3 day measles) | <input type="checkbox"/> Measles (2 week) | <input type="checkbox"/> Mumps           | <input type="checkbox"/> Chickenpox    |
| <input type="checkbox"/> Whooping Cough                 | <input type="checkbox"/> Polio            | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Roseola                        | <input type="checkbox"/> Asthma           | <input type="checkbox"/> Thrush          | <input type="checkbox"/> Epilepsy      |
| <input type="checkbox"/> Mononucleosis                  | <input type="checkbox"/> Strep Throat     | <input type="checkbox"/> Ear infections  | <input type="checkbox"/> Colic         |
| <input type="checkbox"/> Rashes/cradle cap              | <input type="checkbox"/> Constipation     | <input type="checkbox"/> Jaundice        | <input type="checkbox"/> Headaches     |

HOSPITALIZATIONS: \_\_\_\_\_

SURGERIES (with dates): \_\_\_\_\_

X-rays, CAT scans, Mammograms, or other studies you have had: \_\_\_\_\_

Major accidents/traumas (with dates): \_\_\_\_\_

Severe stresses/emotional traumas: \_\_\_\_\_

Immunizations: \_\_\_ Polio \_\_\_ Tetanus \_\_\_ Measles/Mumps/Rubella \_\_\_ Pertussis \_\_\_ Diphtheria  
\_\_\_ Hepatitis B \_\_\_ chicken pox \_\_\_ H. influenzae \_\_\_ Flu shot \_\_\_ Other for travel \_\_\_\_\_

### FAMILY HISTORY: (Please list ages and if deceased, what they passed from and at what age)

#### Mother's Side

Grandfather \_\_\_\_\_

Grandmother \_\_\_\_\_

Mother \_\_\_\_\_

Your Sisters \_\_\_\_\_

Your Brothers \_\_\_\_\_

#### Father's Side

Grandfather \_\_\_\_\_

Grandmother \_\_\_\_\_

Father \_\_\_\_\_

Has any BLOOD RELATIVE had any of the following:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Hay Fever            | <input type="checkbox"/> Kidney Disease     |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Heart Attack         | <input type="checkbox"/> Mental Illness     |
| <input type="checkbox"/> Asthma/hayfever   | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Alzheimers         |
| <input type="checkbox"/> Bleeding (easily) | <input type="checkbox"/> Seizure/Epilepsy     | <input type="checkbox"/> Alcoholism         |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Sickle Cell Anemia   | <input type="checkbox"/> Obesity            |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> High Cholesterol     | <input type="checkbox"/> Osteoporosis       |
| <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> Thyroid (hyper/hypo) | <input type="checkbox"/> Liver Disease      |
| <input type="checkbox"/> Eczema            | <input type="checkbox"/> Tuberculosis (TB)    | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Glaucoma          | <input type="checkbox"/> Venereal Disease     | <input type="checkbox"/> Autoimmune Disease |

**LIFESTYLE:**

Do you drink alcohol?  Yes  No How often?: wine \_\_\_\_\_ beer \_\_\_\_\_ other alcohol \_\_\_\_\_  
Do you use tobacco or have you in the past?  No  Yes, how long? \_\_\_\_\_ how much daily? \_\_\_\_\_  
Do you now or have you in the past used recreational drugs?  Yes  No \_\_\_\_\_  
Have you ever been exposed to toxic chemicals, solvents or other possible harmful toxins?  Yes  No  
If yes, please explain \_\_\_\_\_

Do you exercise?  Yes  No What form(s)? \_\_\_\_\_  
How often? \_\_\_\_\_

Do you make time for rest, relaxation or meditation during the day and/or before bed?  Yes  No  
How often? \_\_\_\_\_ How do you relax? \_\_\_\_\_

What are your interests or hobbies? \_\_\_\_\_

Which of the following do you do regularly:  Jogging  Swimming  Walking  Biking  Gardening  
 Yoga  Breathing Exercises  Meditation  Weightlifting  Pilates  Pray  
 Other activities: \_\_\_\_\_

Do you use regularly?  Electric Hair dryer  Electric Blanket  Heating pad  Cosmetics, Perfumes

