STRONGLIFE
FUNCTIONAL MEDICINE & WEIGHT LOSS

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PATIENT APPLICATION

Name: _____ Date: ___/___/___

Address: _____

City: _____ State: _____ Zip: _____

Phone number: _____ Email Address: _____

Date of Birth: ___/___/___ Height: _____ Weight: _____

Do we have your permission to communicate your health information via email? Yes ☐ No ☐

(Federal guidelines require this information)

Marital Status: _____

Occupation: _____

Emergency Contact: _____ Ph: _____ Relationship: _____

How did you hear about our clinic? _____

On a scale of 1 to 100 please rate your perception of your current level of health and wellness: _____%

Please list your chief symptoms in order of decreasing severity, **starting with the worst/most concerning one.**

Problem	Onset	Frequency	Severity
Example: Headaches	*June 2007*	*4 times per week*	*Mild / Moderate / Severe*

What diagnosis or explanation have you been given for these symptoms?

Are you visiting us today to:

- ☐ Resolve your immediate symptoms?
- ☐ Seek long-term wellness through an optimized lifestyle program?
- ☐ Both?
- ☐ Other: _____

How would you describe your mindset regarding conventional medicine?

- ☐ The conventional system has failed me and I am frustrated by the lack of answers and results
- ☐ I still like conventional medicine, but I know they don't have all the answers
- ☐ Conventional medicine is great for things like emergencies, but I want to get better naturally

Which of the following would you like us to help you to improve?

- ☐ Energy
- ☐ Gut Health: Gas, bloating, IBS, indigestion, constipation
- ☐ Sleep: Falling asleep, staying asleep or waking refreshed
- ☐ Blood Sugar Control
- ☐ Ability to handle stress
- ☐ Thyroid function
- ☐ Control inflammation
- ☐ Immune function (including autoimmunity)
- ☐ Hormone Balance
- ☐ Brain Health: Brain fog, poor focus, mental fatigue, memory
- ☐ Overall sense of Wellbeing

Please check all the treatments you have tried for your condition(s) that have <u>HELPED</u>.

- ☐ Conventional medicine and prescription medications
- ☐ Surgery
- ☐ Anti-aging, or alternative medicine
- ☐ Chiropractic
- ☐ Acupuncture
- ☐ Naturopathy
- ☐ Exercise
- ☐ Diet changes
- ☐ Nutritional Supplements
- ☐ Other _____

Please check all the treatments you have tried for your condition(s) that have <u>NOT</u> HELPED.

- ☐ Conventional medicine and prescription medications
- ☐ Surgery
- ☐ Anti-aging, or alternative medicine
- ☐ Chiropractic
- ☐ Acupuncture
- ☐ Naturopathy
- ☐ Exercise
- ☐ Diet changes
- ☐ Nutritional Supplements
- ☐ Other _____

What do you fear will suffer or be affected negatively if things do not change?

- ☐ My Job/career
- ☐ My kids and my ability to be an involved parent
- ☐ My marriage
- ☐ My freedom and ability to do things I love
- ☐ My future quality of life
- ☐ My finances
- ☐ My Time

Are there any major health issues you are afraid this might turn into?

- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ Autoimmune disease
- ☐ Weight gain I can't lose
- ☐ Chronic Fatigue Syndrome
- ☐ Fibromyalgia
- ☐ Uncontrollable Stress
- ☐ Depression
- ☐ Anxiety and/or panic attacks
- ☐ Heart disease
- ☐ Stroke
- ☐ Alzheimer's or Parkinson's
- ☐ Disabling arthritis
- ☐ Cancer

When your problem is at its worst how does it make you feel?

How do these issues interfere with your family, work, hobbies and quality of life in general?

What would be different or better in your life without these problems hampering you?

If we sat down in 3 years from now to discuss your life, and we looked back to today, what would have had to have happened/changed for you to be happy with your progress? Please take your time and don't sell yourself short! Include anything that is part of your happiness, whether it is health and wellness, family, work, travel, marriage or your "bucket list".

In regards to the above, what potential barriers do you foresee that would prevent you from accomplishing these things?

Do you feel it is possible to eliminate or prevent these barriers?

What are your strengths that will enable you to accomplish your goals?

PATTERNS AND PIVOT POINTS

A "Pattern" is something that has been consistent and true for you over time. Common Patterns might be hormone symptoms, fatigue, anxiety or poor sleep etc. Please indicate your Patterns below.

