O'Keefe Matz
functional health clinic

Nutrition Patient Questionnaire

Date: _____
SS#: _____

Name _____ Date of Birth _____
Address _____ City/State/Zip _____
Email _____
Telephone (home) _____ (Work) _____
Place of Employment _____ Occupation _____
Married _____ Single _____ Divorced _____ Widow(er) _____ # of Children _____
Spouse's Name _____ Place of Employment _____
Primary Physician _____ Date of last physical _____
Dentist Date of last visit _____
Date of last chiropractic adjustment _____ Given by Dr. _____
In case of emergency, who should we contact?
Name _____ Phone _____ Relationship _____
How did you hear about our office? _____

We will provide a receipt for you to submit to your insurance.
You are responsible for payment in full at the time of service.

** I clearly understand that all services rendered me are my responsibility and payment is expected at the time of service.
Patient's Signature _____ Date _____

If under 18 years of age, parent or guardian's signature _____

Nutritional Informed Consent

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean, *"articles intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease."*
A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy. Although a Vitamin a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone. Therefore, plese be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom.

Nutritional counseling vitamin recommendations, nutritional advice and the adjuctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body. Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment.

I have read and understand the above:

Signature _____ Date _____

O'Keefe Matz
chiropractic & functional health clinic

Nutrition Program Agreement

It is the policy of **O'Keefe Matz Chiropractic Clinic** to inform you fully of the expectations of the nutrition program – so that you may determine whether or not it is a good fit for you at this point. As you review this document – please let us know if you have any questions.

The biggest precursor to success at our program is the personal commitment and enthusiasm to engage in the program fully. Our type of treatment is a conversation between doctor and patient and requires not only the guidance of Dr. O'Keefe but also the patient's willingness to co-participate in their own journey to health.

Please review carefully and initial the following statements:

1. **Financial & Personal Commitment:**

   A large part of your success in the nutrition program is understanding that our approach requires both a financial and time commitment. This is broken down into several different parts:
   - I understand that an average commitment to see lasting results in the program requires at least a 6 – 12 month full commitment to the program. ** Although we often see changes right away as well!
   - I understand that the Nutrition program is a cash based practice and that all payment is due up front for services (lab work, consultation time, and supplements).

   ____ initial

2. **Commitment to clear and concise communication**

   I understand that it is required to be upfront and honest in regards to my personal goals with the program as well as any concurrent treatment that I am receiving from other providers (all medications, etc.)

   I also understand that it is my responsibility upon beginning the program to contact the office of O'Keefe Matz Chiropractic when any of the following occur:
   - Any symptoms worsen or new ones occur
   - Any treatments commence or change with other providers
   - Any part of the program is stopped (i.e supplements, diet, etc.)
   - Financial status has changed and there is a need to change treatment protocol as a result.
   - At any point feel the need to quit the program. **____ initial**

3. **Agreement to Supplement policy:**

   Part of the success of the nutrition program in addition to basing treatment on lab results is the sourcing of very high quality supplementation and medical products. Our supplement policy is as follows:

   I understand that in order to see lasting results in the program I need to participate fully in it (lab tests, communication with doctor, taking full prescription of supplements). In addition, I understand that this requires I buy my supplements through the clinic or another certified medical office (NOT amazon, vitacost, etc.) Supplements bought through other sellers cannot be returned here. **____initial**

   I understand that if I change my supplement regimen without communicating it to Dr. O'Keefe OR purchase my supplements elsewhere, my results and success in the program can be altered significantly. **____initial**

   Finally, I understand that all supplements can be returned (unopened) within 30 days of purchase with the exception of probiotics, medical food and special order supplements. Returns over $200 have a15% restocking fee. **____initial**

I, the undersigned, have read and understand the above mentioned clinic policies and understand my responsibilities and how they relate to the success of the nutrition program.

Signature_____**Date**_____

O'Keefe Matz
chiropractic & functional health clinic

Financial Policy & Agreement

It is the policy of **O'Keefe Matz Chiropractic Clinic** to inform you of charges incurred so that you can plan for payment of your care in advance of your visit.

Please review and initial the following statements:

1. I understand that O'Keefe Matz Chiropractic is not a provider for any major medical insurance company. Auto, Workman's compensation, and Major Medical insurance are accepted with "out of network" coverage. We submit medical insurance forms (**for an extra $15 fee**) and ask that **deductibles and con-insurance payments be made at the time of service. Patients are responsible for any charges incurred that their insurance does not cover. If coverage has not been determined by the first visit – patient are required to pay at time of service.**

   ____ initial

2. I understand that cash patients are to pay for services at the time that they are rendered. Patients are required to contact the front desk if special payment arrangements are necessary. ***We accept payment by cash, check or credit card (Visa, Mastercard, American Express or Discover).***

   ____ initial

3. I understand that the discount program and return policy for the services that I am receiving are the following:

   Supplement Discount Policy (applies only to CURRENT Nutrition patients)
   Current nutrition patients receive a 5% discount on purchases more than $200 and 10% on $300 and up.
   There is no discount on VSL #3 probiotics and medical food.

   Supplement Return Policy (within 30 days)
   We offer a 100% return on **unopened** supplements, returned within 30 days under $200.
   Return orders over $200 have a 15% restocking fee. There are **NO** returns on probiotics and medical food.

   ____initial

4. I understand that I need to provide 24 hours notice for cancellation of your chiropractic appointment. A late cancellation fee of $25 will be assessed and will be the responsibility of the patient and is **NOT BILLABLE** to the insurance company. After two missed or cancelled appointments, you may be billed for the full cost of a chiropractic appointment.

   ____initial

I, the undersigned, have read and understand the above mentioned clinic policies and realize that I am responsible for any and all charges not covered by my insurance. I also understand that there will be an 18% APR charge on all accounts 30 days past due as well as a collection fee if this account is sent to a collection agency or an attorney.

Signature_____ **Date**_____

Name:_____ Date_____

Please fill out the following as completely as you can. Use additional blank sheets if necessary.

YOUR HEALTH HISTORY

Give the primary reason you are consulting with our doctor. Be sure to give a detailed account including when and why it started, what has been done to date, the results you have had and if the problem is getting better, worse or is the same.

_____

_____

Give any secondary health problems you are experiencing. List the most severe first.

_____

_____

List all the nutritional supplement products you are taking. Include the name of the company, amount, why you are taking them and how long you have been taking them. We ask that you bring all bottles to your consultation.

Name Company Amount Why taking How long

_____

_____

_____

List all drugs (prescription or not) you are taking. Include the reason taken, amount, length of time taken and results. List all other drugs you have taken in the past.

Name Amount WhyTaken How long Results

_____

_____

List all surgeries you have had including the date, Why it was done and the results.

Surgery Date Why done Results

_____

_____

_____

List any allergies you have to food, drugs or other substances along with the symptoms they produce and indicate how long you have suffered from each item.

Allergy Symptoms How long

_____

_____

Answer the following questions to the best of your ability. If you don't know the answer, leave blank:

( ) yes ( ) no My mother was healthy while pregnant with me. If no, describe._____

( ) yes ( ) no Was your birth natural? If no, please check ( ) Anesthesia ( ) Forceps ( ) C-section

( ) yes ( ) no Were you breast fed for at least the first 6 months?_____

( )yes ( ) no Were you fed anything other than breast or cow formula milk in the first 6 months? List items:

_____

( ) yes ( ) no Were you a colicky baby? Until what age?_____

( ) yes ( ) no Have you been to or lived in a foreign country? List:_____

( ) yes ( ) no Have you ever fainted or had a convulsion? Describe_____

_____

Mark any you have/had: ( ) Measles ( ) Chicken Pox ( ) Mumps ( ) German Measles ( ) Hepatitis
( ) Scarlet Fever ( ) Rheumatic Fever ( ) Lymes Disease ( ) Mononucleosis
( ) Herpes ( ) Shingles ( ) Venereal Disease ( ) HIV/AIDS

Name:_____ Date_____

DIET HISTORY

Mark each one usig a "0" or NONE when appropriate

Give the amount of each you consume:

_____	ounces water	_____day	_____ not daily
_____	ounces alcohol	_____day	_____ not daily
_____	ounces coffee/tea	_____day	_____ not daily
_____	ounces soda	_____day	_____ not daily
_____	ounces juice	_____day	_____ not daily
_____	other_____	_____day	_____ not daily

List your 10 most favorite foods eaten most frequently: _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Give percentaage for each of the following. Total for each line to equal 100%

Where daily diet prepared: _____ Home _____ Restaurant _____ Fast Food _____ Vending machine

How food is prepared: _____ Baked_____ Broiled_____ Boiled _____ Fried _____ Steamed _____ Microwaved

Food prepared from: _____ Fresh_____ Canned_____ Frozen_____ Prepackaged

My appetite is: ( ) Normal ( ) Excessive ( ) Poor ( ) None

I crave: ( ) Sweets ( ) Salt ( ) Chocolate ( ) Water ( ) Dirt ( ) Other _____

Type of water used for drinking/cooking: ( ) Tap/City ( ) Spring ( ) Well ( ) Rain ( ) Bottled distilled ( ) Bottled filtered ( ) Reverse osmosis

If purchase water, is it in: ( ) Soft plastic ( ) Hard plastic ( ) Glass

Foods that disagree with you: ( ) Raw vegetables ( ) Raw fruit ( ) Fats ( ) Fried ( ) Milk/dairy ( ) Greasy ( ) Eggs ( ) Onions ( ) Highly spiced ( ) Beans ( ) Cabbage ( ) Sugar ( ) Other _____

What symptoms do you get from foods that disagree with you? _____

_____

Do you fast? ( ) Yes ( ) No If yes, how often and how long? _____

Have you ever done a detoxification program? ( ) Yes ( ) No Explain: _____

Check any of the following diets you have ever tried?