Are your home and/or work environments well ventilated?  Yes  No Mold?  Yes  No

Are there unusual/unpleasant smells in your work/living environment?  Yes  No

When were the ducts in your home last cleaned? \_\_\_\_\_

**DIET:**

How many meals do you generally eat each day?  One  Two  Three  More than three

Do you: \_\_\_ eat out often \_\_\_ diet frequently \_\_\_ skip meals frequently

Do you have any special diet or eating restrictions?  Yes  No if yes, please explain \_\_\_\_\_

List the primary foods you include in your diet? \_\_\_\_\_

List the foods you exclude from your diet \_\_\_\_\_

Mark which of these you consume regularly.  Coffee  Caffeinated teas  Artificial sweeteners  
 Processed foods  Preservatives  Refined foods  Margarine  Trans-fatty acids  Sugar/sweets

List any other foods you eat which you suspect may be harmful to your health \_\_\_\_\_

List any foods you crave, regardless of their nutritional value (include sweets, chocolate, bread, salty, sour, rich, fatty foods, etc.) \_\_\_\_\_

List any foods to which you have a bad reaction: \_\_\_\_\_

Are you thirsty often?  Yes  No at night?  Yes  No How much water do you drink daily? \_\_\_\_\_

What temperature do you prefer to drink?  Hot  Cold  Room Temp.

Are you satisfied with your diet as it is now?  Yes  No If no, why not? \_\_\_\_\_

**SLEEP:** Do you have trouble falling asleep?  Yes  No If yes, what keeps you up? \_\_\_\_\_

Do you wake at night and can't fall back to sleep?  Yes  No \_\_\_\_\_

Do you wake feeling refreshed?  Yes  No \_\_\_\_\_

Do you have recurring dreams?  Yes  No If yes, what is the theme? \_\_\_\_\_

What position do you sleep in? \_\_\_\_\_

For Doctor use only: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PERSONAL:**

Are you happy in your job or career?  Yes  No \_\_\_\_\_

What personal goals do you have? \_\_\_\_\_

What makes you happy? \_\_\_\_\_

What are you grateful for? \_\_\_\_\_

What is your individual & unique purpose in this life? \_\_\_\_\_

Religious/spiritual affiliation \_\_\_\_\_

What would you like to change most about your life? \_\_\_\_\_

What behaviors, habits, or thoughts would you like to eliminate? \_\_\_\_\_

Is your present sex life satisfactory? \_\_\_\_\_

**General Status:**

Listed below are factors which may or may not influence your state of being. Please check the appropriate box of ONLY those with SIGNIFICANT influence on your health.

- | BETTER                   | WORSE   | BETTER                   | WORSE  |
|--------------------------|---|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Winter                   | <input type="checkbox"/> | <input type="checkbox"/> Spring                  |
| <input type="checkbox"/> | <input type="checkbox"/> Summer                   | <input type="checkbox"/> | <input type="checkbox"/> Autumn                  |
| <input type="checkbox"/> | <input type="checkbox"/> Cold                     | <input type="checkbox"/> | <input type="checkbox"/> Heat                    |
| <input type="checkbox"/> | <input type="checkbox"/> Dampness or dryness      | <input type="checkbox"/> | <input type="checkbox"/> Storms                  |
| <input type="checkbox"/> | <input type="checkbox"/> Sun                      | <input type="checkbox"/> | <input type="checkbox"/> Wind                    |
| <input type="checkbox"/> | <input type="checkbox"/> Open air (being outside) | <input type="checkbox"/> | <input type="checkbox"/> Confined (stuffy) air   |
| <input type="checkbox"/> | <input type="checkbox"/> Change of weather        | <input type="checkbox"/> | <input type="checkbox"/> Moonlight               |
| <input type="checkbox"/> | <input type="checkbox"/> Ocean seashore           | <input type="checkbox"/> | <input type="checkbox"/> Mountains               |
| <input type="checkbox"/> | <input type="checkbox"/> Physical exertion        | <input type="checkbox"/> | <input type="checkbox"/> Upon rising             |
| <input type="checkbox"/> | <input type="checkbox"/> Morning                  | <input type="checkbox"/> | <input type="checkbox"/> Afternoon               |
| <input type="checkbox"/> | <input type="checkbox"/> Evening                  | <input type="checkbox"/> | <input type="checkbox"/> Night                   |
| <input type="checkbox"/> | <input type="checkbox"/> Bath                     | <input type="checkbox"/> | <input type="checkbox"/> Warm application        |
| <input type="checkbox"/> | <input type="checkbox"/> Cold application         | <input type="checkbox"/> | <input type="checkbox"/> Traveling               |
| <input type="checkbox"/> | <input type="checkbox"/> Before menstruation      | <input type="checkbox"/> | <input type="checkbox"/> During menstruation     |
| <input type="checkbox"/> | <input type="checkbox"/> After menstruation       | <input type="checkbox"/> | <input type="checkbox"/> Having the windows open |