Pattern Recognition: I have always had a problem, or struggled with:

A "Pivot Point" is some event, or timeframe, when your health changed significantly for the better, or worse. Some Pivot Points are positive, meaning you got/felt better. Other Pivot Points are negative (things started or got worse). Common Pivot Points are injuries, illnesses, major stressors, getting pregnant, childbirth, menopause etc. Please indicate and positive or negative Pivot Points below.

Positive Pivot Points: I felt good, or got better, when:

Negative Pivot Points: I got worse, or everything started, when:

TYPICAL DIETARY & LIFESTYLE HABITS

Please rate how close your diet is to the following statement:

"I eat lean meat and fish, nuts and seeds, leafy greens and crunchy veggies, some fruit, little starch, and no sugar."

- ☐ Strongly Disagree
- ☐ Moderately Disagree
- ☐ Neither Agree nor Disagree
- ☐ Slightly Agree
- ☐ Moderately Agree
- ☐ Strongly Agree

Are there any foods, or foods groups (like, wheat/gluten or dairy), that you COMPLETELY avoid?

Do you CURRENTLY exercise on a regular basis?
(Defined as: At least 20 minutes of moderately elevated heart rate, at least 3-4 days per week?)

- ☐ No
- ☐ Yes (Describe below):

NUTRITIONAL SUPPLEMENTATION

Please list all vitamins, minerals and other nutritional supplements

Supplement Name	Taking how long?	Dosage	Reason for taking

MEDICATIONS

Medication Name	Taking how long?	Dosage	Reason for taking

READINESS ASSESSMENT

Please rate the following questions on a scale of 1-10: (10 = VERY important, VERY prepared etc)

_____ How important is it for you to resolve your health concerns now rather than later?

_____ How prepared are you to make lifestyle and diet changes that are necessary to achieve your goals?

_____ Are you coachable and willing to work with a mentor to help you?

What kind of "student" would you describe yourself to be?

☐ I am an "A" student: I will do everything you say, as you say, when you say it!

☐ I am a "B" student: I know I need to get better and I am motivated, but I might make some mistakes along the way and will need your help (most of our clients are B students!)

☐ I am a "C" student: My health is not really that important to me and I am not truly motivated to change

Consent to Professional Treatment

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time.

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete copy of the Health Information Portability and Accountability Act (HIPAA) is available here: Final Rule as seen in Federal Register 2/20/2003

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.
6. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Financial Obligation and Appointment Policy

The patient accepts full financial responsibility for services rendered by this practice. This office reserves the right to charge fair market value for missed appointments or appointments canceled without any advanced notification required by this office. Payment in full is required for all services rendered at the time of visit. Patient accepts full responsibility for any fees incurred, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts.

The patient further authorizes the practice to retain credit card, debit card, checking account or other payment source(s) supplied by patient to the practice for current and future charges, when incurred.

INFORMED CONSENT REGARDING EMAIL

STRONGLIFE provides patients the opportunity to communicate by e-mail. Transmitting confidential health information by e-mail, however, has a number of risks, both general and specific, that should be considered before using e-mail.

1. Risks:

a. General e-mail risks are the following: e-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward e-mail to other recipients without the original sender(s) permission, or knowledge; users can easily misaddress an e-mail; e-mail is easier to falsify than handwritten, or signed documents; backup copies of e-mail may exist even after the sender, or recipient has deleted his/her history.

b. Specific e-mail risks are the following: e-mail containing information pertaining to diagnosis and/or treatment must be included in the protected personal health information; all individuals who have access to the protected personal health information will have access to the e-mail messages; patients who send, or receive e-mail from their place of employment risk having their employer read their email.

2. It is the policy of STRONGLIFE that all e-mail messages sent, or received, which concern the diagnosis, or treatment, of the patient will be a part of that patient's protected personal health information and will treat such e-mail messages, or internet communications, with the same degree of confidentiality as afforded other portions of the protected personal health information. STRONGLIFE will use reasonable means to protect the security and confidentiality of e-mail, or Internet communication. Because of the risks outlined above, we cannot; however, guarantee the security and confidentiality of e-mail, or Internet communications.

