

**Natural Horizons Wellness Center**  
**10640 Main Street, Suite 300, Fairfax, VA 22030**  
**Tel: (703)246-9355; Fax: (703)267-6977**

**Personal Profile (please print)**

Date : \_\_\_\_\_

Last Name	<input type="text"/>	Date of Birth	<input type="text"/>	Age	<input type="text"/>
First Name	<input type="text"/>	Home Phone	<input type="text"/>	Race	<input type="text"/>
Address	<input type="text"/>	Work Phone	<input type="text"/>	Height	<input type="text"/>
City	<input type="text"/>	Cell Phone	<input type="text"/>	Weight	<input type="text"/>
State	<input type="text"/>	E-Mail	<input type="text"/>	Sex	Male <input type="checkbox"/> Female <input type="checkbox"/>
Zip Code	<input type="text"/>	SSN	<input type="text"/>	Adopted	Yes <input type="checkbox"/> No <input type="checkbox"/>

**Medical Provider**

**How did you learn about Natural Horizons Wellness Center ?**

**The reason I am seeking care and treatment at Natural Horizons is:**

<b>Medical Profile</b>	(check boxes if applicable)						<b>Lifestyle Profile</b>
History	Self	Father	Mother	Grand Parent	Brother / Sister	Uncle/ Aunt	(Enter number or yes/no)
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke? <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
Uterine Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use smokeless tobacco? <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aerobic exercise (hours per wk) <input type="text"/>
Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight training (hours per wk) <input type="text"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you feel severe stress? <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you experience mood swings? <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
Blocked Arteries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you fatigued? <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you take an aspirin daily? <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
Pancreatic Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a low sex drive? <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stomach Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you currently on hormone therapy? <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/>
Other Cancers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please list:
Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Short Term Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
							Hormone      Dose      Patch, Pill, Cream      Freq. of use

### Past Surgeries, Traumas, Accidents

1	
2	
3	
4	
5	
6	

### Allergies

1	Medications:
2	Food:
3	Environmental:
4	Other:

### Current Medications

	<u>Name</u>	<u>Dose per day</u>
1		
2		
3		
4		
5		
6		
7		

### Current Nutritional Supplements and/or Herbs

	<u>Name</u>	<u>Dose per day</u>
1		
2		
3		
4		
5		
6		
7		

### Medical History

(Past and Present - Check all that apply)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Aids                 | <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Seasonal Allergies        |
| <input type="checkbox"/> Angina               | <input type="checkbox"/> Aortic Aneurysms        | <input type="checkbox"/> Artificial Heart Valve    |
| <input type="checkbox"/> Artificial Joints    | <input type="checkbox"/> Bladder Infections      | <input type="checkbox"/> Bronchitis                |
| <input type="checkbox"/> Autoimmune Diseases  | <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Congenital Heart Disease  |
| <input type="checkbox"/> Depression           | <input type="checkbox"/> Dermatitis              | <input type="checkbox"/> Developmentally Disabled  |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Emphysema               | <input type="checkbox"/> High Blood Pressure       |
| <input type="checkbox"/> Endometriosis        | <input type="checkbox"/> Heart Attack            | <input type="checkbox"/> Epilepsy/ Seizures        |
| <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Heart Pacemaker         | <input type="checkbox"/> Endometriosis             |
| <input type="checkbox"/> Hepatitis B          | <input type="checkbox"/> Irritable Bowel Disease | <input type="checkbox"/> Kidney Trouble            |
| <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Low Back Pain           | <input type="checkbox"/> Mitral Valve Prolapse     |
| <input type="checkbox"/> Multiple Sclerosis   | <input type="checkbox"/> Osteoporosis/penia      | <input type="checkbox"/> Fibroids                  |
| <input type="checkbox"/> Sickle Cell Disease  | <input type="checkbox"/> Stroke                  | <input type="checkbox"/> Thyroid Problems          |
| <input type="checkbox"/> Tuberculosis         | <input type="checkbox"/> Tumors                  | <input type="checkbox"/> Venereal Disease          |
| <input type="checkbox"/> Prostate Problems    | <input type="checkbox"/> Thrombocytopenia        | <input type="checkbox"/> Gastrointestinal problems |
| <input type="checkbox"/> Diverticular Disease | <input type="checkbox"/> Acid reflux             | <input type="checkbox"/> Other _____               |