For Doctor use only:

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**\*\*PLEASE CHECK IF YOU HAVE NOW OR HAVE HAD IN THE PAST, ANY OF THESE SYMPTOMS\*\***

**Skin/hair/nails**

NOW/PAST (please circle any applicable in this section)

- \_\_\_\_\_ \_\_\_\_\_ Skin-rough, dry, scaly, bumpy, itching
- \_\_\_\_\_ \_\_\_\_\_ Rashes, warts, moles, cysts
- \_\_\_\_\_ \_\_\_\_\_ Acne/Pimples, hives, athletes foot, eczema, psoriasis, skin infections
- \_\_\_\_\_ \_\_\_\_\_ Nails: Color changes, ridges, pits, weak or brittle, white spots on nails
- \_\_\_\_\_ \_\_\_\_\_ Hair loss, coarse hair, hair thinning, hair growth on face or body(females only)
- \_\_\_\_\_ \_\_\_\_\_ Herpes, shingles, brown spots or bronzing of skin
- \_\_\_\_\_ \_\_\_\_\_ Cuts heal slowly, bruise easily, peeling of skin on feet
- \_\_\_\_\_ \_\_\_\_\_ Painful lymph nodes, swollen glands, difficulty stopping bleeding

For doctor use only: \_\_\_\_\_

**Endocrine**

NOW/ PAST

- \_\_\_\_\_ \_\_\_\_\_ Unexplained weight loss/gain
- \_\_\_\_\_ \_\_\_\_\_ Prefers hot weather
- \_\_\_\_\_ \_\_\_\_\_ Prefers cold weather
- \_\_\_\_\_ \_\_\_\_\_ Can't stand cold
- \_\_\_\_\_ \_\_\_\_\_ Can't stand heat

NOW/ PAST

- \_\_\_\_\_ \_\_\_\_\_ Cold hands or feet
- \_\_\_\_\_ \_\_\_\_\_ Chronic fatigue
- \_\_\_\_\_ \_\_\_\_\_ Weakness
- \_\_\_\_\_ \_\_\_\_\_ Increased thirst
- \_\_\_\_\_ \_\_\_\_\_ Increased hunger

**Head**

NOW/ PAST

- \_\_\_\_\_ \_\_\_\_\_ Dizziness
- \_\_\_\_\_ \_\_\_\_\_ Severe headaches(sinus, tension)
- \_\_\_\_\_ \_\_\_\_\_ Seizures, convulsions

NOW/ PAST

- \_\_\_\_\_ \_\_\_\_\_ Double vision
- \_\_\_\_\_ \_\_\_\_\_ Fainting spells
- \_\_\_\_\_ \_\_\_\_\_ Migraines

**Eyes**

NOW/ PAST

- \_\_\_\_\_ \_\_\_\_\_ Poor eyesight (near or far-sighted)
- \_\_\_\_\_ \_\_\_\_\_ Light hurts eyes
- \_\_\_\_\_ \_\_\_\_\_ Eye dryness, eyes itchy

NOW/ PAST

- \_\_\_\_\_ \_\_\_\_\_ Glaucoma
- \_\_\_\_\_ \_\_\_\_\_ Eyes bulging
- \_\_\_\_\_ \_\_\_\_\_ Double vision

**Ears**

NOW/ PAST

- \_\_\_\_\_ \_\_\_\_\_ Discharge from ears
- \_\_\_\_\_ \_\_\_\_\_ Hearing loss
- \_\_\_\_\_ \_\_\_\_\_ Sensitivity to noise