INFORMED CONSENT REGARDING E-MAIL continued

3. Patients must consent to the use of e-mail for confidential medical information after having been informed of the above risks. Consent to the use of e-mail includes agreement with the following conditions:

a. All e-mail to, or from, patients concerning diagnosis and/or treatment will be made a part of the protected personal health information. As a part of the protected personal health information, other individuals, STRONGLIFE physicians, nurses, other healthcare practitioners, insurance coordinators, and upon written authorization other healthcare providers and insurers will have access to e-mail messages contained in protected personal health information.

b. STRONGLIFE may forward e-mail messages within the practice as necessary for diagnosis and treatment. STRONGLIFE will not; however, forward the e-mail outside the practice without the consent of the patient as required by law.

c. STRONGLIFE will endeavor to read e-mail promptly, but can provide no assurance that the recipient of the particular e-mail will read the e-mail message promptly. Therefore, **e-mail must not be used in a medical emergency.**

d. It is the responsibility of the sender to determine whether the intended recipient received the e-mail and when the recipient will respond.

e. Because some medical information is so sensitive that unauthorized disclosure can be very damaging, e-mail should not be used for communications concerning diagnosis, or treatment of AIDS/HIV infection; other sexually transmissible, or communicable diseases, such as syphilis, gonorrhea, herpes, and the like; Behavioral health, Mental health, or developmental disability; or alcohol and drug abuse.

f. STRONGLIFE cannot guarantee that electronic communications will be private. However, we will take reasonable steps to protect the confidentiality of the e-mail, or Internet, communication, but STRONGLIFE is not liable for improper disclosure of confidential information not caused by its employee's gross negligence, or wanton misconduct.

g. If consent is given for the use of e-mail, it is the responsibility of the patient to inform STRONGLIFE of any type of information you do not want to be sent by email.

h. It is the responsibility of the patient to protect their password, or other means of access to e-mail sent, or received from STRONGLIFE to protect confidentiality. STRONGLIFE is not liable for breaches of confidentiality caused by the patient.

Any further use of e-mail initiated by the patient that discusses diagnosis, or treatment, constitutes informed consent to the foregoing.

I understand that my consent to the use of e-mail may be withdrawn at any time by e-mail, or written communication, to STRONGLIFE. I have read this form carefully and understand the risks and responsibilities associated with the use of e-mail. I agree to assume all risks associated with the use of e-mail.

BY SIGNING BELOW I AFFIRM THAT I HAVE READ AND ACCEPT THE FOLLOWING PRIOR DISCLOSURES:

- ☐ **Consent to Professional Treatment**
- ☐ **Patient Health Information and Privacy Policy**
- ☐ **Financial Obligations and Appointment Policy**
- ☐ **Informed Consent Regarding Email**