### Dental History

(Past and Present - Check all that apply)

- |  |                                     |  |
|--|-------------------------------------|--|
| <input type="checkbox"/> Amalgam/Silver filling(s) | <input type="checkbox"/> Denture(s) | <input type="checkbox"/> Periodontal Disease |
| <input type="checkbox"/> Bridge(s)                 | <input type="checkbox"/> Crown(s)   | <input type="checkbox"/> Jaw Pain            |
| <input type="checkbox"/> Implant(s)                |                                     |  |

### Contraception History (for self or partner)

(place a "c" (current) or "p" (previous) next to appropriate items below)

- |                     |                     |                           |
|---------------------|---------------------|---------------------------|
| ____ Not applicable | ____ Hysterectomy   | ____ Vasectomy            |
| ____ Condoms        | ____ Tubal ligation | ____ Foam                 |
| ____ IUD            | ____ Diaphragm      | ____ Other                |
| ____ Pill           | ____ Patch          | ____ # of years(of pills) |

## Food Profile

How many times do you eat per day? .....

How many times per week do you eat out? .....

How many times per week do you eat fast foods? .....

How many times in a day do you eat processed or "ready-made" food?.....

How many cups of water do you drink per day? .....

Please indicate how often you eat the following foods per week. Refer to the key.

Food	Frequency
<b><u>Dairy</u></b>	
Milk	
Cheese	
Eggs	
Ice Cream	
Yogurt	
<b><u>Whole grains</u></b>	
Whole grain bread	
Whole grain pasta	
Brown rice	
Oatmeal	
Millet/Barley	
<b><u>Refined sweets/White flour:</u></b>	
Donuts / Cakes	
Bagels	
Candy / Chocolates	
White Bread	
White pasta	
Cookies	
<b><u>Meat</u></b>	
Beef	
Tuna fish	
Pork	
Chicken	
Turkey	
Salmon	
<b><u>Legumes</u></b>	
Beans	
Peas	
Lentils	
<b><u>Beverages</u></b>	
Coffee	
Soft Drinks	
Black Tea	
Green Tea	
Fresh Juice	
Store Bought Juice	
<b><u>Fresh Fruits</u></b>	
<b><u>Vegetables</u></b>	
<b><u>Soy Protein</u></b>	
<b><u>Nuts and Seeds</u></b>	

**Key:**

- 0 = Rare (0-1 servings/week)
- 1 = Infrequent (2-3 servings/week)
- 2 = Moderate (4-6 servings/week)
- 3 = Frequent (>6 servings/week)

## Endocrine Questionnaire

**Key:** 1= mild (occurs monthly), 2= moderate (occurs weekly), 3= Severe (occurs daily); Leave blank if symptom does not occur

<b>Low Adrenal</b>	
Tend to be a night person	
Difficulty falling asleep	
Slow starter in the morning	
Headache/fatigue after exercising	
Chronic low back pain, worse with fatigue	
Become dizzy when stand up suddenly	
Difficulty with manipulative correction	
Pain after manipulative correction	
Arthritic tendencies	
Crave salty foods	
Salt foods before tasting	
Perspire easily	
Chronic fatigue/get drowsy often	
Afternoon yawning	
Afternoon headache	
Asthma, wheezing, difficulty breathing	
Pain on inner side of knee	
Tendency to sprain ankles/"shin splints"	
Tendency to need sunglasses	
Allergies/Intolerances/Hives	
Weakness/ Dizziness	

<b>High Adrenal</b>	
Tend to be keyed up, trouble calming down	
Blood pressure above 120/80	
Feeling wired/jittery after drinking coffee	
Clench or grind teeth	
Calm on the outside, troubled inside	