NOW/ PAST

- \_\_\_\_\_ \_\_\_\_\_ Pain in ears
- \_\_\_\_\_ \_\_\_\_\_ Ringing in ears
- \_\_\_\_\_ \_\_\_\_\_ Ear infections

**Nose**

NOW/ PAST

- \_\_\_\_\_ \_\_\_\_\_ Nose bleeds frequent
- \_\_\_\_\_ \_\_\_\_\_ Sinus congestion
- \_\_\_\_\_ \_\_\_\_\_ Nasal polyps

NOW/ PAST

- \_\_\_\_\_ \_\_\_\_\_ Loss of smell
- \_\_\_\_\_ \_\_\_\_\_ Nasal scabs/crusts
- \_\_\_\_\_ \_\_\_\_\_ Deviated septum

**Mouth**

NOW/ PAST

- \_\_\_\_\_ \_\_\_\_\_ Sore mouth or tongue
- \_\_\_\_\_ \_\_\_\_\_ Speech difficulties
- \_\_\_\_\_ \_\_\_\_\_ Bleeding gums

NOW/ PAST

- \_\_\_\_\_ \_\_\_\_\_ Loss of teeth
- \_\_\_\_\_ \_\_\_\_\_ Cold sores, blisters
- \_\_\_\_\_ \_\_\_\_\_ Tooth pain

**Mouth** continued For doctors use only: \_\_\_\_\_

**NOW/ PAST**

\_\_\_\_\_ \_\_\_\_\_ Grinds teeth at night  
\_\_\_\_\_ \_\_\_\_\_ Reduced sense of taste or smell

**NOW/ PAST**

\_\_\_\_\_ \_\_\_\_\_ Jaw pain, jaw clicks  
\_\_\_\_\_ \_\_\_\_\_ Dental work (a lot)

**Throat**

**NOW/ PAST**

\_\_\_\_\_ \_\_\_\_\_ Persistent hoarseness  
\_\_\_\_\_ \_\_\_\_\_ Difficulty swallowing  
\_\_\_\_\_ \_\_\_\_\_ Recurrent strep throat  
\_\_\_\_\_ \_\_\_\_\_ Feeling of constriction or "lump"

**NOW/ PAST**

\_\_\_\_\_ \_\_\_\_\_ Loss of voice  
\_\_\_\_\_ \_\_\_\_\_ Pain  
\_\_\_\_\_ \_\_\_\_\_ Chronic sore throat  
\_\_\_\_\_ \_\_\_\_\_ Swollen tonsils/glands

**Neck**

**NOW/ PAST**

\_\_\_\_\_ \_\_\_\_\_ Stiffness  
\_\_\_\_\_ \_\_\_\_\_ Pain (describe area/type)

**NOW/ PAST**

\_\_\_\_\_ \_\_\_\_\_ Injuries  
\_\_\_\_\_ \_\_\_\_\_ Swelling

**Respiratory**

**NOW/ PAST**

\_\_\_\_\_ \_\_\_\_\_ Unexplained fever  
\_\_\_\_\_ \_\_\_\_\_ Chest pain when breathing  
\_\_\_\_\_ \_\_\_\_\_ Wheezing/Asthma  
\_\_\_\_\_ \_\_\_\_\_ Difficulty breathing  
\_\_\_\_\_ \_\_\_\_\_ Chest congestion

**NOW/ PAST**

\_\_\_\_\_ \_\_\_\_\_ Sinusitis  
\_\_\_\_\_ \_\_\_\_\_ Bronchitis  
\_\_\_\_\_ \_\_\_\_\_ Shortness of breath  
\_\_\_\_\_ \_\_\_\_\_ Daily cough  
\_\_\_\_\_ \_\_\_\_\_ Sigh frequently

**Cardiovascular**

**NOW/ PAST**

\_\_\_\_\_ \_\_\_\_\_ Chest pain when walking  
\_\_\_\_\_ \_\_\_\_\_ Chest pain when sit/lying  
\_\_\_\_\_ \_\_\_\_\_ Ankle or abdominal swelling  
\_\_\_\_\_ \_\_\_\_\_ Heart palpitations  
\_\_\_\_\_ \_\_\_\_\_ Chest tightness  
\_\_\_\_\_ \_\_\_\_\_ Heaviness in arms/legs

