Nutritional Consultation Informed Consent & Evaluation Forms Synergistic Nutrition is a Private Health Care Membership Association

In order to speak freely without censorship to our conversation and in order to utilize our right to freedom of speech, freedom of association and freedom to choose the type of health care you want to learn about and utilize, we must take our matters out of the public domain and bring them into the private by means of a private agreement format.

By signing this agreement you acknowledge and agree to the following. Stephen Heuer is a Degreed Nutripath not recognized by any State of Federal Agency as a medical practitioner. Stephen is not a medical doctor and does not claim to be able to diagnose, treat or cure disease. He asserts that to every ailment there is a cause or combination of causes that need to be identified and removed. Once the cause(s) are removed and the body is properly nourished physically, mentally and emotionally then the bodies own innate selff healing capacity becomes activated to heal itself of whatever the disease label is.

By signing this document you agree to be a Member of The Private Health Care Association of Synergistic Nutrition. You understand that you have taken your health care needs out of the public domain and chosen to address them in the context of a private association. In a private agreement all disputes are solved between the parties and no governmental agency can be called upon to try to resolve the matter.

Under certain circumstances looking at a drop of your blood under the microscope may be used to further understand and educate you on the status of your health. If such is required, you agree to allow Stephen to prick your finger to get a few drops of blood.

Stephen uses the Qest4 Device, which enables him to preform a Meridian Stress Assessment test. This test has evolved from the early 1950's to a very sophisticated and accurate means of finding imbalances in the body. Based upon empirical evidence using this form of testing has consistently proven accurate when scanning someone in person or remotely with only a specimen of his or her hair. This scan and typing up the recommendations can take up to 2.5 hours or more to perform in conjunction with looking at your health evaluation form. You will need to send a teaspoon amount of hair in a zip lock bag if you have no hair then you can send two Qf tips with saliva swabbed on them and two Qf tips with with urine on it, in a zip lock bag. You will need to send the specimens to Stephen Heuer, 160 Dewey Rd. Greer, SC 29651.

I agree that the information being sought is of a nutritional nature and is not for medical diagnosis, or treatment of any disease. I understand that this facility accepts specimens for research purposes only. I hereby certify that I am not an employee, agent, or otherwise affiliated with the Food and Drug Administration, CLEA, or other

regulatory agencies. I understand that urine and saliva specimens are screenings for research purposes only and that the researcher conducting these sessions is not a Medical Doctor. I understand that any dietary guidelines or nutritional supplements I take, I do so under my own free will choice.

I understand that detoxification is normal and to be welcomed as part of the journey of healing. I also understand that reactions to foods and supplements are something that can be remedied by talking to Stephen Heuer or other health care provider and that this is my responsibility to be sensitive to and make adjustments where needed. I understand some ailments are of a mental/emotional/spiritual nature and as such may go unaffected by nutritional intervention. As such they can only be addressed at the mental/ emotional/spiritual level.

The cost for a consultation with Nutripath, Stephen Heuer is **$235** for a consultation. Follow up consultations are billed at a rate of $150 per hour in increments of 30 minutes. Stephen spends time creating your supplement schedule on his own time and this is also part of the time used to charge for his services. Please scan and email your health evaluation forms to stephen@sgn80.com or send physically to 160 Dewey Rd. Greer, SC 29651.

If applicable I agree to use my typed name on the signature line in lieu of an actual signature as proof that I've agreed to the terms and conditions of this document.

Signature

Printed Name Date

FIRST TIME EVALUATION

Please complete the following questions carefully. This information will help us to build a specialized Nutritional Program personally designed for you.

For in person Consultations do not take any supplements for 2 meals before evaluation.