<b>Insulin High</b>	
Wake soon after sleeping,hard staying asleep	
Crave sweets	
Binge or uncontrolled eating	
Excessive appetite	
Crave coffee or sugar in afternoon	
Sleepy in the afternoon	
Fatigue relieved by eating	
Headache if meals are skipped or delayed	
Irritable before meals	
Shaky if meals delayed	
Family members with diabetes (0=none, 1= 2 or less, 2= 2-4, 3= more than 4)	
Frequent thirst	
Frequent urination	

<b>Low Thyroid</b>	
Difficulty losing weight	
Mentally sluggish/Reduced initiative	
Easily Fatigued/ Sleepy during the day	
Sensitive to cold/ poor circulation	
Chronic constipation	
Excessive hair loss or course hair	
Morning headaches, wear off during day	
Seasonal sadness	

<b>High Thyroid</b>	
Sensitive/Allergic to iodine	
Trouble gaining weight even with large appetite	
Nervous, emotional, can't work under pressure	
Inward trembling	
Flush easily	
Fast pulse at rest	
Intolerance to heat	

<b>Liver and Gallbladder</b>			
Pain between shoulder blades		Alcohol per week(0=<3, 1=<7, 2=<14, 3=>14)	
Stomach upset by greasy foods		Recovering alcoholic(0=no, 1=yes)	
Greasy or shiny stools		History of drug or alcohol abuse(0=no, 1=yes)	
Nausea		History of Hepatitis(0=no, 1=yes)	
Sea, car, airplane, or motion sickness		Long term use of medications(0=no, 1=yes)	
History of morning sickness (0=no, 1=yes)		Sensitive to chemicals(0=no, 1=yes)	
Light or clay colored stools		Sensitive to tobacco smoke(0=no, 1=yes)	
Dry skin, itchy feet, or skin peels on feet		Exposure to diesel fumes	
Headache over eyes		Pain under right side of ribcage	
Gallbladder attacks (0=never, 1=years ago, 2=within last year, 3=within past 3 months)		Hemorrhoids or varicose veins	
Gallbladder removed (0=no, 1=yes)		Nutrasweet(aspartame) consumption	
Become sick if drink wine(0=no, 1=yes)		Sensitive to nutrasweet(0=no, 1=yes)	
Easily intoxicated with wine(0=no, 1=yes)		Chronic fatigue or fibromyalgia	
		Bitter taste in mouth, especially after meals	

## Hormone Analysis

Key: 1=mild (occurs monthly) 2=moderate (occurs weekly) 3=severe (occurs daily); Leave blank if symptom does not occur

<b>Estrogens low</b>	
Hot Flashes	
Night Sweats	
Vaginal Dryness	
Foggy thinking	
Scanty or no menses	
Depressed	
Bone loss	
Tearful	
Memory lapse	
Hair loss	

<b>Estrogens High</b>	
Breast tenderness	
Fibrosis	
PMS	
Endometriosis	
Heavy periods	
Fibrocystic breasts	
Heavy hips or abdomen	
Water retention	
Breast/Prostate enlargement	

<b>Testosterone/DHEA low</b>	
Low sex drive	
Weak muscles	
Low energy	
Bone loss	
Joint aches and pains	
Muscular atrophy	
Masculine hair loss pattern	
Reduced sexual performance	

<b>Testosterone/DHEA high</b>	
Strong morning erections	
High sex drive	
Strong muscles	
High energy	
Masculine hair pattern	
Good mental power	
Good physical stamina	
Acne	
Nightmares	
Facial hair (women)	
Sore nipples	

<b>Progesterone Low</b>	
PMS	
Miscarriages	
Irregular periods	
Heavy periods	
Clots with periods	
Breast tenderness	
Bone loss	
Irritable	
Insomnia	
Migraines	
Fibroids	
Infertile	
Endometriosis	