( ) Low cholesterol	( ) Low salt	( ) Low Purine	( ) All energy
( ) Low fat	( ) Diabetic	( ) Renal/Kidney	( ) High Fiber
( ) Ulcer	( ) Diverticulitis	( ) Complex carbohydrate	( ) High protein

( ) Weight Loss (list which ones) _____

How many days a week do you exercise? _____How long each time? _____ Type of exercise? _____

_____

_____

Name:_____ Date: _____

BOWEL HEALTH BM=Bowel movement or stool

How many times do you have a BM _____ a day _____ a week
Do you use laxatives? ( ) Yes ( ) No How often _____ Brand _____
Do you get the urge to have a BM? ( ) Yes ( ) No Do you have pain with BM? ( ) Yes ( ) No

Answer key for the folloing tables: 0 = never 1 = rarely 2 = frequently 3 = always

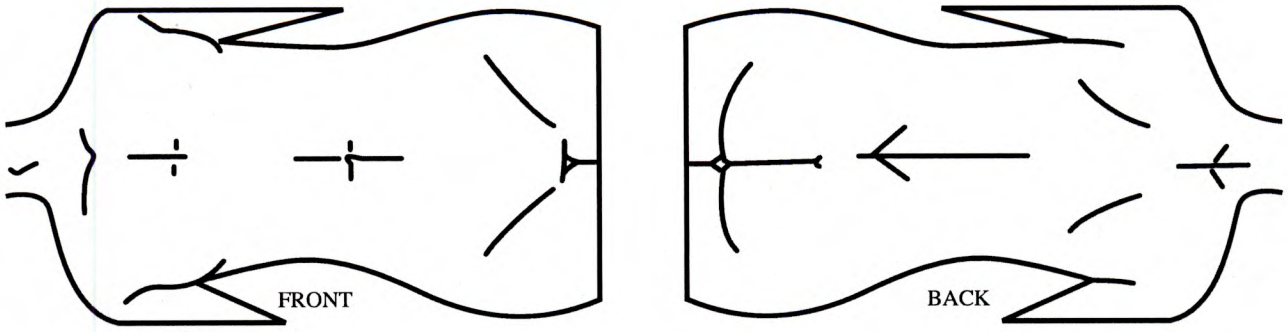
Stool size
_____ 2" wide & 6+" length
_____ 1" wide & 4+" length
_____ Thin, long or narrow
_____ Small, hard
_____ Large, hard
_____ Difficult to pass

Stool consistency
_____ Float like a submarine
_____ Float on top of water
_____ Sink to bottom
_____ Loose but not watery
_____ Diarrhea
_____ Alternate hard/diarrhea

Stool color
_____ Med/ dark brown
_____ Very dark/black
_____ Yellow/tan/clay
_____ Greenish
_____ Blood is visible
_____ Mucus in or around

Have you ever had worms or parasites? ( ) Yes ( ) No How treated?
Do you presently have rectal itching? ( ) Yes ( ) No ( ) Day ( ) Night ( ) Continuously

DIGESTION Mark any areas of distress associated with food intake on the diagram.



I get pain/heartburn: ( ) Before eating ( ) After eating ( ) When I lie down ( ) Upon rising

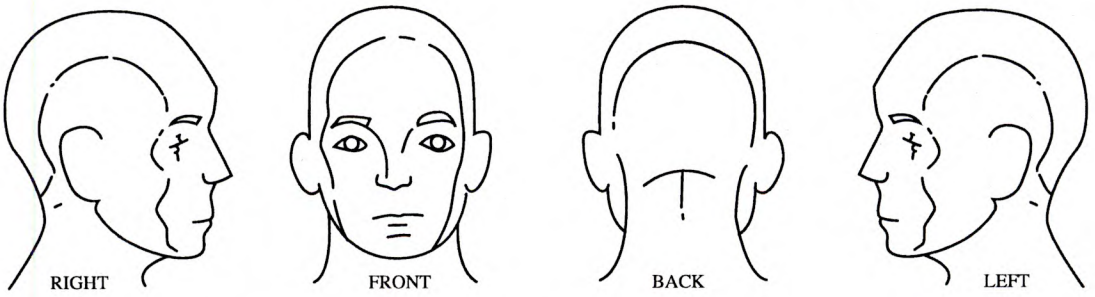
I have ( ) Indigestion ( ) Belching ( ) GERD ( ) Intestinal Gas ( ) Bloating
( ) Immediately after eating ( ) 1 - 2 Hours ( ) 3 - 5 hours ( ) 6+ Hours
( ) No odor ( ) Some odor ( ) Odor usually ( ) Foul smelling
( ) Hiatal Hernia ( ) Esophageal burning/reflux ( ) Raise head of bed to sleep

List any drugs (prescription or OTC) or natural remedies you take for any stomach or bowel symptoms.

Product	Dose	How Frequently	Results

Name: _____ Date:_____

HEAD, MOUTH, THROAT Mark any areas of headache or pain, mark all that apply.



My teeth are: ( ) Good ( ) Some fillings ( ) Bad ( ) Some missing ( ) All missing ( ) Root canal
I wear dentures: ( ) Upper ( ) Lower ( ) Partials ( ) Crowns ( ) More than one metal type in my mouth
My breath is: ( ) Good ( ) Slight odor ( ) Odor off/on ( ) Offensive odor usually
My tongue is: ( ) Covered with small taste buds ( ) Sore ( ) Furrowed ( ) Coated_____ color
My tongue color is: ( ) Pink ( ) Red ( ) Red blotchy ( ) Pink with red tip
My tonsils are: ( ) Normal ( ) Removed at age _____ ( ) Enlarged ( ) Spotted
My sense of taste is: ( ) Normal ( ) Poor ( ) No taste ( ) Over salt food ( ) Canker sores
My lips are: ( ) Normal ( ) Dry ( ) Peel a lot ( ) Fever blisters often ( ) Cracked in corners

I get headaches: ( ) Daily ( ) Weekly ( ) Rarely ( ) Never
( ) Wake up with ( ) Get in AM ( ) Get in PM
( ) Of different types ( ) With some foods or drinks
( ) With aura ( ) With nausea/vomiting

MUSCLE, LIGAMENT, JOINT, NERVES

I have pain in: ( ) Neck ( ) Mid back ( ) Low back
( ) Hip ( ) Knee ( ) Ankle ( ) Feet
( ) Shoulder ( ) Elbow ( ) Wrist ( ) Hands
( ) Other _____

I get: ( ) Swollen joints ( ) Sore joints ( ) Joints pop or crack ( ) Jaw pops
( ) Leg cramps at rest ( ) Leg cramps with activity ( ) Worse at night
( ) Foot cramps at rest ( ) Foot cramps wit activity ( ) Flat feet ( ) Burning feet
( ) Tingling in feet or hands ( ) Restless leg syndrome

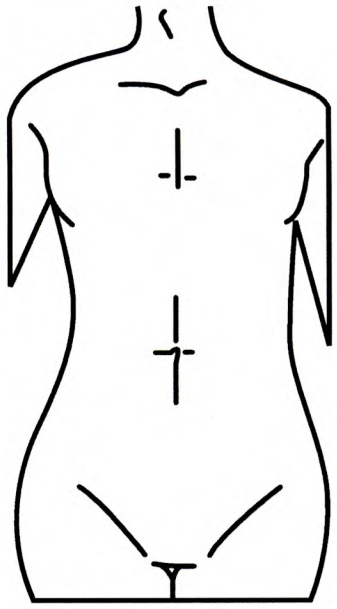
I have: ( ) Nervous tic or twitching - where? _____( ) Bell's Palsy
( ) Ringing in ears ( ) Parkinson's ( ) Sciatic Neuritis ( ) Multiple Sclerosis
( ) Had spinal surgery - where_____ results _____

HAIR, NAILS, SKIN

Hair: ( ) Coarse ( ) Fine ( ) Falls out excessively ( ) Turned grey at age _____( ) Oily ( ) Dry
Male Beard : ( ) Heavy ( ) Light or sparse ( ) None ( ) Ethinic Background
Female: ( ) Facial hair always ( ) Facial hair stated at age _____ ( ) Hair on abdomen or breasts
Finger nails: ( ) Normal ( ) Brittle/break easily ( ) Grow fast ( ) Grow slow ( ) Shaped oddly ( ) Hangnails
Skin: ( ) Normal ( ) Dry ( ) Flaky ( ) Acne ( ) Psoriasis ( ) Boils
( ) Small bumps on upper arms ( ) Skin cancer removed on _____ (date)
Spots on Skin: ( ) Warts ( ) Moles ( ) Small red ( ) Large red ( ) Brown ( ) White
Hands and feet: ( ) Dry cracked or bleeding areas on ( ) Hands ( ) Heels ( ) Feet
( ) Ingrown toenails ( ) Fungus on feet or nails ( ) Athlete's foot