Today's Date:_____Referred by: _____

Name:_____M____F____Birth date_____Age_____

Mailing Address: _____

City: _____State:_____Zip:_____Occupation: _____

Height:_____Weight:_____ Marital Status: ☐ S ☐ M ☐ D ☐ W No. of children: _____

Daytime phone: (_____)_____ Email _____

1. Complaints - Please rank your current complaints and rate their severity (on a scale of 1 to 10, 10 being the most severe):

_____

_____

2. Other Information - Please tell us any additional information or concerns about your health:

_____

_____

3. Medications - Please list any medications you are currently taking and how long you have taken them (*including birth control pills, aspirin, pain medications, etc*):

_____

_____

_____

_____

4. Surgeries - What surgeries, operations, traumas, car accidents, etc. have you had?

_____

_____

_____

a.) Do you have breast implants?_____Other surgical implants or prostheses?__
b.) Have you had elective surgery (tummy tuck, face-lift, burned off moles, etc)? _
c.) Do you have any metal or plastic inside your body (such as pins, clamps, plates, etc)?__
d.) Do you have pierced ears or other body piercings?_____

5. **Scars** - Describe any scars on your body (*major and minor ones):*

_____

_____

_____

_____

_____

6. **Drugs.** *This is strictly confidential information.*

Do you currently use recreational drugs? _____

If so, circle any of the following that you use:

Marijuana Cocaine Heroin Uppers Downers Other:_____

How often:_____

Have you used recreational drugs in the past?_____

If so, for how long?_____

7. **Stress** - Please rate your current stress level (on a scale off to 10, 10 being the highest stress):_____
What are the main reasons for your stress?

_____

_____

_____

If over level 5, what steps are you taking to reduce your stress level?

_____

_____

_____

_____

8. Dental Work. Indicate how many of the following you have.

Silver fillings in your life:_____	Composites(tooth colored): _____	Extractions: _____	Bridgework:_____
Partial/Full Dentures:_____	Gold Crowns or Inlays:_____	Veneers:_____	Stainless steel crowns/ inlays: _____
Root Canals: _____	Root Canals w BioCalex: _____	Posts: _____	Porcelain Crowns/ inlays: _____
Implants_____	Temporaries:_____	Braces: _____	DeGussa Porcelain crowns/inlays: ____
Bleeding Gums_____	Sensitive teeth: _____	Bad bite:_____	New Cavities: _____

Do you need further dental work?_____ If so, what?_____

9. Clothing - How often do you wear 100% natural clothing (*cotton, ramie, wool, silk, or linen*)? _____
Synthetic clothing *(polyester, acrylic, nylon, rayon, etc)?*_____Blends (natural fabric combined with synthetic)? _____

10. Personal Care Products - List the brand names that you use: (*Please take time to complete this list*.)

Shampoo?_____ Shave Cream? _____
Deodorant?_____ Dish Washing Soap? _____
Toothpaste?_____ Laundry Soap? _____
Soap?_____ Tub/Tile Cleaner? _____
Hand/Body Lotion?_____ Glass Cleaner? _____
Facial Cleanser/Moisturizer?_____ All Purpose Cleaner? ___
Hair Spray/Gel?_____ Perfume/Cologne? _____
Personal (sexual) Lubricant?_____ Roach/Ant Spray? _____
Contraceptive jelly/spermacide?_____ Toilet Freshener? _____
Hair Dye? _____ Hair Permanent? _____
Fingernail/Toenail Polish? _____
Other chemical exposure (from yard, workplace, art chemicals, etc.)? _____

11. Appliances - Circle which of the following you use:
Gas stove Electric stove Electric heater Electric blanket Water bed VitaMix Microwave
Oven Air Purifier (Brand:_____) Water Purifier (Brand:_____)

12. Cookware - What type of cookware do you use? *[**Circle:** stainless steel, aluminum, iron, teflon-coated, glass,Ultrex.]*
Other types: _____

13. Shower Filter - What brand of shower filter do you use (for chlorine protection)? _____
When was your filter last changed? _____

14. Pets - Do you have a pet(s)?_____If so, what kind/how many?_____
Is it allowed in the house?_____On your bed?_____What do you feed your pet(s)? _____

Food Choices

Circle each type of food you eat often:

1. **Pre-made foods**: a) canned food b) boxed cereals c) frozen dinners d) bottled or frozen juices e) take-out food
2. **Red meat** *(beef, pork, lamb):* a) commercially grown b) naturally raised (*Brand*:_____)
3. **Chicken**: a) commercially grown b) naturally raised (*Brand*:_____)
4. **Turkey**: a) commercially grown b) naturally raised (*Brand*:_____)
5. **Fish**: a) canned tuna b) fresh fish c) frozen fish d) at restaurants
6. **Fresh vegetables**: a) commercially grown (store-bought) b) organically grown (store-bought) c) organically grown *(direct from farmer)*
   d) from natural growers at a farmer's market
7. **Fresh fruit**: a) commercially grown (store-bought) c) organically grown (store-bought) c) organically grown *(direct from farme*
   d) from natural growers at a farmer's market
8. **Whole grains**: a) commercially grown (store-bought) b) organic (store-bought) c) biogenic *(from PR Labs)*
9. **Whole beans**: a) commercially grown (store-bought) b) organic (store-bought) c) biogenic *(from PR Labs)*
10. **Eggs/Butter**: a) commercial eggs (store-bought) b) naturally grown eggs c) commercial butter d) natural butter
11. **Milk**: a) commercial milk b) grass fed raw milk
12. **Cheese**: a) commercial cheese b) organic cheese (store-bought) c) recommended cheeses by Dr. Marshall
13. **Condiments**: a) commercial salt and/or pepper b) pink sea salt, Celtic salt c) artificial sweeteners *(Equal, Sweet 'NLow, Coffeemate, etc.)*
    d) commercial ketchup or mustard e) vinegar f) commercial olive oil g) PRL Moroccan Olive Oil

Food Stressors

Circle which of the following you have weekly. In the column, indicate how many times per week.

Stimulants		**Toxic Oils**		**Commercial Dairy**		**Highly Heated Foods**	
Coffee *(including decaf)*		Fried foods		Cow's Milk		Bread *(store-bought)*	
Black tea, caffeine drinks		Fast food		Yogurt		Crackers *(store-bought)*	
Soft drinks *(colas, etc.)*		Potato or corn chins		Ice cream		Bagels *(store-bought)*	
Drinks with NutraSweet		Roasted nuts		Cottage cheese		Buns *(store-bought)*	
Alcohol *(wine beer, etc.)*		Mayonnaise		Sour cream		Pasta *(store-bought)*	
Chocolate		Margarine		Cheese *(commercial)*		Muffins *(store-bought)*	
Candy pastries sweets		Peanut butter				Cookies *(store-bought)*	

Health Overview

For the following questions, circle the phrases that apply to you.

1. **Sleep** - How is your sleep? [**Circle:** restful, restless, hard to get to sleep, wake up often, get up during the night, bad dreams.] Other complaints?

_____

What time do you usually go to sleep?_____Number of hours of sleep per night?
_____Type of mattress?_____Type of pillow, sheets, covers, bedding?

_____

2. **Digestion** - How is your digestion? [**Circle:** adequate, poor, acid reflux, burp often, bloating, burning/pain in stomach.] Other complaints?

_____

3. **Urination -** How are your daily urinations? [**Circle:** every 2 to 3 hours, too frequent, sense of urgency, too small amount, too large amount, burning, dribbling, up at night several times.]
Other complaints?

_____

4. **Bowels -** How are your bowel eliminations? [**How often?** 3 times daily, once per day, skip days **Amount:** normal, too little, too large
Consistency: normal, too hard, very soft, diarrhea **Color:** brown, black, whitish **Other:** lots of mucus, lots of gas, foul smell] Other complaints?

_____

5. Women Only: Are you pregnant?_____Are you breast-feeding?_____Do you have monthly periods? _____
Date of last menstrual period?_____Are you going through menopause?_____Have your periods stopped? _____
Had a hysterectomy?_____(If so, when?_)

Are your monthly periods regular (28 day cycles)? _____
Number of days of your menstrual flow? _____
Circle any of the following symptoms you experience associated with your period: cramping, bloating, feeling weak, mood swings, cravings, heavy bleeding, back pain, headaches, bright red blood, dark dotty blood.
Other menstrual complaints?