<b>Progesterone High</b>	
Sleepy	
Dizzy	
Night sweats	

## Women's Health History

Age at start of menstruation \_\_\_\_\_ First date of last period \_\_\_\_\_  
 Average # of days between periods \_\_\_\_\_ Average # of days of bleeding \_\_\_\_\_  
 Cycles are generally (check one)      Fairly regular       Irregular       No periods   
 Last pap \_\_\_\_\_ How often \_\_\_\_\_ Any abnormal paps \_\_\_\_\_  
 Last mammogram \_\_\_\_\_ Any abnormal \_\_\_\_\_  
 Pregnancies # \_\_\_\_\_ Living children # \_\_\_\_\_ Miscarriages # \_\_\_\_\_ Abortions # \_\_\_\_\_  
 Vaginal deliveries# \_\_\_\_\_ C-sections # \_\_\_\_\_  
 Any complications during pregnancy or childbirth \_\_\_\_\_  
 Did you breastfeed your children \_\_\_\_\_ If so, how long \_\_\_\_\_  
 Any family history of breast or gynecological cancers \_\_\_\_\_  
 Have you ever been on HRT (Hormone Replacement Therapy) \_\_\_\_\_

## Men's Health History

Key: 1=mild (occurs monthly) 2=moderate (occurs weekly) 3=severe (occurs daily); Leave blank if symptom does not occur

Date of last PSA: \_\_\_\_\_ Date of last prostate exam: \_\_\_\_\_

Thinning of hair on beard	
Thinning of hair on body	
Reduced libido	
Disturbed sleep	
Depression	
Prostate enlargement/cancer	
Muscle weakness	
Fatigue	
Irritability	
Impotence	

Poor concentration/memory loss	
Abdominal weight gain	
Lost of interest in surroundings	
Night sweats	
Palpitations	
Insomnia	
Thinning skin	
Slow wound healing	
Anxiety	
Baldness/Balding	

### Consent

- I understand that all responsibility for payment for services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 ½ % finance charge (18% APR) will be added to my account.
- I have completed the above information as accurate as possible and to the best of my knowledge.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Responsible Party Signature \_\_\_\_\_ Relationship \_\_\_\_\_

- Dental Only: I authorize NHWC to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by NHWC to make a thorough diagnosis of my dental needs.

Please Initial Here \_\_\_\_\_

# Nutritional Assessment Questionnaire 1.5

Full Name: \_\_\_\_\_

Date : \_\_\_\_\_

Please list your five major health concerns in order of importance:

1 \_\_\_\_\_  
 2 \_\_\_\_\_  
 3 \_\_\_\_\_  
 4 \_\_\_\_\_  
 5 \_\_\_\_\_

**Key:** If any of the symptoms below is present, please put a 1, 2, or 3 in the box next to the symptom.  
 1 - Minor or mild symptom, rarely occurs (monthly)  
 2 - Moderate, occurs occasionally (weekly)  
 3 - Severe, occurs frequently (daily)  
 Leave the box blank if the symptom does not apply to you.

## Upper Gastrointestinal System

- |    |                          |   |    |                          |  |
|----|--------------------------|---|----|--------------------------|--|
| 52 | <input type="checkbox"/> | Belching or gas within 1 hour aft                   | 61 | <input type="checkbox"/> | Feel like skipping breakfast           |
| 53 | <input type="checkbox"/> | Heartburn or acid reflux                            | 62 | <input type="checkbox"/> | Feel better if you don't eat           |
| 54 | <input type="checkbox"/> | Bloating within 1 hour after eating                 | 63 | <input type="checkbox"/> | Sleepy after meals                     |
| 55 | <input type="checkbox"/> | Vegan diet(no dairy, meat, fish, c<br>(0=no, 1=yes) | 64 | <input type="checkbox"/> | Fingernails chip, peel or break easily |
| 56 | <input type="checkbox"/> | Bad breath(halitosis)                               | 65 | <input type="checkbox"/> | Anemia unresponsive to iron            |
| 57 | <input type="checkbox"/> | Loss of taste for meat                              | 66 | <input type="checkbox"/> | Stomach pains or cramps                |
| 58 | <input type="checkbox"/> | Sweat has a strong odor                             | 67 | <input type="checkbox"/> | Diarrhea, chronic                      |
| 59 | <input type="checkbox"/> | Stomach upset by taking vitamin:                    | 68 | <input type="checkbox"/> | Diarrhea shortly after meals           |
| 60 | <input type="checkbox"/> | Sense of excess fullness after m                    | 69 | <input type="checkbox"/> | Black or tarry colored stools          |
|    |                          |   | 70 | <input type="checkbox"/> | Undigested food in stools              |