Name: _____ Date: _____

CHEST AND HEART Mark any areas of pain or discomfort on diagram



FRONT

I have chest pain that is: ( ) Sharp ( ) Dull ( ) Severe
( ) Radiates to my arm, neck, or back
( ) Worse at rest ( ) Worse on exertion
( ) Better with exercise ( ) Worse with exercise

My Pulse/heartbeat: ( ) Too fast ( ) Too slow ( ) Skips beats

I have: ( ) High blood pressure ( ) Low blood pressure
I am: ( ) On HBP medicine ( ) On diuretics
I have had: ( ) A heart attack ( ) A stroke ( ) Angioplasty
( ) Bypass surgery
I have been told I have: ( ) Heart disease ( ) Lung disease
( ) Clogged arteries
I have: ( ) Vericose veins ( ) Spider veins ( ) Hemorrhoids
( ) Had vessel surgery

RESPIRATORY, LUNGS

I have nasal congestion: ( ) Daily ( ) Several times a week ( ) Only on occasion
I have nasal discharge: ( ) Daily ( ) Several times a week ( ) Only on occasion
( ) Clear ( ) Yellow ( ) Green ( ) Blood tinged ( ) Other _____

I have: ( ) Non productive cough (no mucus) ( ) Productive cough (with mucus)
( ) Allergies to _____( ) Hoarseness of voice ( ) Post-nasal drip
( ) Hayfever ( ) Asthma ( ) Wheezing ( ) Snoring

I take: ( ) Allergy shots ( ) Allergy medicine ( ) Decongestants ( ) Nasal sprays ( ) Steroids

I use: ( ) Cigarettes _____pack/day ( ) Snuff/chew ( ) Cigars ( ) Exposed to 2nd had smoke

I have been told I have: ( ) Lung disease _____( ) Emphysema ( ) COPD

EMOTIONAL, NERVOUS AND METABOLISM Mark all that apply

I am/have: ( ) Nervous ( ) Anxious ( ) Depressed ( ) Sensitive to noise ( ) Confused easily
( ) Sleepy during the day ( ) Exhausted a lot ( ) Fatigue easily ( ) Loss of appetite
( ) Rage ( ) Fearful ( ) Hear voices ( ) Weakness ( ) Poor memory
( ) Irritability ( ) Morbid thoughts

I am/have: ( ) Suspicious of others ( ) Thoughts of suicide ( ) Quick mood changes ( ) Fear of insanity
( ) Fear of serious disease like _____
( ) Avoid crowds ( ) Friends avoid me ( ) Have Hypoglycemia or low blood sugar
( ) Had glucose tolerance test and it was ( ) Positive ( ) Negative

I: ( ) Take daytime naps ( ) Am cold when others are comfortable ( ) Feel too hot
( ) Have cold hands ( ) Have cold feet ( ) Perspire too much
( ) Have inadequate perspiration when excercising

Do you feel well rested when you wake up in the morning? ( ) Yes ( ) No
_____Rate the quality of your sleep (1 being awful and 10 being great)

Name: _____ Date:_____

FEMALE SPECIFIC

Age of first period: _____
My menstrual periods are:

( ) Normal ( ) Painful first day ( ) Painful before and during
( ) Flow is excessive ( ) Have clots or hemorrhage ( ) Flow is scanty
( ) Regular every_____ days ( ) Irregular
( ) No period in _____ months ( ) Two or more per month
( ) Abnormal since _____ years of age
( ) Menstrual prombles before first child ( ) Menstrual problems after first child

Menstrual blood color is: ( ) Pink ( ) Red ( ) Brown ( ) Black ( ) Other

I have/have had: ( ) Endometriosis ( ) Constipation with periods ( ) Diarrhea with periods

Organ drop: ( ) Uterus in position ( ) Uterus out of position ( ) Bladder prolapsed

I am/ have been: ( ) On the birth control pill *(Brand)* _____Total years on BCP _____
( ) Menopause at age _____ ( ) Hysterectomy at age _____

I am on hormone replacement: ( ) Estrogen ( ) Progertin ( ) Oral ( ) Patch
( ) Wild yam cream ( ) Bio-identical formulation

I have breast soreness: ( ) Before period ( ) During period ( ) After period ( ) All month long
I have: ( ) Fibrocystic breasts ( ) Had breast cancer ( ) Produce milk but not pregnant or nursing
My breasts are: ( ) Firm ( ) Soft and sagy ( ) Have implants ( ) Had reduction surgery

I: Have _____ children ( )Been pregnant_____ times ( ) Like children ( ) Dislike children
( ) Want more ( ) Don't want more ( ) Am sterile ( ) Have fear of pregnancy

I get: ( ) Bladder infections ( ) Yeast infections ( ) Yeast infections after antibiotics
( ) Vaginal burning/itching on : ( ) Inside ( ) Outside
( ) Vaginal dryness ( ) Painful intercourse

I urinate: _____ times per day | _____ times at night ( ) More frequently than normal
( ) With pain ( ) With difficulty starting/stopping ( ) With itching or burning

My urine color is: ( ) Pale yellow ( ) Bright yellow ( ) Dark yellow ( ) other _____

My urine has: ( ) Odor, describe _____

I have/had: ( ) Venereal disease ( ) Genital herpes ( ) Herpes I ( ) HIV/AIDS

My Libido* is: ( ) Normal ( ) Excessive ( ) Increased ( ) Diminished ( ) Absent
** Libido means desire for sexual relations.*

Proceed to the diagram on next page

MALE SPECIFIC

Name: _____ Date: _____

I am: ( ) Overly tired ( ) Exhausted ( ) Getting too old for anything ( ) Impotent

My prostate is: ( ) Normal ( ) Enlarged ( ) Had cancer ( ) Removed

I have: ( ) Pain on urination ( ) Difficulty starting urine flow ( ) Difficulty stopping urine flow
( ) Dribbling of urine ( ) Decreased stream size ( ) Pain or pressure after sex
( ) Get up to urinate _____ times per night ( ) Burning discharge

My urine color is: ( ) Pale yellow ( ) Bright yellow ( ) Dark yellow ( ) other

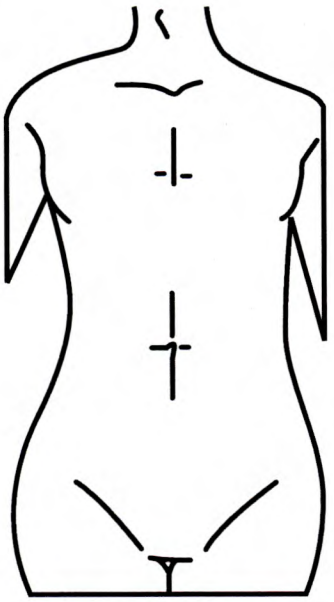
My urine has: ( ) Odor, describe _____

I have: ( ) Hernia ( ) Pain in testicles or scrotum

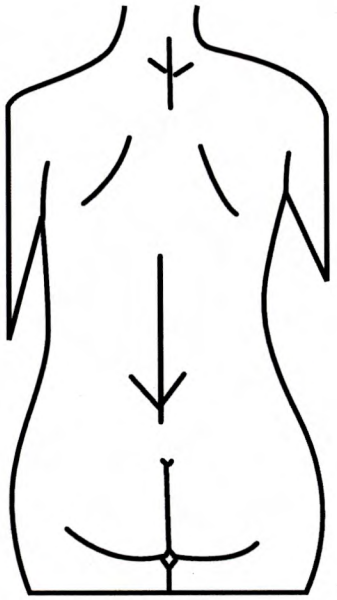
I have/had: ( ) Venereal disease ( ) Genital herpes ( ) HIV/AIDS

My Libido* is: ( ) Normal ( ) Excessive ( ) Increased ( ) Diminished ( ) Absent
** Libido means desire for sexual relations.*

Use the diagrams below to mark all areas of pain or discomfort you have experienced in the past 90 days. Describe your pain/discomfort in the margins and connect with arrow to each area the description applies to.



FRONT



BACK

Name: _____ Date: _____

Are you currently seeing any other healthcare professional such as dentist, massage therapist, accupuncturist, psychologist, etc? Please explain.

_____

_____

_____

Please fill out your family health history on the chart below. Put an "N" in the box if they have it now or a "P" if they had it in the past.

	Alcoholism	Allergies	Alzheimer's Disease	Arthritis	Asthma	Athrosclerosis	Cancer	Diabetes	Epilesy	Glaucoma	Headaches	High Blood Pressure	Kidney Disease	Obesity	Osteoporosis	Sinus Problems	Stroke	Tyroid Problem	Tuberculosis	Ulcers
You																				
Spouse																				
Children																				
Mother																				
Father																				
Maternal Grandparents																				
Paternal Grandparents																				
Sisters																				
Brothers																				

Use this space to add anything else you would like to share about your health concerns or that you think the doctor should know.

_____

_____

_____

Please review this form to be sure our answers are accurate and sign below. Thank you for choosing our clinic. We look forward to working with you on your health goals.