_____

6. Exercise –
What kind of exercise do you do? _____

How often?_____
For how long at a time?_____

7. Sunlight .

-Amount of natural sunlight you receive daily outside?_____

-Amount of sunlight you receive daily through windows?_____

-Hours spent daily under fluorescent lights? _____

-Do you use Chromalux light bulbs at home?_____At work? _____

8. Eyewear - Do you wear contact lenses? _____Glasses?_____If so, how many hours per day? _____
Do your lenses have tints? _____ An anti-glare coating? _____ A scratch-resistant coating? _____

9. Electromagnetic Exposure - ***How many hours do you spend daily:***

Watching TV?_____
Wearing a pager?_____
Riding in a car/truck/vehicle?_____
Wearing a headset?_____
Talking on the phone?_____
Talking on a cellular phone?_____

Working on a computer?_____
Near electrical equipment for long periods of time?_____
EX-copy machines, power lines, computers
When you sleep is your head within 10 feet of a plug in clock?___
EX- Such as on a night stand
Wearing a wrist watch (with battery)?_____

Food Habits

1. Eating Out - Do you eat out at restaurants?_____If yes, how often?_____Where? _____
What type of food do you eat at restaurants? _____

2. Home Meals - Do you prepare meals at home?_____If so, how often? _____

3. If yes, what type of food do you prepare?_____

---

4. Meal Habits - ***Do You: [circle]*** a) skip meals often b) have irregular eating times c) eat food past 7 PM

5. MSG - Do you avoid food/drinks that list "natural flavors" (which means hidden MSG) on the label? _____

6. Water - Do you drink tap water?_____What brand of drinking water do you use?_____

7. If you have a home water purifier, when was the cartridge last changed? _____

Typical Diet

Please fill out your typical diet for the last few weeks. Please be as detailed as possible. (For example, instead of writing "chicken," identify what brand and how it was made such as "baked Foster Farms chicken. "Instead of writing "salad," identify what it made of such as "salad made with organic baby green lettuce, commercial cherry tomatoes and PRL Moroccan Olive Oil.) PLEASE, BE HONEST!

Do you prepare your own food most of the time? _____

What percentage of your diet is organic or hormone antibiotic free?_____

Please place a check mark after the following symptoms that most apply to you:

Category One:

- Very strong willed
- Competitive at sports
- Obsessive/compulsive tendencies
- Seasonal Allergies
- Addictive Tendencies
- High Libido
- Family history of high accomplishment
- Calm demeanor, but high inner tension
- High fluidity (tears, saliva, etc)
- Non-compliance with therapies

Please place a check mark after the following symptoms that most apply to you:

Category Two:

- High Anxiety, sleep disorder
- High energy, verbosity
- Artistic/musical ability
- Antihistamine Intolerance
- High Empathy for Others
- Non-competitive in sports
- Food and chemical sensitivities
- Absence of seasonal Allergies
- Low Libido, Dry Eyes and mouth
- Adverse reaction to SSRI's, Same, Methionine
- Low blood histamine, Elevated Same/sah ratio

PART I Read the following questions and circle the number that applies:

KEY: **0 = Do not consume or use** **2 = Consume or use weekly**
1 = Consume or use 2 to 3 times monthly **3 = Consume or use daily**

DIET

1. 0 1 2 3 Alcohol
2. 0 1 2 3 Artificial sweeteners
3. 0 1 2 3 Candy, desserts, refined sugar
4. 0 1 2 3 Carbonated beverages
5. 0 1 2 3 Chewing tobacco
6. 0 1 2 3 Cigarettes
7. 0 1 2 3 Cigars/pipes
8. 0 1 2 3 Caffeinated beverages
9. 0 1 2 3 Fast foods
10. 0 1 2 3 Fried foods
11. 0 1 2 3 Luncheon meats
12. 0 1 2 3 Margarine
13. 0 1 2 3 Milk products
14. 0 1 Radiation exposure (0=no, 1=yes)
15. 0 1 2 3 Refined flour/baked goods
16. 0 1 2 3 Vitamins and minerals
17. 0 1 2 3 Water, distilled
18. 0 1 2 3 Water, tap
19. 0 1 2 3 Water, well
20. 0 1 2 3 Diet often for weight control

