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GENERAL INFORMATION SHEET

Name____________________________DOB:____________ Age____ Sex: M F Date____________
Address____
______________________________ City_________________________ State/Prov.______________________
Postal Code_________ Country__________________
Home Phone___________________ Mobile Phone__________________
Business Phone____________________________
E-Mail Address__________________________________ Height________ Weight_________
Occupation____________________ How were you referred?__________________________
What are your main health concerns or conditions?____
____
Please list any medications or food supplements you are currently taking:
____
____
Please list any recent medical tests results you have, such as blood tests:
____

____
Any past surgeries and dates:
____
____
Please list illnesses in your family such as heart disease, cancer, TB, diabetes or arthritis.____

DIET: What are examples of typical breakfasts for you? Beverages
____|__________________
____|__________________
Mid-morning Snacks____|__________________
What are typical lunches for you? Beverages
____|__________________
____|__________________
Mid-afternoon Snacks_______________________________________|__________________
What are typical dinners for you? Beverages
____|__________________
____|__________________
Evening Snacks____|__________________
How often and what kind of exercise do you do?____________________________________
____
About how many hours of sleep do you get per day?_________________________________

Alcohol use:
Type___________ Ounces_____________ How often?_____________
Tobacco use:
Type___________ How often?____________
Recreational Drug Use:
Type___________ How often?____________

Name_________________ ***Date*____________** ***SYMPTOMS SHEET***

CIRCLE any conditions or symptoms that presently describe you.
PLACE A STAR next to the symptoms most important to you.

Joint Pain
Joint Stiffness
Arthritis, Osteo
Arthritis, Rheumatoid
Muscle Pain
Muscle Weakness
Muscle Cramps
Bursitis
Fractures
Osteoporosis
Gout

Sweet Cravings
Sugar Reactions
Irritable before meals
Can't Skip Meals
Hypoglycemia
Crave Starches
Fat Cravings
Other Food Cravings
Food Allergies
Excessive hunger
No hunger
Diabetes

Rapid Heart Rate
Skipped Heart Beats
Heart Palpitations
Heart Attack
Poor Circulation
Dizziness
Low or High Blood Pressure
Angina
Arteriosclerosis
High Cholesterol______
High Triglycerides____

Cough
Bronchitis
Asthma
Post-nasal Drip
Sinus Congestion
Allergies
Emphysema

Fatigue
Hypothyroidism
Low Body Temperature
Cold in Winter/Dry Skin
Tend to Gain Weight
Hyperthyroidism
Acne
Eczema
Fungal Infections/Candida
Psoriasis

Hives
Hair Loss
Slow Wound Healing
Cataracts
Glaucoma
Meniere's Disease
Tooth Decay
Excessive Plaque on Teeth
Gum Disease

Infections/Viruses
Tumors/Cancer
Multiple Sclerosis
Parkinson's Disease
Scleroderma
Fear
Anger
Anxiety
Bipolar Disorder
Brain Fog
Confusion
Depression
Irritability
Mind Races
Mood Swings
Obsessive/Compulsive
Panic Attacks
Poor Memory
Schizophrenia
Trouble Sleeping
Suicidal thoughts
Autism
Attention Deficit
Hyperkinesis
Dyslexia
Seizures
Learning Disability
Mental Retardation
Delayed Development

Bladder Infections
Kidney Infections
Trouble Urinating
Frequent Urination
Painful Urination
Kidney Stones
Water Retention
Kidney Stones
Water Retention
Sinus Headaches
Tension Headaches

Migraine Headaches
Neuritis
Eye diseases
Constipation
Diarrhea
Intestinal Gas
Bloating
Heartburn
Ulcer
Stomach Pain
Colitis
Gall Stones
Fissures
Hemorrhoids
Cirrhosis
Diverticulitis
Tend to Gain Weight
Tend to Lose Weight

Anemia
Easy Bruising

Dental Amalgams
Drug Addiction
Alcoholism
Smoking

WOMEN:
Premenstrual Syndrome
Water Retention
Cramps
No Menstruation
Heavy periods
Light/Irregular Periods
Ovarian Cysts
Fibroid Tumors
Abnormal Pap Smear
Menopause
Fibrocystic Breasts
Breast Tumors
Yeast Infections
Hot Flashes
Currently pregnant
Abuse
Rape

MEN:
Prostate Problems
Impotence
Infertility

Other Symptoms or Comments: ____