Signature: _____ Date: _____

PATIENT SYMPTOM SURVEY

***DATE*_____**

***PATIENT'S NAME*_____ *AGE*_____**

***WEIGHT*_____ *HEIGHT*_____ *BLOOD PRESSURE*_____ *PULSE*_____ *O_2*_____**

This is a confidential patient symptom survey. Please check each condition which is true for you. Take your time. If you are not sure the condition applies to you or do not understand a term, do not check the box. Use common sense. For example, Insomnia once last month probably isn't that important and would not be marked. However, Insomnia 1-2 times per week is notable and would be marked. Please take your time…

Primary Complaints

090 ☐ General Good Health
091 ☐ Desires Nutritional & Metabolic Analysis
001 ☐ Skin Disorder L25.9
002 ☐ Acne L70.8
003 ☐ Psoriasis L40.8
004 ☐ Urticaria (Hives) L50.9
005 ☐ ADD/ADHD F90.1/F90.9
006 ☐ Allergies, Unspecified J30.9
007 ☐ Allergic Rhinitis from food J30.5
008 ☐ Sinusitis J01.90
009 ☐ Alzheimer's G30.9
010 ☐ Poor Concentration/Memory F07.8
011 ☐ Parkinson's Disease G20
012 ☐ Anemia D64.9
013 ☐ Arthritic Disorder M12.9
014 ☐ Osteoporosis M81.0
015 ☐ Asthma J45.909
016 ☐ Emphysema J43.9
017 ☐ Cancer
- 018 ☐ Breast C50.919female C50.929male
- 019 ☐ Prostate C61
- 020 ☐ Lung C34.90
- 021 ☐ Colon and Rectal C18.9
- 022 ☐ Skin C44.90
- 023 ☐ Leukemia w/o remission C95.90 Leukemia w/ remission C95.91
- 024 ☐ Lymphoma, malignant C85.89
- 025 ☐ Brain Tumor, malignant C71.9

027 ☐ Anxiety Disorder F41.9
028 ☐ Autism F84.0
033 ☐ Edema R60.9
034 ☐ Eczema L25.9
035 ☐ Chronic Fatigue R53.82
036 ☐ Circulatory Disorder I99.9
037 ☐ Heart Disease I51.9
038 ☐ High Cholesterol E78.0
039 ☐ High Blood Pressure I10
040 ☐ Low Blood Pressure I95.9
041 ☐ Tachycardia (High Heart Rate) R00.0
042 ☐ Numbness R20.9
043 ☐ Constipation K59.00
044 ☐ Indigestion K30
045 ☐ Ulcerative Colitis K51.90
046 ☐ Depression F32.9
047 ☐ Diabetes Mellitus E11.9
030 ☐ Diabetes Type I E10.9
031 ☐ Diabetes Type II E11.65
029 ☐ Hyperglycemia [high blood sugar] R73.09
048 ☐ Hypoglycemia [low blood sugar] E16.2
049 ☐ Dizziness/Balance Problem R42
050 ☐ Ear Infection H65.90
051 ☐ Epstein Barr B27.90
052 ☐ Eye Problems H57.13
053 ☐ Cataracts H26.9
054 ☐ Glaucoma H40.9
055 ☐ Macular Degeneration H35.30
056 ☐ Fever R50.9
057 ☐ Fibromyalgia M79.7
058 ☐ Gallbladder Disorder K82.9
059 ☐ Gout M10.9
060 ☐ Headaches R51
061 ☐ Hearing Loss H91.90
062 ☐ Infertility, male N46.9
064 ☐ Liver Disease K76.9
- 065 ☐ Hepatitis K71.6
- 066 ☐ Hepatitis B B16.9
- 067 ☐ Hepatitis C B17.10

068 ☐ Kidney Disorder N28.9 or Bladder Disorder N32.9
063 ☐ Prostate Disorder N42.9
069 ☐ Hyperthyroidism E05.90
070 ☐ Hypothyroidism E03.9
071 ☐ Systemic Lupus M32.10
072 ☐ Infertility, female N97.9
073 ☐ Interstitial Cystitis N30.11
074 ☐ Irregular Menstrual Cycle N92.6
075 ☐ Menopausal Symptoms N95.1
076 ☐ Hot Flashes N95.1
077 ☐ Mental Disorder F99
078 ☐ Insomnia G47.00
079 ☐ Mouth/Throat/Tongue
080 ☐ Canker Sores K12.0
081 ☐ Overweight E66.3
082 ☐ Underweight R63.6
083 ☐ Sexual Disorder F66
084 ☐ Spinal Problems M53.9
085 ☐ Obesity E66.9
086 ☐ GERD K21.9
087 ☐ HIV B20
088 ☐ Crohn's Disease K50.90
089 ☐ Irritable Bowel Syndrome K58.9
092 ☐ Normal Pregnancy Z33.1
**only applicable if *currently* pregnant
093 ☐ Shingles B02.9
140 ☐ Migraines G43.909
141 ☐ Rheumatoid Arthritis M06.9
142 ☐ Non-Systemic Lupus L93.0
143 ☐ Multiple Sclerosis G35
144 ☐ ALS (Lou Gehrig's) G12.21
145 ☐ Polymyalgia Rheumatica M35.3
146 ☐ Scleroderma M34.9
171 ☐ Goiter E04.9
178 ☐ Raynaud's Syndrome I73.00
179 ☐ Hemochromatosis E83.119
180 ☐ Thalassemia D56.8
181 ☐ Brain aneurysm I61.9

If necessary, please state your most significant concern...

_____

_____

General Health

100 ☐ Fingernail base is pink
101 ☐ Fingernail base is purple
102 ☐ Fingernails have ridges or white spots
103 ☐ Fingernails are soft
104 ☐ Fingernails are splitting
105 ☐ Fingernails peel
106 ☐ Pale fingernail beds
107 ☐ Blacks out easily
108 ☐ Balance problems
109 ☐ Difficulty walking
110 ☐ Has tattoos
111 ☐ Brittle hair
112 ☐ Dry hair
113 ☐ Thin hair
114 ☐ Hair loss
115 ☐ Drinks alcoholic beverages daily
116 ☐ Drinks less than 8 glasses of water per day
117 ☐ Currently on Chemotherapy
118 ☐ Currently on radiation treatment
119 ☐ Had chemotherapy in the past
120 ☐ Has had radiation treatments in the past
121 ☐ Gained over 20 lbs in the last 12 months
122 ☐ Somewhat Overweight
123 ☐ Somewhat Underweight
124 ☐ Unexplained loss of >20lbs in last 4 months
125 ☐ Energy level is worse than it was 5 years ago
127 ☐ Sleeps less than 6 hours per night
128 ☐ Unable to recall dreams the next day
129 ☐ Sensitive to chemicals, paint, fumes, cologne
130 ☐ Had blood transfusion in the past
131 ☐ Had transplant in the past
138 ☐ Takes anti-rejection drugs
132 ☐ Had a major accident or injury
137 ☐ Sleep Apnea
139 ☐ Toxic chemical exposure
175 ☐ Has been out of the country recently
176 ☐ Had childhood vaccines
177 ☐ Had a vaccine in the last 12 months
147 ☐ Had a flu shot last year
182 ☐ Had a pneumonia vaccine last year
183 ☐ Had a Hepatitis B vaccine in the last 2 years

Has a family history of:
- 184 ☐ Cancer
- 185 ☐ Heart Disease
- 186 ☐ Diabetes
- 187 ☐ Alcoholism
- 188 ☐ Depression
- 189 ☐ Obesity

Allergies:
- 206 ☐ Dairy
- 207 ☐ Eggs
- 208 ☐ Garlic
- 209 ☐ Gluten
- 210 ☐ Mold
- 211 ☐ Peanut
- 212 ☐ Ragweed
- 213 ☐ Shellfish
- 214 ☐ Soy
- 215 ☐ Sulfa drugs
- 216 ☐ Tree nuts
- 217 ☐ Wheat
- 218 ☐ Other allergies

Lifestyle & Environment

380 ☐ Drinks beverages from a can
370 ☐ Drinks alcohol
371 ☐ Drinks caffeinated coffee
372 ☐ Drinks caffeinated pop/soda
373 ☐ Drinks caffeinated tea
374 ☐ Drinks decaffeinated coffee
375 ☐ Drinks decaffeinated pop/soda
376 ☐ Drinks decaffeinated tea
377 ☐ Drinks >3 cups of coffee daily
378 ☐ Drinks >3 cups of tea per day
388 ☐ Drinks diet pop/soda
379 ☐ Drinks >1 pop/sodas per day

I had 4 alcoholic drinks in one day:
- 172 ☐ never
- 173 ☐ more than 3 months ago
- 174 ☐ less than 3 months ago

381 ☐ Has >5 alcoholic drinks/week
391 ☐ Craves sugar / starches
382 ☐ Currently smokes
383 ☐ Quit smoking in last 5 years
384 ☐ Smoked for >5 years
385 ☐ Smokes >1 pack per day
126 ☐ Rarely exercises
133 ☐ Regularly exercises
386 ☐ Takes Vitamins
134 ☐ Vegetarian
135 ☐ Eats no red meat
136 ☐ Eats no meat, no dairy
387 ☐ Frequent use of artificial sweeteners
389 ☐ Anorexia
390 ☐ Bulimic
340 ☐ Home has well water
341 ☐ Home has city water
342 ☐ Home water is filtered