LIFESTYLE

21. 0 1 2 3 Exercise per week (0 = 2 or more times a week, 1 = 1 time a week, 2 = 1 or 2 times a month, 3 = never, less than once a month)
22. 0 1 2 3 Changed jobs (0 = over 12 months ago, 1 = within last 12 months, 2 = within last 6 months, 3 = within last 2 months)
23. 0 1 2 3 Divorced (0 = never, over 2 years ago, 1 = within last 2 years, 2 = within last year, 3 = within last 6 months)
24. 0 1 2 3 Work over 60 hours/week (0 = never, 1 = occasionally, 2 = usually, 3 = always)

MEDICATIONS Indicate any medications you're currently taking or have taken in the last month (0=no, 1=yes):

25. 0 1 Antacids
26. 0 1 Antianxiety medications
27. 0 1 Antibiotics
28. 0 1 Anticonvulsants
29. 0 1 Antidepressants
30. 0 1 Antifungals
31. 0 1 Aspirin/Ibuprofen
32. 0 1 Asthma inhalers
33. 0 1 Beta blockers
34. 0 1 Birth control pills/implant contraceptives
35. 0 1 Chemotherapy
36. 0 1 Cholesterol lowering medications
37. 0 1 Cortisone/steroids
38. 0 1 Diabetic medications/insulin
39. 0 1 Diuretics
40. 0 1 Estrogen or progesterone (pharmaceutical, prescription)
41. 0 1 Estrogen or progesterone (natural)
42. 0 1 Heart medications
43. 0 1 High blood pressure medications
44. 0 1 Laxatives
45. 0 1 Recreational drugs
46. 0 1 Relaxants/Sleeping pills
47. 0 1 Testosterone (natural or prescription)
48. 0 1 Thyroid medication
49. 0 1 Acetaminophen (Tylenol)
50. 0 1 Ulcer medications
51. 0 1 Sildenafal citrate (Viagra)

PART II (See key at bottom of page)

Section 1 – Upper Gastrointestinal System

52. 0 1 2 3 Belching or gas within one hour after eating
53. 0 1 2 3 Heartburn or acid reflux
54. 0 1 2 3 Bloating within one hour after eating
55. 0 1 Vegan diet (no dairy, meat, fish or eggs) (0=no, 1=yes)
56. 0 1 2 3 Bad breath (halitosis)
57. 0 1 2 3 Loss of taste for meat
58. 0 1 2 3 Sweat has a strong odor
59. 0 1 2 3 Stomach upset by taking vitamins
60. 0 1 2 3 Sense of excess fullness after meals
61. 0 1 2 3 Feel like skipping breakfast
62. 0 1 2 3 Feel better if you don't eat
63. 0 1 2 3 Sleepy after meals
64. 0 1 2 3 Fingernails chip, peel or break easily
65. 0 1 2 3 Anemia unresponsive to iron
66. 0 1 2 3 Stomach pains or cramps
67. 0 1 2 3 Diarrhea, chronic
68. 0 1 2 3 Diarrhea shortly after meals
69. 0 1 2 3 Black or tarry colored stools
70. 0 1 2 3 Undigested food in stool

KEY: 0=No, symptom does not occur
1=Yes, minor or mild symptom, rarely occurs (monthly)
2=Moderate symptom, occurs occasionally (weekly)
3=Severe symptom, occurs frequently (daily)

©2003 Nutritional Therapy Association, Inc.® All Rights Reserved.