## Small Intestines

- |     |                          |   |     |                          |  |
|-----|--------------------------|---|-----|--------------------------|--|
| 99  | <input type="checkbox"/> | Food allergies                                    | 108 | <input type="checkbox"/> | Crohn's Disease(0=no, 1=yes, in the past,<br>2=currently mild condition, 3=severe) |
| 100 | <input type="checkbox"/> | Abdominal bloating 1 to 2 hours after eating      | 109 | <input type="checkbox"/> | Wheat or grain sensitivity   |
| 101 | <input type="checkbox"/> | Specific foods make you tired or<br>(0=no, 1=yes) | 110 | <input type="checkbox"/> | Dairy sensitivity  |
| 102 | <input type="checkbox"/> | Pulse speeds after eating                         | 111 | <input type="checkbox"/> | Are there food you could not give up?<br>(0=no, 1=yes)                             |
| 103 | <input type="checkbox"/> | Airborne allergies                                | 112 | <input type="checkbox"/> | Asthma, sinus infections, stuffy nose  |
| 104 | <input type="checkbox"/> | Experience hives                                  | 113 | <input type="checkbox"/> | Bizarre vivid dreams, nightmares   |
| 105 | <input type="checkbox"/> | Sinus congestion, "stuffy head"                   | 114 | <input type="checkbox"/> | Use over the counter pain medications  |
| 106 | <input type="checkbox"/> | Crave bread or noodles                            | 115 | <input type="checkbox"/> | Feel spacey or unreal  |
| 107 | <input type="checkbox"/> | Alternating constipation and diarr                |     |                          |  |

## Large Intestines

- |     |                          |   |     |                          |  |
|-----|--------------------------|---|-----|--------------------------|--|
| 116 | <input type="checkbox"/> | Anus itches   | 126 | <input type="checkbox"/> | Stools have corners or edges, are flat or<br>ribbon shaped |
| 117 | <input type="checkbox"/> | Coated tongue   | 127 | <input type="checkbox"/> | Stools are not well formed(loose)                          |
| 118 | <input type="checkbox"/> | Feel worse in moldy or musty pla                                    | 128 | <input type="checkbox"/> | Irritable bowel or mucus colitis                           |
| 119 | <input type="checkbox"/> | Taken antibiotic for total accumul<br>(0=never, 1=<1 mon, 2=<3 mon, | 129 | <input type="checkbox"/> | Blood in stool   |
| 120 | <input type="checkbox"/> | Fungus or yeast infections  | 130 | <input type="checkbox"/> | Mucus in stool   |
| 121 | <input type="checkbox"/> | Ring worm, "jock itch", "athlete's<br>nail fungus                   | 131 | <input type="checkbox"/> | Excessive foul smelling lower bowel gas                    |
| 122 | <input type="checkbox"/> | Yeast symptoms increase with su<br>starch or alcohol                | 132 | <input type="checkbox"/> | Bad breath or strong body odors                            |
| 123 | <input type="checkbox"/> | Stools hard or difficult to pass                                    | 133 | <input type="checkbox"/> | Painful to press along outer sides of thighs               |
| 124 | <input type="checkbox"/> | History of parasites(0=no, 1=yes)                                   | 134 | <input type="checkbox"/> | Cramping in lower abdominal region                         |
| 125 | <input type="checkbox"/> | Less than 1 bowel movement per day                                  | 135 | <input type="checkbox"/> | Dark circles under eyes                                    |