Home pipes are:
- 343 ☐ Steel
- 344 ☐ PVC
- 345 ☐ Copper
- 346 ☐ PEX

347 ☐ Home built prior to 1978
348 ☐ Home renovations within the last year
349 ☐ Uses chlorine bleach or other heavy duty chemicals
360 ☐ Has worked in plumbing, automotive or metallurgic industry
361 ☐ Has worked around industrial solvents, chemicals or pesticides

Surgeries

700 ☐ Tonsillectomy and/or Adenoids
701 ☐ Appendix
702 ☐ Gallbladder
703 ☐ Thyroid
704 ☐ Hysterectomy, complete
705 ☐ Hysterectomy, partial
706 ☐ Tubal ligation
707 ☐ Breast implants
708 ☐ Cancer
709 ☐ Coronary by-pass
710 ☐ Spinal surgery
711 ☐ Extremity surgery
712 ☐ Hip replacement
713 ☐ Knee replacement
714 ☐ Splenectomy
715 ☐ Radiated thyroid
716 ☐ Cataract surgery
717 ☐ Hemorroidectomy
718 ☐ Bariatric/Weight loss
Type: _____

Gastrointestinal

265 ☐ 4-5 bowel movements per week
266 ☐ 3 or less bowel movements per week
267 ☐ 6 or more bowel movements per week
268 ☐ Black tarry stools
269 ☐ Pale or yellow colored stool
270 ☐ Blood stools
271 ☐ Constipation
272 ☐ Hemorrhoids
273 ☐ Loose bowel movements
274 ☐ Frequent diarrhea
275 ☐ Frequent nausea
276 ☐ Frequent vomiting
277 ☐ Abdominal gas
278 ☐ Belching and burping after eating
279 ☐ Bloated after eating
280 ☐ Severe abdominal pains
281 ☐ Stomach ulcers
282 ☐ Uses digestive aids
283 ☐ Uses laxatives
284 ☐ Immediate indigestion upon eating
285 ☐ Indigestion in 2 hours or more after meals
286 ☐ Indigestion within 1 hour after meals
287 ☐ Difficulty swallowing
288 ☐ Eating relieves fatigue
289 ☐ Eats when nervous
290 ☐ Excessive hunger
291 ☐ Poor appetite
292 ☐ Experiences fainting spells when hungry
293 ☐ Feels shaky when hungry
294 ☐ Frequently drowsy after eating a meal
295 ☐ Gall bladder disease
296 ☐ Has had intestinal worms
297 ☐ Reflux/Hiatal hernia
298 ☐ Liver disease
299 ☐ Irritable Bowel Syndrome
300 ☐ Diverticulitis
301 ☐ Diverticulosis

Respiratory

485 ☐ Catches severe colds
486 ☐ Chronic chest condition
487 ☐ Chronic cough
488 ☐ Constant runny nose
489 ☐ COPD
490 ☐ Difficulty breathing
491 ☐ Frequent colds
492 ☐ Frequent nose bleeds
493 ☐ Frequent sinus infections
494 ☐ Frequent stuffy nose
495 ☐ Hay fever
496 ☐ Nasal polyps
497 ☐ Night sweats
498 ☐ Post nasal drip
499 ☐ Sneezing spells
500 ☐ Spits up blood
501 ☐ Spits up phlegm
502 ☐ Wheezes

Mouth and Throat

400 ☐ Bad breath
401 ☐ Bitter taste in the mouth in the morning
402 ☐ Dry mouth
403 ☐ Excessive saliva
404 ☐ Sores or cracks in the corners of the mouth
405 ☐ Glands often swell
406 ☐ Frequent canker sores
407 ☐ Frequent fever blisters
408 ☐ Frequent sore throats
409 ☐ Frequently has a sore tongue
410 ☐ Sore gums
411 ☐ Swollen gums
412 ☐ Swollen tongue
413 ☐ Tongue burns
414 ☐ Tongue has grooves or fissures
415 ☐ Tongue is coated
416 ☐ Gums bleed when brushing teeth
417 ☐ Toothaches
418 ☐ Amalgam dental fillings
420 ☐ Other dental fillings (gold, composite, etc)
419 ☐ Has had root canal(s)

Endocrine

245 ☐ Coarse hair
246 ☐ Coarse skin
247 ☐ Diabetic
248 ☐ Excessive thirst
249 ☐ Frequently feels cold
250 ☐ Frequently feels hot
251 ☐ Gets lightheaded when standing quickly
252 ☐ Heals slowly
253 ☐ Unusually jumpy or nervous
254 ☐ Unusually tired most of the time

Cardiovascular

190 ☐ Cold feet
191 ☐ Cold hands
192 ☐ Experiences shortness of breath while sitting still
193 ☐ Heart skips beats
194 ☐ Tendency of High blood pressure
195 ☐ Leg cramps during bedtime
196 ☐ Leg cramps during daytime
197 ☐ Low blood pressure at times
198 ☐ Pain in leg/hips when walking
199 ☐ Frequent swollen ankles
200 ☐ Pains in the heart or chest
201 ☐ Spells of rapid heart rate
202 ☐ Troubled with blood clots
203 ☐ Unusually slow pulse rate
204 ☐ Varicose veins
205 ☐ Heart palpitations

Skin

520 ☐ Bruises easily
521 ☐ Excessive perspiration
522 ☐ Frequent goose bumps
523 ☐ Has acne
524 ☐ Has Psoriasis
525 ☐ Hives
526 ☐ Itchy skin
527 ☐ Problems with Eczema
528 ☐ Has moles which are changing in size and/or color
530 ☐ Skin is rough, especially on the back of the arms
529 ☐ Skin eruptions
531 ☐ Skin is tender
532 ☐ Sores that heal slowly
533 ☐ Troubled with boils
534 ☐ Dry skin

Ears

220 ☐ Discharge from ears
221 ☐ Hard of hearing
222 ☐ Punctured ear drum
223 ☐ Recurrent ear infection
224 ☐ Ringing or noises in the ears
225 ☐ Tinnitus

Eyes

320 ☐ Bloodshot eyes
321 ☐ Blurred vision
322 ☐ Cross eyes
323 ☐ Eye pain
324 ☐ Eyes feel gritty
325 ☐ Eyes watery
326 ☐ Mild Glaucoma
327 ☐ Far sighted
328 ☐ Developing cataracts
329 ☐ Mild Macular degeneration
330 ☐ Itchy eyes
331 ☐ Near sighted
332 ☐ Dry Eyes

Feet

350 ☐ Corns
351 ☐ Frequent foot cramps
352 ☐ Heel spurs
353 ☐ Painful feet
354 ☐ Plantar warts
355 ☐ Swelling in the feet and/or ankles
356 ☐ Plantar fasciitis
357 ☐ Fungal Infection

Neuromuscular

440 ☐ Bites nails
441 ☐ Frequent muscle soreness
442 ☐ Muscle spasms
443 ☐ Muscle weakness
444 ☐ Tremors
445 ☐ Frequent headaches
446 ☐ Often dizzy
447 ☐ Frequently feels faint
448 ☐ Has Epilepsy
449 ☐ Has motion sickness
450 ☐ Has Osteoarthritis
451 ☐ Has Rheumatism
452 ☐ Rheumatoid Arthritis
453 ☐ Joint stiffness in the morning
454 ☐ Swollen joints
455 ☐ Leg pain at rest
456 ☐ Spinal curvature
457 ☐ Low back pain
458 ☐ Neck pain
459 ☐ Pain between the shoulders
460 ☐ Shoulder/arm pain
461 ☐ Numbness/tingling in the body
462 ☐ Sleep walks
463 ☐ Stutters or stammers
464 ☐ Nerve pain

Behavior Patterns

150 ☐ Afraid to eat anywhere except home
151 ☐ Always needs someone to advise
152 ☐ Cries often
153 ☐ Difficulty concentrating
154 ☐ Difficulty falling asleep
155 ☐ Difficulty staying asleep
156 ☐ Easily angered
157 ☐ Feelings are easily hurt
158 ☐ Frequently becomes scared for no reason
159 ☐ Frequently miserable or blue
160 ☐ Has to be on guard even with friends
161 ☐ Often annoyed by people
162 ☐ Recurrent bad dreams
163 ☐ Sometimes wishes to be dead or away from it all
164 ☐ Upset by criticism
165 ☐ Poor memory
166 ☐ Scared to be alone
167 ☐ Strange people or places cause fear
168 ☐ Under considerable emotional stress
169 ☐ Unhappy when others are happy
170 ☐ Brain fog

Urinary

555 ☐ Urinates more than 2 times per night
556 ☐ Bed wetting
557 ☐ Blood in the urine
558 ☐ Difficulty starting urination
559 ☐ Painful urination
560 ☐ Frequent urination
561 ☐ Troubled by urgent urination
562 ☐ Incontinence when sneezing or laughing
563 ☐ Loses bladder control
564 ☐ Frequent bladder infections
565 ☐ Frequent kidney infections
566 ☐ Kidney stones