**NOW/ PAST**

\_\_\_\_\_ \_\_\_\_\_ Leg vein problems  
\_\_\_\_\_ \_\_\_\_\_ Leg pain when walking  
\_\_\_\_\_ \_\_\_\_\_ Numbness/tingling in extremities  
\_\_\_\_\_ \_\_\_\_\_ Heart murmur type: \_\_\_\_\_  
\_\_\_\_\_ \_\_\_\_\_ Stroke  
\_\_\_\_\_ \_\_\_\_\_ High altitude discomfort

**Gastrointestinal**

**NOW/ PAST**

\_\_\_\_\_ \_\_\_\_\_ Constipation  
\_\_\_\_\_ \_\_\_\_\_ Diarrhea  
\_\_\_\_\_ \_\_\_\_\_ Alternating constipation & diarrhea  
\_\_\_\_\_ \_\_\_\_\_ Change in bowel movements  
\_\_\_\_\_ \_\_\_\_\_ Hemorrhoids  
\_\_\_\_\_ \_\_\_\_\_ Black stools  
\_\_\_\_\_ \_\_\_\_\_ Blood in stools  
\_\_\_\_\_ \_\_\_\_\_ Stools - yellow, grey, green, foul  
\_\_\_\_\_ \_\_\_\_\_ Frequency of bowel movements  
\_\_\_\_\_ \_\_\_\_\_ Loss of appetite

**NOW/ PAST**

\_\_\_\_\_ \_\_\_\_\_ Indigestion immediately after a meal.  
\_\_\_\_\_ \_\_\_\_\_ Indigestion 2-3 hours after meals with fullness, bloating or pain.  
\_\_\_\_\_ \_\_\_\_\_ Stomach aches  
\_\_\_\_\_ \_\_\_\_\_ Symptoms worse with stress & tension  
\_\_\_\_\_ \_\_\_\_\_ Heavy, full feeling after eating  
\_\_\_\_\_ \_\_\_\_\_ Mucous in stool  
\_\_\_\_\_ \_\_\_\_\_ Undigested food in stool  
\_\_\_\_\_ \_\_\_\_\_ Appetite change: increase or decrease  
\_\_\_\_\_ \_\_\_\_\_ Date of last test for blood in stool

\_\_\_\_\_ \_\_\_\_\_ Insatiable appetite  
 \_\_\_\_\_ \_\_\_\_\_ Vomiting blood  
 \_\_\_\_\_ \_\_\_\_\_ Frequent/severe nausea  
 \_\_\_\_\_ \_\_\_\_\_ Excessive belching  
 \_\_\_\_\_ \_\_\_\_\_ Excessive lower bowel gas  
 \_\_\_\_\_ \_\_\_\_\_ Abdominal bloat/distension  
 \_\_\_\_\_ \_\_\_\_\_ Distress from fat or greasy foods  
 \_\_\_\_\_ \_\_\_\_\_ Bad breath(halitosis)  
 \_\_\_\_\_ \_\_\_\_\_ Body odor (including feet)  
 \_\_\_\_\_ \_\_\_\_\_ Liver problems/pain

\_\_\_\_\_ \_\_\_\_\_ Weight change: increase or decrease  
 \_\_\_\_\_ \_\_\_\_\_ Heartburn or ulcers  
 \_\_\_\_\_ \_\_\_\_\_ Bitter/metallic taste in mouth  
 \_\_\_\_\_ \_\_\_\_\_ Compulsive eating  
 \_\_\_\_\_ \_\_\_\_\_ Addictive eating  
 \_\_\_\_\_ \_\_\_\_\_ Parasites  
 \_\_\_\_\_ \_\_\_\_\_ Sickness from foreign travel  
 \_\_\_\_\_ \_\_\_\_\_ Coated tongue  
 \_\_\_\_\_ \_\_\_\_\_ Itchiness in anus/rectum  
 \_\_\_\_\_ \_\_\_\_\_ Gallbladder stones/attacks

**Urinary tract**

**NOW/ PAST**

\_\_\_\_\_ \_\_\_\_\_ Frequent urination  
 \_\_\_\_\_ \_\_\_\_\_ Night urination  
 \_\_\_\_\_ \_\_\_\_\_ Difficulty holding urine  
 \_\_\_\_\_ \_\_\_\_\_ Bladder infections  
 \_\_\_\_\_ \_\_\_\_\_ Strong odor to urine