## Mineral Needs

- |     |                          |   |     |                          |                                     |
|-----|--------------------------|---|-----|--------------------------|-------------------------------------|
| 136 | <input type="checkbox"/> | History of carpal tunnel syndrome                   | 150 | <input type="checkbox"/> | History of bone loss (0=no, 1=yes)  |
| 137 | <input type="checkbox"/> | History of lower right abdominal pain (0=no, 1=yes) | 151 | <input type="checkbox"/> | Morning stiffness                   |
| 138 | <input type="checkbox"/> | History of stress fracture(0=no, 1=yes)             | 152 | <input type="checkbox"/> | Nausea with vomiting                |
| 139 | <input type="checkbox"/> | Bone loss (reduced density on bone scan)            | 153 | <input type="checkbox"/> | Crave chocolate                     |
| 140 | <input type="checkbox"/> | Are you shorter than you used to be (0=no, 1=yes)   | 154 | <input type="checkbox"/> | Feet have a strong odor             |
| 141 | <input type="checkbox"/> | Calf, foot, or toe cramps at rest                   | 155 | <input type="checkbox"/> | History of anemia                   |
| 142 | <input type="checkbox"/> | Cold sores, fever blisters, or herpes               | 156 | <input type="checkbox"/> | Whites of eyes(sclera) blue tinted  |
| 143 | <input type="checkbox"/> | Frequent fevers                                     | 157 | <input type="checkbox"/> | Hoarseness                          |
| 144 | <input type="checkbox"/> | Frequent skin rashes and/or hives                   | 158 | <input type="checkbox"/> | Difficulty swallowing               |
| 145 | <input type="checkbox"/> | Herniated disc(0=no, 1=yes)                         | 159 | <input type="checkbox"/> | Lump in throat                      |
| 146 | <input type="checkbox"/> | Excessively flexible joints, "double jointed"       | 160 | <input type="checkbox"/> | Dry mouth, eyes, and/or nose        |
| 147 | <input type="checkbox"/> | Joints pop or click                                 | 161 | <input type="checkbox"/> | Gag easily                          |
| 148 | <input type="checkbox"/> | Pain or swelling in joints                          | 162 | <input type="checkbox"/> | White spots on fingernails          |
| 149 | <input type="checkbox"/> | Bursitis or tendonitis                              | 163 | <input type="checkbox"/> | Cuts heal slowly and/or scar easily |
|     |                          |   | 164 | <input type="checkbox"/> | Decreased sense of taste or smell   |

### **Essential Fatty Acids**

- |     |                          |  |     |                          |  |
|-----|--------------------------|--|-----|--------------------------|--|
| 165 | <input type="checkbox"/> | Experience pain relief with aspirin  | 169 | <input type="checkbox"/> | Headaches when out in the hot sun      |
| 166 | <input type="checkbox"/> | Crave fatty or greasy foods  | 170 | <input type="checkbox"/> | Sunburn easily or suffer sun poisoning |
| 167 | <input type="checkbox"/> | Low or reduced fat diet(0=no, 1=within past year, 2=with in past year, 3=currentlly) | 171 | <input type="checkbox"/> | Muscles easily fatigued                |
| 168 | <input type="checkbox"/> | Tension headaches at base of skull   | 172 | <input type="checkbox"/> | Dry flaky skin or dandruff             |