Section 2 – Liver and Gallbladder

71. 0 1 2 3 Pain between shoulder blades
72. 0 1 2 3 Stomach upset by greasy foods
73. 0 1 2 3 Greasy or shiny stools
74. 0 1 2 3 Nausea
75. 0 1 2 3 Sea, car, airplane or motion sickness
76. 0 1 History of morning sickness (0 = no, 1 = yes)
77. 0 1 2 3 Light or clay colored stools
78. 0 1 2 3 Dry skin, itchy feet or skin peels on feet
79. 0 1 2 3 Headache over eyes
80. 0 1 2 3 Gallbladder attacks (0=never, 1=years ago, 2=within last year, 3=within past 3 months)
81. 0 1 Gallbladder removed (0=no, 1=yes)
82. 0 1 2 3 Bitter taste in mouth, especially after meals
83. 0 1 Become sick if you were to drink wine (0=no, 1=yes)
84. 0 1 Easily intoxicated if you were to drink wine (0=no, 1=yes)
85. 0 1 Easily hung over if you were to drink wine (0=no, 1=yes)
86. 0 1 2 3 Alcohol per week (0=<3, 1=<7, 2 =<14, 3=>14)
87. 0 1 Recovering alcoholic (0=no, 1=yes)
88. 0 1 History of drug or alcohol abuse (0=no, 1=yes)
89. 0 1 History of hepatitis (0=no, 1=yes)
90. 0 1 Long term use of prescription/recreational drugs (0=no, 1=yes)
91. 0 1 2 3 Sensitive to chemicals (perfume, cleaning agents, etc.)
92. 0 1 2 3 Sensitive to tobacco smoke
93. 0 1 2 3 Exposure to diesel fumes
94. 0 1 2 3 Pain under right side of rib cage
95. 0 1 2 3 Hemorrhoids or varicose veins
96. 0 1 2 3 Nutrasweet (aspartame) consumption
97. 0 1 2 3 Sensitive to Nutrasweet (aspartame)
98. 0 1 2 3 Chronic fatigue or Fibromyalgia

Section 3 – Small Intestine

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

Section 4 – Large Intestine

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

Section 5 – Mineral Needs

136. 0 1 History of carpal tunnel syndrome (0=no, 1=yes)
137. 0 1 History of lower right abdominal pains or ileocecal valve problems (0=no, 1=yes)
138. 0 1 History of stress fracture (0=no, 1=yes)
139. 0 1 2 3 Bone loss (reduced density on bone scan)
140. 0 1 Are you shorter than you used to be? (0=no, 1=yes)
141. 0 1 2 3 Calf, foot or toe cramps at rest
142. 0 1 2 3 Cold sores, fever blisters or herpes lesions
143. 0 1 2 3 Frequent fevers
144. 0 1 2 3 Frequent skin rashes and/or hives
145. 0 1 Herniated disc (0=no, 1=yes)
146. 0 1 2 3 Excessively flexible joints, "double jointed"
147. 0 1 2 3 Joints pop or click
148. 0 1 2 3 Pain or swelling in joints
149. 0 1 2 3 Bursitis or tendonitis
150. 0 1 History of bone spurs (0=no, 1=yes)
151. 0 1 2 3 Morning stiffness
152. 0 1 2 3 Nausea with vomiting
153. 0 1 2 3 Crave chocolate
154. 0 1 2 3 Feet have a strong odor
155. 0 1 2 3 History of anemia
156. 0 1 2 3 Whites of eyes (sclera) blue tinted
157. 0 1 2 3 Hoarseness
158. 0 1 2 3 Difficulty swallowing
159. 0 1 2 3 Lump in throat
160. 0 1 2 3 Dry mouth, eyes and/or nose
161. 0 1 2 3 Gag easily
162. 0 1 2 3 White spots on fingernails
163. 0 1 2 3 Cuts heal slowly and/or scar easily
164. 0 1 2 3 Decreased sense of taste or smell

KEY: 0=No, symptom does not occur
1=Yes, minor or mild symptom, rarely occurs (monthly)
2=Moderate symptom, occurs occasionally (weekly)
3=Severe symptom, occurs frequently (daily)

©2003 Nutritional Therapy Association, Inc.® All Rights Reserved.

Section 6 – Essential Fatty Acids

165. 0 1 Experience pain relief with aspirin (0=no, 1=yes)
166. 0 1 2 3 Crave fatty or greasy foods
167. 0 1 2 3 Low- or reduced-fat diet (0=never, 1=years ago, 2=within past year, 3=currently)
168. 0 1 2 3 Tension headaches at base of skull
169. 0 1 2 3 Headaches when out in the hot sun
170. 0 1 2 3 Sunburn easily or suffer sun poisoning
171. 0 1 2 3 Muscles easily fatigued
172. 0 1 2 3 Dry flaky skin or dandruff