**NOW/ PAST**

\_\_\_\_\_ \_\_\_\_\_ Painful(burning) urination  
 \_\_\_\_\_ \_\_\_\_\_ Difficult starting urine  
 \_\_\_\_\_ \_\_\_\_\_ Blood in urine  
 \_\_\_\_\_ \_\_\_\_\_ Urinary tract infections  
 \_\_\_\_\_ \_\_\_\_\_ Unusual color to urine

**Male Reproductive**

**NOW/ PAST**

\_\_\_\_\_ \_\_\_\_\_ Prostate problems  
 \_\_\_\_\_ \_\_\_\_\_ Swelling, lumps, pain in testicles  
 \_\_\_\_\_ \_\_\_\_\_ Discharge from penis  
 \_\_\_\_\_ \_\_\_\_\_ Infertility  
 \_\_\_\_\_ \_\_\_\_\_ Venereal disease

**NOW/ PAST**

\_\_\_\_\_ \_\_\_\_\_ Painful erection  
 \_\_\_\_\_ \_\_\_\_\_ Difficult achieving/maintaining erection  
 \_\_\_\_\_ \_\_\_\_\_ Difficulty or premature ejaculation  
 \_\_\_\_\_ \_\_\_\_\_ Sex drive reduced  
 \_\_\_\_\_ \_\_\_\_\_ Urine stream not as forceful

**Female Reproductive**

**NOW/ PAST**

\_\_\_\_\_ \_\_\_\_\_ Lumps in breast(s)  
 \_\_\_\_\_ \_\_\_\_\_ Nipple discharge  
 \_\_\_\_\_ \_\_\_\_\_ Breast pain  
 \_\_\_\_\_ \_\_\_\_\_ Pelvic pain  
 \_\_\_\_\_ \_\_\_\_\_ Abnormal vaginal discharge  
 \_\_\_\_\_ \_\_\_\_\_ Vaginal itching/burning  
 \_\_\_\_\_ \_\_\_\_\_ Genital eruptions  
 \_\_\_\_\_ \_\_\_\_\_ Yeast infections frequent  
 \_\_\_\_\_ \_\_\_\_\_ Endometriosis  
 \_\_\_\_\_ \_\_\_\_\_ Hysterectomy

**NOW/ PAST**

\_\_\_\_\_ \_\_\_\_\_ Painful sex  
 \_\_\_\_\_ \_\_\_\_\_ Lack of sexual desire  
 \_\_\_\_\_ \_\_\_\_\_ Difficulty feeling sexual arousal  
 \_\_\_\_\_ \_\_\_\_\_ Never/seldom have orgasms  
 \_\_\_\_\_ \_\_\_\_\_ Menstruation excessive  
 \_\_\_\_\_ \_\_\_\_\_ Menstruation absent  
 \_\_\_\_\_ \_\_\_\_\_ Bleed/spot between periods  
 \_\_\_\_\_ \_\_\_\_\_ Infertility  
 \_\_\_\_\_ \_\_\_\_\_ Hot flashes, vaginal dryness  
 \_\_\_\_\_ \_\_\_\_\_ Fibroids/cysts

Have you ever used birth control pills?  Yes  No If yes, how long \_\_\_\_\_

Have you ever used an **I.U.D.**?  Yes  No How long? \_\_\_\_\_ What kind? \_\_\_\_\_

Age of first menstruation \_\_\_\_\_ Did you have a normal puberty?  Yes  No \_\_\_\_\_

Periods occur every \_\_\_\_\_ days. Regular?  Yes  No Periods usually last \_\_\_\_\_ days (average).