### **Vitamin Need**

- |     |                          |  |     |                          |  |
|-----|--------------------------|--|-----|--------------------------|--|
| 186 | <input type="checkbox"/> | Muscles become easily fatigued                 | 200 | <input type="checkbox"/> | Can hear heart beat on pillow at night       |
| 187 | <input type="checkbox"/> | Feel exhausted or sore after moderate exercise | 201 | <input type="checkbox"/> | Whole body or limb jerk as falling asleep    |
| 188 | <input type="checkbox"/> | Vulnerable to insect bites                     | 202 | <input type="checkbox"/> | Night sweats                                 |
| 189 | <input type="checkbox"/> | Loss of muscle tone, heaviness in muscles      | 203 | <input type="checkbox"/> | Restless leg syndrome                        |
| 190 | <input type="checkbox"/> | Enlarged heart or congestive heart failure     | 204 | <input type="checkbox"/> | Cracks at corner of mouth(Cheilosis)         |
| 191 | <input type="checkbox"/> | Pulse below 65 per minute(0=no, 1=yes)         | 205 | <input type="checkbox"/> | Fragile skin, easily chaffed, as in shaving  |
| 192 | <input type="checkbox"/> | Ringing in the ears(tinnitus)                  | 206 | <input type="checkbox"/> | Polyps or warts                              |
| 193 | <input type="checkbox"/> | Numbness, tingling, or itching in limbs        | 207 | <input type="checkbox"/> | MSG sensitivity                              |
| 194 | <input type="checkbox"/> | Depressed                                      | 208 | <input type="checkbox"/> | Wake up without remembering dreams           |
| 195 | <input type="checkbox"/> | Fear or impending doom                         | 209 | <input type="checkbox"/> | Small bumps on back of arms                  |
| 196 | <input type="checkbox"/> | Worrier, apprehensive, anxious                 | 210 | <input type="checkbox"/> | Strong light at night irritates eyes         |
| 197 | <input type="checkbox"/> | Nervous or agitated                            | 211 | <input type="checkbox"/> | Nosebleeds and/or tend to bruise easily      |
| 198 | <input type="checkbox"/> | Feelings of insecurity                         | 212 | <input type="checkbox"/> | Bleeding gums especially when brushing teeth |
| 199 | <input type="checkbox"/> | Heart races                                    |     |                          |  |

## Cardiovascular

- |     |                      |  |     |                      |  |
|-----|----------------------|--|-----|----------------------|--|
| 297 | <input type="text"/> | Aware of heavy and/or irregular t          | 302 | <input type="text"/> | Ankles swell, especially at end of day |
| 298 | <input type="text"/> | Discomfort at high altitudes               | 303 | <input type="text"/> | Cough at night                         |
| 299 | <input type="text"/> | "Air hunger" or sigh frequently            | 304 | <input type="text"/> | Blush or face turns red for no reason  |
| 300 | <input type="text"/> | Compelled to open windows in a             | 305 | <input type="text"/> | Dull pain or tightness in chest and/or |
| 301 | <input type="text"/> | Shortness of breath with moderate exertion |     |                      | radiates into arm, worse with exertion |
|     |                      |  | 306 | <input type="text"/> | Muscle cramps with exertion            |

## Kidney and bladder

- |     |                      |                                       |     |                      |                                   |
|-----|----------------------|---------------------------------------|-----|----------------------|-----------------------------------|
| 307 | <input type="text"/> | Pain in mid back region               | 310 | <input type="text"/> | Cloudy, bloody, or darkened urine |
| 308 | <input type="text"/> | Puffy around the eyes, dark circle    | 311 | <input type="text"/> | Urine has a strong odor           |
| 309 | <input type="text"/> | History of kidney stones(0=no, 1=yes) |     |                      |                                   |

## Immune System

- |     |                      |  |     |                      |   |
|-----|----------------------|--|-----|----------------------|---|
| 312 | <input type="text"/> | Runny or drippy nose   | 318 | <input type="text"/> | Acne(adult)   |
| 313 | <input type="text"/> | Catch colds at the beginning of w  | 319 | <input type="text"/> | Itchy skin(dermatitis)  |
| 314 | <input type="text"/> | Mucus producing cough  | 320 | <input type="text"/> | Cysts, boils, rashes  |
| 315 | <input type="text"/> | Frequent colds or flu(0=1 or less<br>1=2-3/year, 2=4-5/year, 3=>6/year)  | 321 | <input type="text"/> | History of epstein-bar, mono, herpes,<br>shingles, chronic fatigue syndrome,hepatitis,<br>or other chronic viral condition(0=no, 1=yes,<br>in the past, 2=currentl mild condition,<br>3=severe) |
| 316 | <input type="text"/> | Other infections(0=1 or less per year,<br>1=2-3/year, 2=4-5/year, 3=>6/year)   |     |                      |   |
| 317 | <input type="text"/> | Never get sick(0=sick only 1-2 times in last<br>2 years, 1=not sick in last 2 years, 2=not<br>sick in last 4 years, 3=not sick in last<br>7 years) |     |                      |   |