Men Only

585 ☐ Difficulty completing intercourse
586 ☐ Difficulty getting or keeping an erection
587 ☐ Discharge from the urethra
588 ☐ Had a vasectomy
589 ☐ Had difficulty fathering children
590 ☐ Lumps in the testicles
591 ☐ Painful genitals
592 ☐ Prostate troubles
593 ☐ Sores on external genitalia
594 ☐ Herpes
595 ☐ Sexual diseases

Women Only

610 ☐ Heavy hair growth on face or body
611 ☐ Cycles are every 27-29 days
612 ☐ Abnormal cycle >29 days and/or <26 days
613 ☐ PMS
614 ☐ Menstrual cramps
615 ☐ Painful periods
616 ☐ Acne worse at menstruation
617 ☐ Excessive menstrual flow
618 ☐ Retains fluid during periods
619 ☐ Pre-menstrual depression
620 ☐ Currently taking birth control medication
621 ☐ Has taken birth control medication more than 1 year
622 ☐ Has taken birth control medication within the last year
623 ☐ Has had miscarriage
624 ☐ Hot flashes
625 ☐ Takes hormone replacement medication
627 ☐ Diminished sexual desire
628 ☐ Painful intercourse
629 ☐ Poor or infrequent orgasm
630 ☐ Lumps in the breasts
631 ☐ Tender breasts
633 ☐ Vaginal discharge
634 ☐ Bloody spotting discharge
635 ☐ Yeast infections
636 ☐ Sores on external genitalia
637 ☐ Herpes
638 ☐ Sexual diseases
639 ☐ Endometriosis
640 ☐ Breast reduction
641 ☐ Breast augmentation
642 ☐ Abortion
643 ☐ D&C
644 ☐ Tubal pregnancy
645 ☐ Uterine fibroids
646 ☐ Ovarian fibroids
647 ☐ Breast fibroids
648 ☐ Currently Breastfeeding

Medications

Please list all drugs you are currently taking on a daily basis.

DRUG	***PRESCRIBED FOR:***	***HOW LONG***

Please list all drugs taken within the last year and/or you take as needed including over the counter drugs, antibiotics, aspirin, inhalers, etc.

DRUG	***PRESCRIBED FOR:***	***HOW LONG***

Supplements

Please list all vitamins/herbs/supplements you are currently taking and dosages.

VITAMIN	***BRAND***	***DOSAGE***

WEEKLY DIET DIARY

NAME: _____ START DATE: _____

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Breakfast							
Lunch							
Dinner							
Snacks							
#Glasses H_20							
Comments							

*Be sure to include approximate portions

**In "Comments" include symptoms such as headaches, stomach upset, sleeplessness etc., experienced that day

DYSBIOSIS QUESTIONNAIRE AND SCORE SHEET

This questionnaire is designed for adults and the scoring system is not as appropriate for children. It lists factors in your medical history which are known to contribute to the disruption of normal healthy gastrointestinal bacteria, directly or indirectly promoting the overgrowth of yeast, fungi and other pathogens, (Section A), and symptoms commonly found in individuals with dysbiosis related illness (Section B and C).

Filling out and scoring this questionnaire should help you and your physician evaluate the possible role of dysbiosis in contributing to your health problems. Yet will not provide and automatic "Yes" or "No" answer.

Note: ***Dysbiosis refers to the condition where the normal healthy population of beneficial bacteria in the intestines had been disrupted, leaving it open to the overgrowth of yeast, fungi, parasites and potentially harmful strains of bacteria. This intestinal imbalance in turn adversely effects other important systems via toxic stress and interfering with nutrient absorption and utilization.***

Name: _____ **Date:** _____

SECTION A: HISTORY

For each "yes" answer in Section A, circle the point score for that question. Total your score and record it in the box at the end of the section. Then move to sections B and C and score them as directed.

1. Have you taken tetracyclines (Sumycin, Panmycin, Vibramycin, etc.) or other antibiotics for skin acne or anything else for one month (or longer)? 25

2. Have you **at any time in your life,** taken other antibiotics for respiratory, urinary or other infections in shorter courses four or more times in a one year period? 20

3. Have you taken an antibiotic drug – even a single course? 6

4.Have you, at any time in your life, been bothered by recurrent or persistent prostatitis, vaginitis or other problems affecting your reproductive organs? 25

5. Have you taken birth control pills.....
for more than 5 years? 25
for more than 2 years? 15
for 6 months to 2 years? 8

6. Have you been pregnant.....
two or more times? 5
one time? 3

7. Have you taken prednisone, Decadron or other cortisone type drugs.....
For more than 6 months? 25
For more than 2 weeks? 15
For 2 weeks or less? 6

8. Does exposure to perfumes, insecticides, fabric shop odors and other chemicals provoke...
Moderate to severe symptoms? 20
Mild symptoms? 5

9. Are your symptoms worse on damp, muggy days or in moldy places? 20

10. Have you had athlete's foot, ring worm, "jock itch" or other chronic fungous infections of the skin or nails? (Y/N)
Have such infections been.....
Severe or persistent? 20
Mild to moderate? 10

11. Do you crave sugar? 10

12. Do you crave breads? 10

13. Do you crave alcoholic beverages? 10

14. Does tobacco smoke really bother you? 10

15. Have you ever had a parasitic infection, dysentery, or unexplained episode of prolonged diarrhea and intestinal distress? 15

16. Have you ever consumed chlorinated (tap) drinking water for more than 3 months? 15

17. Do you consume non-organic meat on a regular basis? 15

18. Do you eat processed/packaged food regularly? 20

19. Do you drink alcohol or coffee daily? 20

20. Do you have or have you ever had an ulcer, colitis, crohn's disease or diverticulitis? 35

Total Score, Section A: _____

Name: _____ Date: _____

SECTION B: MAJOR SYMPTOMS

For each of your symptoms, enter the appropriate figure on the line following the question:
If a symptom is occasional or mild = 3 points
If a symptom is frequent &/or moderate = 6 points
If a symptom is severe or disabling = 9 points
Add total score and record it in the box at the end of the section.

1. Fatigue or lethargy _____
2. Feeling of being drained _____
3. Poor memory _____
4. Feeling "spacey" or "unreal" _____
5. Depression _____
6. Numbness, burning or tingling _____
7. Muscle aches _____
8. Muscle weakness or paralysis _____
9. Pain &/or swelling in joints _____
10. Abdominal pain _____
11. Constipation _____
12. Diarrhea _____
13. Bloating _____
14. Troublesome vaginal discharge _____
15. Persistent vaginal burning or itching _____
16. Prostatitis _____
17. Impotence _____
18. Loss of sexual desire _____
19. Endometriosis _____
20. Cramps and /or other menstrual irregularities _____
21. Premenstrual tension _____
22. Spots in front of eyes _____
23. Erratic vision _____
24. Eczema, dermatitis, psoriasis _____

Total Score, Section B _____

SECTION C: OTHER SYMPTOMS

For each of your symptoms, enter the appropriate figure on the line following that question.
If the symptom is occasional or mild = 1pt
If the symptom is frequent &/or moderately severe = 2pt
If the symptom is sever &/or disabling = 3pt

1. Drowsiness _____
2. Irritability _____
3. Poor coordination _____
4. Inability to concentrate _____
5. Frequent mood swings _____
6. Headache _____
7. Dizziness/loss of balance _____
8. Pressure above ears, feeling of head swelling and tingling _____
9. Itching _____
10. Other rashes _____
11. Heartburn _____
12. Indigestion _____
13. Belching & intestinal gas _____
14. Mucus in stools _____
15. Hemorrhoids _____
16. Dry mouth _____
17. Rash or blisters in mouth _____
18. Bad Breath _____
19. Nasal congestion or discharge _____
20. Joint swelling or arthritis _____
21. Postnasal drip _____
22. Nasal itching _____
23. Sore or dry throat _____
24. Cough _____
25. Pain or tightness in chest _____
26. Wheezing or shortness of breath _____
27. Urgency or urinary frequency _____
28. Burning on urination _____
29. Failing vision _____
30. Burning or tearing of eyes _____
31. Recurrent infection or fluid in ears _____
32. Ear pain or hearing loss _____

Total Score Section C: _____

Total Score Section A: _____

Total Score Section B: _____

Grand Total Score ☐

The grand total score will help you and your physician decide if your health problems are dysbiosis related. Scores in women will run higher as 7 items in the questionnaire apply exclusively to women, while only 2 apply exclusively to men.

Dysbiosis related health problems are almost certainly present in women with scores over 180, and in men with scores over 140.

Dysbiosis related health problems are probably present in women with scores over 120 and in men with scores over 80.

With scores of less than 60 in women and 40 in men, dysbiosis is unlikely to be contributing to your health challenges.

Name: _____ Date: ____

Toxicity Questionnaire

The Toxicity Questionnaire is designed to aid the practitioner in assessing a patient's or client's potential need for a Clinical Purification™ program.

Section I: Symptoms

Rate each of the following based upon your health profile for the past 90 days.