Print Name: _____

Signature: _____

Date: ___/___/___

NAME: _____		Date: _____	
SECTION A – ANEMIA HISTORY		**CATECHOLAMINE BALANCE**	
Have you been diagnosed with any type of Anemia?	NO	Decreased mental alertness	0 1 2 3
Iron Deficiency	YES	Slower mental processing speed	0 1 2 3
B12/Folate Deficiency or Pernicious Anemia	YES	Poor focus and concentration	0 1 2 3
Other: _____		Brain just doesn't perform well	0 1 2 3
SECTION B – BLOOD SUGAR & BRAIN HEALTH		Brain works better with caffeine	0 1 2 3
Reactive Hypoglycemia	0 1 2 3		
I'm not hungry when I wake up	0 1 2 3	**SECTION C – CORTISOL AND STRESS RESPONSES**	
I generally feel better after I eat	0 1 2 3	**Stress Survey**	
Shaky or jittery if meals missed	0 1 2 3	Rate your stress levels (10 is highest)	0 1 2 3
Irritable/mood changes if meals missed	0 1 2 3	Light and/or noise bother me	0 1 2 3
Lightheaded if meals missed	0 1 2 3	I startle easily	0 1 2 3
Fatigued if meals missed	0 1 2 3	If I get startled/upset, it takes a long time to calm down	0 1 2 3
Eating relieves any symptom not mentioned above	0 1 2 3	I have major, unresolved stressors in my life	0 1 2 3
Agitated or upset easily	0 1 2 3	I have stressors that I can change if I need to	0 1 2 3
Blurry vision that comes and goes	0 1 2 3	**Circadian Rhythm**	
Insulin Resistance	0 1 2 3	My energy fluctuates through the day	0 1 2 3
I get tired after I eat	0 1 2 3	My mental alertness varies throughout the day	0 1 2 3
I have cravings after I eat	0 1 2 3	I have abnormal sleep patterns	0 1 2 3
Eating sweets/carbs does not relieve my cravings	0 1 2 3	My worst time of day is: Morning Afternoon Night	
I am hungry all the time	0 1 2 3		
I have difficulty losing weight	0 1 2 3	**SECTION D – DIET PROFILE AND DETOX**	
Increased thirst and appetite	0 1 2 3	**DIET MODIFICATIONS**	
My waist is larger than my hips	0 1 2 3	Standard Diet (no special modifications)	YES
		100% Gluten Free	YES
GENERAL BRAIN HEALTH		"Mostly" Gluten Free	YES
History of head injury or concussion	0 1 2 3	Dairy Free	YES
Brain Fog	0 1 2 3	Soy Free	YES
Poor mental endurance	0 1 2 3	Corn Free	YES
Reading, computer work or driving makes me tired/worse	0 1 2 3	Nut Free	YES
I'm worried about my brain health	0 1 2 3	Nightshade Free	YES
SEROTONIN BALANCE		Paleo/Primal Diet	YES
I don't enjoy life/food/things like I used to	0 1 2 3	Autoimmune Paleo Diet	YES
I'm depressed and feel bad about it	0 1 2 3	Leaky Gut Diet or SIBO Diet	YES
I feel down on overcast days	0 1 2 3	**DIET "STYLE"**	
I'm more sensitive to pain than others	0 1 2 3	I tend to skip breakfast and/or other meals	0 1 2 3
I get overwhelmed easily	0 1 2 3	I get caught without food when I need it	0 1 2 3
DOPAMINE BALANCE		I frequently eat out	0 1 2 3
Silly things upset/bother me	0 1 2 3	I eat in a rush	0 1 2 3
I feel hopeless and/or worthless at times	0 1 2 3	**DETOX SYMPTOMS**	
Stress makes me angry/irritable	0 1 2 3	Acne and unhealthy skin	0 1 2 3
I'm tired when I wake up	0 1 2 3	For Women: Acne and skin worse during menstrual cycle	0 1 2 3
I tend to be a loner	0 1 2 3	Excessive hair loss	0 1 2 3
I don't care much about others	0 1 2 3	General sense of bloating	0 1 2 3
People tell me I am too rigid and inflexible	0 1 2 3	Joint and tissue swelling for no reason	0 1 2 3
I have low motivation	0 1 2 3	Hormonal imbalances	0 1 2 3
I have poor follow through even on things I want to do	0 1 2 3	Unexplained weight gain	0 1 2 3
ACETYLCHOLINE BALANCE		Poor bowel function	0 1 2 3
Poor recall for images and shapes	0 1 2 3	Bad/foul smelling sweat	0 1 2 3
Poor word recall	0 1 2 3		
Poor memory or "senior moments"	0 1 2 3	**SECTION E – ENERGY, EXERCISE & SLEEP PROFILE**	
Can't do easy math anymore	0 1 2 3	Morning fatigue	0 1 2 3
Harder to learn and retain things than before	0 1 2 3	Afternoon fatigue/slump	0 1 2 3
Get lost sometimes	0 1 2 3	I "wake up" when it's time to go to bed	0 1 2 3
Can't remember faces or objects	0 1 2 3	I have problems falling asleep	0 1 2 3
Family history of dementia/Alzheimer's	0 1 2 3	I have problems staying asleep	0 1 2 3
GABA BALANCE		Number of times you wake up at night	0 1 2 3+
Feel nervous and anxious for no reason	0 1 2 3	If I wake up at night I am:	
Knot in my stomach	0 1 2 3	*Restless and toss and turn for a while*	0 1 2 3
Worry over simple/daily decisions	0 1 2 3	*Wide awake enough to get up and do stuff*	0 1 2 3
Can't turn mind off at night	0 1 2 3	*Some degree of heart racing, sweats and/or anxiety*	0 1 2 3
Sense of inner tension, trembling	0 1 2 3	I wake up feeling poorly rested and unrecovered	0 1 2 3
Scattered thoughts and disorganized	0 1 2 3	I am usually in bed and lights out by (time)	0 1 2 3
Anxiety or panic attacks	0 1 2 3	I usually wake up and am out of bed by (time)	0 1 2 3