Date of last period \_\_\_\_\_

\_\_\_\_\_ # of pregnancies \_\_\_\_\_ # of births \_\_\_\_\_ # of miscarriages \_\_\_\_\_ #of abortions

(Please mark **B** if before, **D** if during or **A** if after menstruation for any below)

**PMS-A ('Anxiety')**

\_\_\_\_\_ Nervous tension  
\_\_\_\_\_ Irritability  
\_\_\_\_\_ Mood changes  
\_\_\_\_\_ Anxiety  
\_\_\_\_\_ Insomnia

**PMS-D ('Depression')**

\_\_\_\_\_ Depression  
\_\_\_\_\_ Forgetful  
\_\_\_\_\_ Crying  
\_\_\_\_\_ Confusion  
\_\_\_\_\_ Dizziness or fainting

**PMS-C ('Craving')**

\_\_\_\_\_ Headache  
\_\_\_\_\_ Craving for sweets  
\_\_\_\_\_ Increased appetite  
\_\_\_\_\_ Heart pounding

**PMS-H ('Hyperhydration')**

\_\_\_\_\_ Weight gain  
\_\_\_\_\_ Bloating  
\_\_\_\_\_ Extremity swelling  
\_\_\_\_\_ Breast tenderness

**Pituitary**

**NOW/ PAST**

\_\_\_\_\_ Failing memory  
\_\_\_\_\_ Low blood pressure  
\_\_\_\_\_ Increase sex desire  
\_\_\_\_\_ Splitting headaches  
\_\_\_\_\_ Menstrual disorders  
\_\_\_\_\_ Low sugar intolerance

**NOW/ PAST**

\_\_\_\_\_ Intestinal bloating  
\_\_\_\_\_ Abnormal thirst  
\_\_\_\_\_ Decreased sex desire  
\_\_\_\_\_ Chunky hips or waist  
\_\_\_\_\_ Ulcers, colitis  
\_\_\_\_\_ High sugar tolerance

**Thyroid**

**NOW/ PAST**

\_\_\_\_\_ Overweight  
\_\_\_\_\_ Difficulty losing weight  
\_\_\_\_\_ Constipation  
\_\_\_\_\_ Tired upon rising  
\_\_\_\_\_ Easily fatigued  
\_\_\_\_\_ Dry or scaly skin  
\_\_\_\_\_ Chilly/sensitive to cold  
\_\_\_\_\_ Mental slowness  
\_\_\_\_\_ Hair loss, hair coarse

**NOW/ PAST**

\_\_\_\_\_ Decrease appetite  
\_\_\_\_\_ Nervousness  
\_\_\_\_\_ Heart palpitations  
\_\_\_\_\_ Irritable/restless  
\_\_\_\_\_ Increased appetite  
\_\_\_\_\_ Underweight  
\_\_\_\_\_ Flush/get hot easily  
\_\_\_\_\_ Insomnia  
\_\_\_\_\_ Intolerant to high temperature

**Adrenals**

**NOW/ PAST**

\_\_\_\_\_ Easily stressed  
\_\_\_\_\_ Easily/chronically fatigued  
\_\_\_\_\_ Dizziness on standing  
\_\_\_\_\_ Headaches  
\_\_\_\_\_ Hot flashes  
\_\_\_\_\_ Bronzing of the skin  
\_\_\_\_\_ Craves salt

**NOW/ PAST**

\_\_\_\_\_ Nails weak, ridged  
\_\_\_\_\_ Tendency to get hives  
\_\_\_\_\_ Rheumatism/arthritis  
\_\_\_\_\_ Perspire easily  
\_\_\_\_\_ Low blood pressure  
\_\_\_\_\_ Weak after getting a cold  
\_\_\_\_\_ Facial hair (women)

**Neurological**

**NOW/ PAST**

\_\_\_\_\_ Loss of balance/fainting  
\_\_\_\_\_ Dizziness regularly  
\_\_\_\_\_ Convulsions (seizures)  
\_\_\_\_\_ Tremor (shaking, trembling)  
\_\_\_\_\_ Blurred/double vision

**NOW/ PAST**

\_\_\_\_\_ Paralysis  
\_\_\_\_\_ Numbness/tingling (circle)  
\_\_\_\_\_ Temporary loss of sensation  
\_\_\_\_\_ Lack of strength  
\_\_\_\_\_ Memory loss

**Musculoskeletal****NOW/ PAST**

\_\_\_\_\_ \_\_\_\_\_ Joint pain/stiffness  
 \_\_\_\_\_ \_\_\_\_\_ Arthritis  
 \_\_\_\_\_ \_\_\_\_\_ Backaches  
 \_\_\_\_\_ \_\_\_\_\_ Bone pain  
 \_\_\_\_\_ \_\_\_\_\_ Heel spurs  
 \_\_\_\_\_ \_\_\_\_\_ Herniated disc