Circle the corresponding number.	
0	Rarely or Never Experience the Symptom
1	Occasionally Experience the Symptom, Effect is Not Severe
2	Occasionally Experience the Symptom, Effect is Severe
3	Frequently Experience the Symptom, Effect is Not Severe
4	Frequently Experience the Symptom, Effect is Severe

1. DIGESTIVE

a. Nausea and/or vomiting	0	1	2	3	4
b. Diarrhea	0	1	2	3	4
c. Constipation	0	1	2	3	4
d. Bloated feeling	0	1	2	3	4
e. Belching and/or passing gas	0	1	2	3	4
f. Heartburn	0	1	2	3	4

Total: _____

2. EARS

a. Itchy ears	0	1	2	3	4
b. Earaches or ear infections	0	1	2	3	4
c. Drainage from ear	0	1	2	3	4
d. Ringing in ears or hearing loss	0	1	2	3	4

Total: _____

3. EMOTIONS

a. Mood swings	0	1	2	3	4
b. Anxiety, fear, or nervousness	0	1	2	3	4
c. Anger, irritability	0	1	2	3	4
d. Depression	0	1	2	3	4
e. Sense of despair	0	1	2	3	4
f. Uncaring or disinterest	0	1	2	3	4

Total: _____

4. ENERGY / ACTIVITY

a. Fatigue or sluggishness	0	1	2	3	4
b. Hyperactivity	0	1	2	3	4
c. Restlessness	0	1	2	3	4
d. Insomnia	0	1	2	3	4
e. Startled awake at night	0	1	2	3	4

Total: _____

5. EYES

a. Watery or itchy eyes	0	1	2	3	4
b. Swollen, reddened, or sticky eyelids	0	1	2	3	4
c. Dark circles under eyes	0	1	2	3	4
d. Blurred or tunnel vision	0	1	2	3	4

Total: _____

6. HEAD

a. Headaches	0	1	2	3	4
b. Faintness	0	1	2	3	4
c. Dizziness	0	1	2	3	4
d. Pressure	0	1	2	3	4

Total: _____

7. LUNGS

a. Chest congestion	0	1	2	3	4
b. Asthma or bronchitis	0	1	2	3	4
c. Shortness of breath	0	1	2	3	4
d. Difficulty breathing	0	1	2	3	4

Total: _____

8. MIND

a. Poor memory	0	1	2	3	4
b. Confusion	0	1	2	3	4
c. Poor concentration	0	1	2	3	4
d. Poor coordination	0	1	2	3	4
e. Difficulty making decisions	0	1	2	3	4
f. Stuttering, stammering	0	1	2	3	4
g. Slurred speech	0	1	2	3	4
h. Learning disabilities	0	1	2	3	4

Total: _____

9. MOUTH / THROAT

a. Chronic coughing	0	1	2	3	4
b. Gagging or frequent need to clear throat	0	1	2	3	4
c. Swollen or discolored tongue, gums, lips	0	1	2	3	4
d. Canker sores	0	1	2	3	4

Total: _____

10. NOSE

a. Stuffy nose	0	1	2	3	4
b. Sinus problems	0	1	2	3	4
c. Hay fever	0	1	2	3	4
d. Sneezing attacks	0	1	2	3	4
e. Excessive mucous	0	1	2	3	4

Total: _____

11. SKIN

a. Acne	0	1	2	3	4
b. Hives, rashes, or dry skin	0	1	2	3	4
c. Hair loss	0	1	2	3	4
d. Flushing	0	1	2	3	4
e. Excessive sweating	0	1	2	3	4

Total: _____

12. HEART

a. Skipped heartbeats	0	1	2	3	4
b. Rapid heartbeats	0	1	2	3	4
c. Chest pain	0	1	2	3	4

Total: _____

13. JOINTS / MUSCLES

a. Pain or aches in joints	0	1	2	3	4
b. Rheumatoid arthritis	0	1	2	3	4
c. Osteoarthritis	0	1	2	3	4
d. Stiffness or limited movement	0	1	2	3	4
e. Pain or aches in muscles	0	1	2	3	4
f. Recurrent back aches	0	1	2	3	4
g. Feeling of weakness or tiredness	0	1	2	3	4

Total: _____

14. WEIGHT

a. Binge eating or drinking	0	1	2	3	4
b. Craving certain foods	0	1	2	3	4
c. Excessive weight	0	1	2	3	4
d. Compulsive eating	0	1	2	3	4
e. Water retention	0	1	2	3	4
f. Underweight	0	1	2	3	4

Total: _____

15. OTHER

a. Frequent illness	0	1	2	3	4
b. Frequent or urgent urination	0	1	2	3	4
c. Leaky bladder	0	1	2	3	4
d. Genital itch, discharge	0	1	2	3	4

Total: _____

Section I Total: _____

Name: _____ Date: _____

Section II: Risk of Exposure

Rate each of the following situations based upon your environmental profile for the past 120 days.

16.	Circle the corresponding number for questions 16a - 16f below.									
0	Never	1	Rarely	2	Monthly	3	Weekly	4	Daily	

a. How often are strong chemicals used in your home? (disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleaners, etc.)	0	1	2	3	4
b. How often are pesticides used in your home?	0	1	2	3	4
c. How often do you have your home treated for insects?	0	1	2	3	4
d. How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense, or varnish in your home or office?	0	1	2	3	4
e. How often are you exposed to nail polish, perfume, hair spray, or other cosmetics?	0	1	2	3	4
f. How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes?	0	1	2	3	4

Total: _____

17.	Circle the corresponding number for questions 17a - 17b below.							
0	No	1	Mild Change	2	Moderate Change	3	Drastic Change	

a. Have you noticed any negative change in your health since you moved into your home or apartment?	0	1	2	3
b. Have you noticed any negative change in your health since you started your new job?	0	1	2	3

Total: _____

18.	Answer yes or no and circle the corresponding number for questions 18a - 18d below.		
		No	Yes
a. Do you have a water purification system in your home?		2	0
b. Do you have any indoor pets?		0	2
c. Do you have an air purification system in your home?		2	0
d. Are you a dentist, painter, farm worker, or construction worker?		0	2

Total: _____

Section II Total: _____

GRAND TOTAL (Section I + Section II) _____

Add up the numbers to arrive at a total for each section, and then add the totals for each section to arrive at the grand total. If any individual section total is 6 or more, or the grand total is 40 or more, you may benefit from a Clinical Purification™ program.

Adapted with permission from the author of *Clinical Purification™: A Complete Treatment and Reference Manual*, Dr. Gina L. Nick.

Name: _____ Date: _____

Taking Your Basal Axillary Body Temperature

O'Keefe Matz Functional Health Clinic
1052 Ashland Avenue
St. Paul, MN 55104 (651) 292-8072

The basal body temperature is perhaps the most sensitive functional test of thyroid function. Your body temperature reflects your metabolic rate, which is largely determined by hormones secreted by the thyroid gland. The function of the thyroid gland can be determined by simply measuring your basal body temperature. The measurement of axillary temperature has become more important recently, since many people with normal levels of thyroid hormones are functionally hypothyroid.

All you need is a thermometer. You may purchase special digital thermometers at local drug store chains, or use an old fashioned mercury thermometer. Mercury thermometers are no longer in general use because of concerns about mercury poisoning, particularly in children, after thermometers break.

INSTRUCTIONS

1. Please use an old-fashioned thermometer if available. Otherwise a digital will work, but not the tape strips.
2. Put the thermometer in your armpit (for ten minutes) and record the temperature. Do this before you've gotten out of bed, urinated, had coffee, food, or any other activity.
3. Repeat this for at least 6 mornings.

Helpful hints:

- Colds, flu, and other acute infections, and allergic reactions may raise your temperature. Wait until you recover before making your record.
- Since ovulation raises body temperature, women who still menstruate should begin the test on the second or third day of their cycle. Men and non-menstruating women may begin anytime.

Interpretation

Your basal body temperature should be between 97.6 and 98.2 degrees Fahrenheit. Low basal body temperatures are quite common and may reflect hypothyroidism. Common signs and symptoms of hypothyroidism are: low basal body temperature, depression, difficulty in losing weight, dry skin, headaches, lethargy or fatigue, menstrual problems, recurrent infections, constipation, and sensitivity to cold.

High basal body temperatures (above 98.6 degrees Fahrenheit) are less common, but may be evidence of hyperthyroidism. Common signs and symptoms of hyperthyroidism include: bulging eyeballs, fast pulse, hyperactivity, inability to gain weight, insomnia, irritability, menstrual problems, and nervousness.

Results: Average 5 day temperature: _____ Date completed: _____

DAY	DATE	TIME	TEMPERATURE (°F)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Name: _____ Date: _____

Stress Indicator Test

Name: ..... Date: .....