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EXERCISE AND DAILY ACTIVITY	
My Activity Level is best described as	YES
Sedentary: Little or no exercise/desk job	YES
Lightly Active: Light exercise/sports 1-3 days/week	YES
Moderately Active: Moderate exercise 3-5 days/week	YES
Very Active: Heavy exercise/sports 6-7 days/week	YES
Extremely Active: Very heavy exercise/physical labor	YES
I am unhappy with my current conditioning level	0 1 2 3
I don't tolerate any exercise	0 1 2 3
I can exercise a little but it's easy to overdo it	0 1 2 3
I can exercise rigorously and recover well	0 1 2 3
SECTION F - FOOD SENSITIVITIES	NO YES
I have had prior POSITIVE food sensitivity testing	NO YES
I suspect I have sensitivities but don't know what they are	NO YES
Certain foods cause symptoms that are not in my gut	
SECTION G- GUT HEALTH	
GENERAL GUT HEALTH	
Prior diagnosis of:	NONE
Gluten sensitivity	YES
Celiac Disease	YES
Irritable Bowel Syndrome	YES
Crohn's Disease	YES
Ulcerative Colitis	YES
History of abdominal surgery	YES
Has your Gallbladder been removed?	YES
HCL & PROTEIN TOLERANCE	0 1 2 3
Common/frequent belching, burping and bloating	0 1 2 3
Gas immediately following a meal	0 1 2 3
Bad breath	0 1 2 3
Feels like food/protein just sits in my stomach	0 1 2 3
Feel full during and right after meals	0 1 2 3
Use antacids for heartburn	0 1 2 3
Stomach pain, burning or aching 1-4 hours after eating	0 1 2 3
Heartburn with position changes	0 1 2 3
Heartburn worse with specific foods	0 1 2 3
Digestion problems get better with less stress	0 1 2 3
Prior diagnosis of reflux and/or ulcers	0 1 2 3
SMALL INTESTINAL HEALTH	
Gut bloats/distends after eating sugars, starches or fibers	0 1 2 3
Gut bloats/distends after using probiotics	0 1 2 3
Constipation	0 1 2 3
Loose stools/diarrhea	0 1 2 3
Alternating loose stools and constipation	0 1 2 3
PANCREAS	
Intolerant to roughage and fibrous foods	0 1 2 3
Indigestion and fullness starts 2-4 hours after eating	0 1 2 3
Pain, tenderness, sense of fullness under left side ribs	0 1 2 3
Nausea and/or vomiting	0 1 2 3
Undigested food in stool	0 1 2 3
History of high blood sugar problems	0 1 2 3
GALL BLADDER	
History of Gallstones or GB attacks?	0 1 2 3
High fat foods cause abdominal distress?	0 1 2 3
Sense of fullness/discomfort under right side of rib cage	0 1 2 3
Bitter, metallic taste in mouth, especially in the morning?	0 1 2 3
Unexplained itchy skin	0 1 2 3
Burp up fish oils	0 1 2 3
Yellowish cast to eyes	0 1 2 3
Stool sometimes clay colored	0 1 2 3

LARGE INTESTINE AND COLON	
Feel like bowels don't empty completely	0 1 2 3
Flatulence	0 1 2 3
Large amounts of foul smelling gas	0 1 2 3
Lower abdominal pain relieved after passing gas	0 1 2 3
Gas and or bloating that comes on 3-4 hours after eating	0 1 2 3
More than 3 bowel movements daily	0 1 2 3
Hard, dry or small stool	0 1 2 3
Frequent use of laxatives	0 1 2 3
Mucus or pus in stool	0 1 2 3
Tongue is fuzzy or has white coat	0 1 2 3
LEAKY GUT POTENTIAL	0 1 2 3
Suspect malabsorption and/or nutritional deficiencies?	0 1 2 3
Reacting to more foods than ever before	0 1 2 3
Reactions to foods are not consistent/unpredictable	0 1 2 3
Unpredictable abdominal swelling/bloating	0 1 2 3
Frequent prior use of antibiotics?	0 1 2 3
SECTION H - HORMONE BALANCE	
LOW THYROID SYMPTOMS	
Prior diagnosis of Hypothyroidism	0 1 2 3
Fatigue	0 1 2 3
Cold hand and feet	0 1 2 3
Easily gain weight	0 1 2 3
Need more sleep to function	0 1 2 3
Constipation	0 1 2 3
Losing hair (head, body or genitals)	0 1 2 3
Losing outer third of eyebrow	0 1 2 3
Depression and/or low motivation	0 1 2 3
Brain fog/poor mental endurance	0 1 2 3
Dry skin and scalp	0 1 2 3
Morning headaches that wear off over time	0 1 2 3
HIGH THYROID SMYPTOMS	
Heart palpitations	0 1 2 3
Nervousness	0 1 2 3
Jittery inside	0 1 2 3
High resting heart rate (greater than 72 beats per minute	0 1 2 3
Insomnia	0 1 2 3
MALE HORMONE BALANCE	
Low sex drive	0 1 2 3
Soft erections	0 1 2 3
Can't maintain erection	0 1 2 3
Fewer morning erections	0 1 2 3
Increased body fat around hips, waist and chest	0 1 2 3
More emotional than in the past	0 1 2 3
Sweating attacks	0 1 2 3
Lost sense of vigor and youthfulness	0 1 2 3