**NOW/ PAST**

\_\_\_\_\_ \_\_\_\_\_ Muscle cramps  
 \_\_\_\_\_ \_\_\_\_\_ Stiffness in morning  
 \_\_\_\_\_ \_\_\_\_\_ Sciatica  
 \_\_\_\_\_ \_\_\_\_\_ Scoliosis  
 \_\_\_\_\_ \_\_\_\_\_ Referred pain down legs or arms  
 \_\_\_\_\_ \_\_\_\_\_ Jaw pain

**Emotional****NOW/ PAST**

\_\_\_\_\_ \_\_\_\_\_ Anxiety  
 \_\_\_\_\_ \_\_\_\_\_ Restlessness  
 \_\_\_\_\_ \_\_\_\_\_ Excessive worry  
 \_\_\_\_\_ \_\_\_\_\_ Depression  
 \_\_\_\_\_ \_\_\_\_\_ Despair/Discontent  
 \_\_\_\_\_ \_\_\_\_\_ Suicidal thoughts  
 \_\_\_\_\_ \_\_\_\_\_ Suicide attempts  
 \_\_\_\_\_ \_\_\_\_\_ Loneliness/feel alone  
 \_\_\_\_\_ \_\_\_\_\_ Mood swings  
 \_\_\_\_\_ \_\_\_\_\_ Prefer to be with company  
 \_\_\_\_\_ \_\_\_\_\_ Prefer to be left alone  
 \_\_\_\_\_ \_\_\_\_\_ Afraid when left alone  
 \_\_\_\_\_ \_\_\_\_\_ Would rather be left alone  
 \_\_\_\_\_ \_\_\_\_\_ when not feeling well

**NOW/ PAST**

\_\_\_\_\_ \_\_\_\_\_ Fears/phobias  
 \_\_\_\_\_ \_\_\_\_\_ Mental confusion  
 \_\_\_\_\_ \_\_\_\_\_ Decreased concentration, comprehension  
 \_\_\_\_\_ \_\_\_\_\_ Obsessive thoughts  
 \_\_\_\_\_ \_\_\_\_\_ Shy, timid  
 \_\_\_\_\_ \_\_\_\_\_ Critical of self  
 \_\_\_\_\_ \_\_\_\_\_ Critical of others  
 \_\_\_\_\_ \_\_\_\_\_ Lack self-confidence  
 \_\_\_\_\_ \_\_\_\_\_ Suspicious/jealous  
 \_\_\_\_\_ \_\_\_\_\_ Sensitive to noises  
 \_\_\_\_\_ \_\_\_\_\_ Extremely neat/clean  
 \_\_\_\_\_ \_\_\_\_\_ Post traumatic stress syndrome  
 \_\_\_\_\_ \_\_\_\_\_ Anger feelings  
 \_\_\_\_\_ \_\_\_\_\_ Claustrophobia

**Blood Sugar issues****NOW/ PAST**

\_\_\_\_\_ \_\_\_\_\_ Eat when nervous  
 \_\_\_\_\_ \_\_\_\_\_ Excessive appetite  
 \_\_\_\_\_ \_\_\_\_\_ Loss of Appetite  
 \_\_\_\_\_ \_\_\_\_\_ Hungry between meals  
 \_\_\_\_\_ \_\_\_\_\_ Irritable if meals skipped  
 \_\_\_\_\_ \_\_\_\_\_ Fatigue relieved by eating

**NOW/ PAST**

\_\_\_\_\_ \_\_\_\_\_ Get shaky if meal missed  
 \_\_\_\_\_ \_\_\_\_\_ Crave sweets/coffee  
 \_\_\_\_\_ \_\_\_\_\_ Lightheaded if miss meal  
 \_\_\_\_\_ \_\_\_\_\_ Overeating sweets upsets  
 \_\_\_\_\_ \_\_\_\_\_ Low blood sugar  
 \_\_\_\_\_ \_\_\_\_\_ Awaken a few hours after sleeping

Thank you very much. I look forward to assisting you in your healing process.