Stress can cause every known symptom, but there is no specific diagnostic test for it. However, cumulative stress leads to an increasing number of symptoms and may raise the adrenal horones DHEA and cortisol. **Please check only those symptoms you have now or have been significant in the past 6 months.**

___ Depressed mood
___ Significant weight loss or gain
___ Insomnia
___ Oversleeping
___ Fatigue, low energy
___ Feelings of worthlessness or guilt
___ Difficulty concentrating
___ Indecisiveness
___ Recurrent death or suicide thoughts
___ Nervous exhaustion
___ Anxiety or worry
___ Frequent crying
___ Being extremely shy
___ Lumps or swelling in neck
___ Vision problems
___ Hearing problems
___ Sore or sensitive tongue
___ Change in sense of taste
___ Breathing problems
___ Frequent colds
___ Sore throat or hoarseness
___ Enlarged tonsils
___ Difficulty in swallowing
___ Coughing spells
___ High or low blood pressure
___ Heart problem
___ Shortness of breath
___ Heartburn
___ Feeling bloated
___ Excess belching
___ Nausea
___ Peptic ulcer
___ Loss of appetite
___ Digestive problems
___ Excess hunger
___ Frequent urination at night
___ Urinary problems
___ Constipation
___ Diarrhea
___ Other bowel problems
___ Frequent stomach trouble
___ Intestinal worms
___ Hemorrhoids
___ Yellow jaundice
___ Biting your nails
___ Stuttering or stammering
___ Sexual problems
___ Hernia or rupture
___ Kidney or bladder disease
___ Stiff or painful muscles or joints
___ Back or shoulder pain
___ Painful feet
___ Itching or burning skin
___ Dizziness
___ Cold hands or feet
___ Epilepsy
___ Tendency to shake or tremble
___ Tendency to be too hot or cold
___ Sedentary
___ Overweight or underweight
___ Dental problems
___ Coated tongue
___ Varicose veins
___ Headaches
___ Surgery in past year
___ Get angry easily
___ Feel lonely or sad

FOR MEN ONLY:

___ Weak or slow urine stream
___ Prostate trouble
___ Swelling or lumps in testicles
___ Trouble getting erections

FOR WOMEN ONLY:

___ Difficult or heavy menses
___ PMS
___ On birth control pills (during last year)
___ Vaginal discharge
___ Hot Flashes
___ Have had hysterectomy
___ On hormonal replacement
___ Lumps in breast

TOTAL SCORE _____

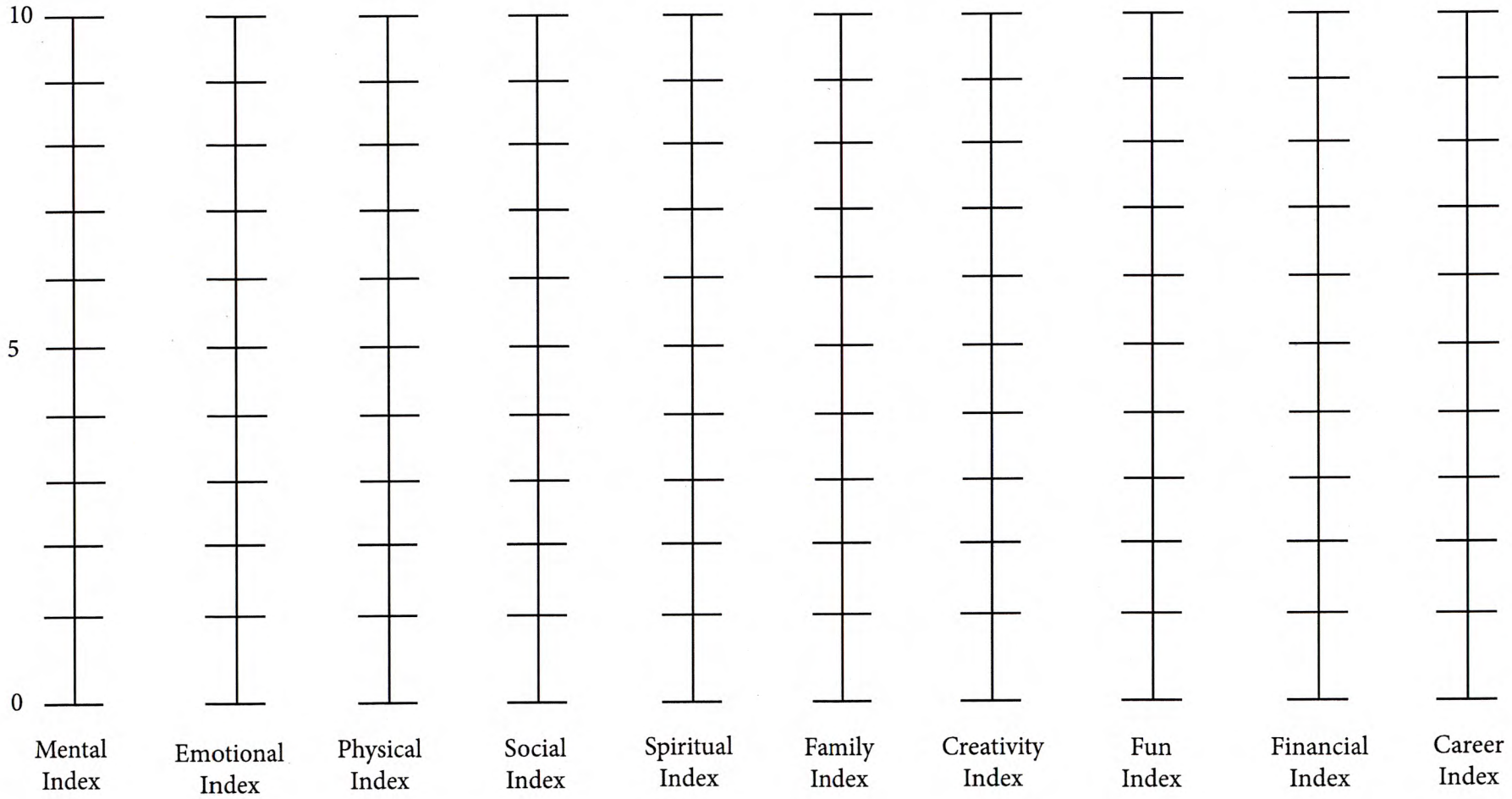
SCORING: If you have 20 or more symptoms at the same time, stress is most likely aggravating your symptoms. If you have less than 10 symptoms, it is likely your adrenal glands are functioning satisfactorily.

Name: _____ Date: _____

Lifestyle Index

Please indicate on each of these scales where you think and feel you are currently functioning in these areas of your life. There are obviously no right or wrong answers here so just be honest with yourself, listen to you intuition and mark your response by circling the mark at the appropriate level.

Scale: 0 = Non-Existent .... to .... 10 = Ideal



Name: _____ Date: _____

Vitality Survey

How often do you? 0 = Never 1 = Seldom 2 = Occasionally 3 = Often 4 = Very Often

1.	Experience indifference (don't care)?	
2.	Lose your sense of humor and take life too seriously?	
3.	Experience doubt or indecision?	
4.	Experience worry and anxiety?	
5.	Feel pessimistic or over cautious?	
6.	Experience stress or feel nervous or tense?	
7.	Feel irritable or oversensitive?	
8.	Experience difficulty concentrating and loss of clear thought?	
9.	Experience inadequate energy or fatigue?	
10.	Use coffee, tea, tobacco, sugar or other stimulants as an energy/mood "pick-up"?	
11.	Experience nervous indigestion?	
12.	Experience loss of sex drive?	
13.	Experience difficulty sleeping?	
14.	Experience difficulty getting up in the morning?	
15.	Feel run down?	
16.	Feel depressed?	
17.	Feel like crying for no reason?	
18.	Find it difficult to sit quietly (without fidgeting, talking, reading, watching TV, etc)?	
19.	Find it difficult to express your feelings?	
20.	Experience rapid heart beat or panic?	
21.	Feel moody?	
22.	Feel suicidal or wonder whether life is worth living?	
23.	Have anxiety about not having enough money?	
24.	Fear ill health?	
25.	Fear criticism?	
26.	Fear loss of love?	
27.	Fear old age or death?	
28.	Feel "something is the matter with me" but don't know what?	
29.	Think you might be "losing it" (going crazy)?	
	Score total	

Scoring

0-30 High Vitality – Powerful Nerve Force
31-40 Good Vitality – Strong Nerve Force
41-50 Average Vitality – Moderate Nerve Force
51-60 Low Vitality – Low Nerve Force
61-70 General Fatigue – Nervous Fatigue
71-80 Extreme Depletion – Nervous Exhaustion
81+ Severe Burnout – Serious Nervous Exhaustion

Health Opinionaire

Name: _____
Date: _____

PLEASE READ EACH STATEMENT, decide how you feel about it and then mark your answer in the space beside the statement.

(1) STRONGLY DISAGREE
(2) DISAGREE
(3) SLIGHTLY DISAGREE
(4) SLIGHTLY AGREE
(5) AGREE
(6) STRONGLY AGREE

____ 1. If I get sick, it is my own behavior which determines how soon I get well again.

____ 2. No matter what I do, if I am going to get sick, I will get sick.

____ 3. Having regular contact with my physician is the best way for me to avoid illness.

____ 4. I am in control of my health.

____ 5. My family has a lot to do with my becoming sick or staying healthy.

____ 6. If I take the right actions, I can stay healthy.

____ 7. Health professionals control my health.

____ 8. The main thing that affects my health is what I do.

____ 9. If I take care of myself, I can avoid illness.

____ 10. When I recover from an illness, it is usually because other people (for example: doctors, family, friends) have taken good care of me.

____ 11. If it is meant to be, I will stay healthy.

____ 12. When I get sick, I am to blame.