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WOMEN (MENSTRUATING)	
Age menses started: _____	
Are you perimenopausal? NO YES Unsure	
Use of birth control pill: Now In Past Never	
How Long? _____	
Is your cycle (choose one)?	
Absent *< 28 days* *28-32 days* *>32 days*	0 1 2 3
Blood flow is: Absent Light Heavy Variable	0 1 2 3
PMS symptoms the week before cycle	0 1 2 3
Mood changes before/during cycle	0 1 2 3
Pain and cramping during period	0 1 2 3
Breast pain and tenderness during cycle	0 1 2 3
Pelvic pain during cycle	0 1 2 3
Acne comes on/worsens during cycle	0 1 2 3
History of PCOS? NO YES Unsure	
WOMEN (POST MENOPAUSE)	
Year Menopause started:	
On hormone replacement? NO YES In Past Never	
Estrogen Progesterone Testosterone DHEA	
Type Used: Bioidentical Synthetic	
How Delivered: Pill Cream Injection	
Since menopause have you had any uterine bleeding?	0 1 2 3
Hot flashes	0 1 2 3
Brain fog after menopause started	0 1 2 3
Low libido	0 1 2 3
Mood swings	0 1 2 3
Depression or mood swings associated with menopause	0 1 2 3
Adult Acne	0 1 2 3
Shrinking breast tissue	0 1 2 3
Vaginal dryness, pain or itching	0 1 2 3
Painful intimacy	0 1 2 3

SECTION I – IMMUNE BALANCE AND CONTROL	
INFLAMMATION	0 1 2 3
Unexplained joint and/muscle pain	0 1 2 3
Unexplained joint swelling	0 1 2 3
Fatigue with stress or immune challenge	0 1 2 3
Brain fog with stress or immune challenge	0 1 2 3
Can't lose weight despite good diet and exercise	0 1 2 3
Scale goes up/down 2-4 pounds/1-2 kg overnight	0 1 2 3
INFECTIONS	
Known/suspect gut infections	0 1 2 3
Known suspected chronic viral infections	0 1 2 3
Chronic or recurrent sinus infections	0 1 2 3
Unexplained, persistent low grade fever	0 1 2 3
Unexplained fever that comes and goes	0 1 2 3
Symptoms that come and go for no apparent reason	0 1 2 3
Known/suspected Lyme infection/coinfection	0 1 2 3
For Women: History of vaginal infections	0 1 2 3
For Women: History of recurrent UTI	0 1 2 3
CHEMICAL SENSITIVITY	0 1 2 3
Known allergies to grass, pollen, weeds etc.	0 1 2 3
Intolerance to odors and smells	0 1 2 3
Intolerance to shampoos, lotions, detergents etc.	0 1 2 3
Multiple smell and chemical sensitivities	0 1 2 3
Skin reacts to jewelry	0 1 2 3
Sensitive to smell/presence of mold	0 1 2 3
Known/suspected exposure to mold	0 1 2 3
HISTORY OF AUTOIMMUNITY	NO
Personal history of autoimmunity (Select all that apply)	YES
Hashimoto's Hypothyroidism	YES
Grave's Disease	YES
Type 1 Diabetes	YES
Multiple Sclerosis	YES
Lupus/Sjogren's	YES
Rheumatoid Arthritis	
Other: _____	NO YES
Family history of autoimmune disease of any kind?	

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