Section 7 – Sugar Handling

173. 0 1 2 3 Awaken a few hours after falling asleep, hard to get back to sleep
174. 0 1 2 3 Crave sweets
175. 0 1 2 3 Binge or uncontrolled eating
176. 0 1 2 3 Excessive appetite
177. 0 1 2 3 Crave coffee or sugar in the afternoon
178. 0 1 2 3 Sleepy in afternoon
179. 0 1 2 3 Fatigue that is relieved by eating
180. 0 1 2 3 Headache if meals are skipped or delayed
181. 0 1 2 3 Irritable before meals
182. 0 1 2 3 Shaky if meals delayed
183. 0 1 2 3 Family members with diabetes (0=none, 1=1 or 2, 2=3 or 4, 3=more than 4)
184. 0 1 2 3 Frequent thirst
185. 0 1 2 3 Frequent urination

Section 8 – Vitamin Need

186. 0 1 2 3 Muscles become easily fatigued
187. 0 1 2 3 Feel exhausted or sore after moderate exercise
188. 0 1 2 3 Vulnerable to insect bites
189. 0 1 2 3 Loss of muscle tone, heaviness in arms/legs
190. 0 1 2 3 Enlarged heart or congestive heart failure
191. 0 1 2 3 Pulse below 65 per minute (0=no, 1=yes)
192. 0 1 2 3 Ringing in the ears (Tinnitus)
193. 0 1 2 3 Numbness, tingling or itching in hands and feet
194. 0 1 2 3 Depressed
195. 0 1 2 3 Fear of impending doom
196. 0 1 2 3 Worrier, apprehensive, anxious
197. 0 1 2 3 Nervous or agitated
198. 0 1 2 3 Feelings of insecurity
199. 0 1 2 3 Heart races
200. 0 1 2 3 Can hear heart beat on pillow at night
201. 0 1 2 3 Whole body or limb jerk as falling asleep
202. 0 1 2 3 Night sweats
203. 0 1 2 3 Restless leg syndrome
204. 0 1 2 3 Cracks at corner of mouth (Cheilosis)
205. 0 1 2 3 Fragile skin, easily chaffed, as in shaving
206. 0 1 2 3 Polyps or warts
207. 0 1 2 3 MSG sensitivity
208. 0 1 2 3 Wake up without remembering dreams
209. 0 1 2 3 Small bumps on back of arms
210. 0 1 2 3 Strong light at night irritates eyes
211. 0 1 2 3 Nose bleeds and/or tend to bruise easily
212. 0 1 2 3 Bleeding gums especially when brushing teeth

Section 9 – Adrenal

213. 0 1 2 3 Tend to be a "night person"
214. 0 1 2 3 Difficulty falling asleep
215. 0 1 2 3 Slow starter in the morning
216. 0 1 2 3 Tend to be keyed up, trouble calming down
217. 0 1 2 3 Blood pressure above 120/80
218. 0 1 2 3 Headache after exercising
219. 0 1 2 3 Feeling wired or jittery after drinking coffee
220. 0 1 2 3 Clench or grind teeth
221. 0 1 2 3 Calm on the outside, troubled on the inside
222. 0 1 2 3 Chronic low back pain, worse with fatigue
223. 0 1 2 3 Become dizzy when standing up suddenly
224. 0 1 2 3 Difficulty maintaining manipulative correction
225. 0 1 2 3 Pain after manipulative correction
226. 0 1 2 3 Arthritic tendencies
227. 0 1 2 3 Crave salty foods
228. 0 1 2 3 Salt foods before tasting
229. 0 1 2 3 Perspire easily
230. 0 1 2 3 Chronic fatigue, or get drowsy often
231. 0 1 2 3 Afternoon yawning
232. 0 1 2 3 Afternoon headache
233. 0 1 2 3 Asthma, wheezing or difficulty breathing
234. 0 1 2 3 Pain on the medial or inner side of the knee
235. 0 1 2 3 Tendency to sprain ankles or "shin splints"
236. 0 1 2 3 Tendency to need sunglasses
237. 0 1 2 3 Allergies and/or hives
238. 0 1 2 3 Weakness, dizziness

Section 10 – Pituitary

239. 0 1 Height over 6' 6" (0=no, 1=yes)
240. 0 1 Early sexual development (before age 10) (0=no, 1=yes)
241. 0 1 2 3 Increased libido
242. 0 1 2 3 Splitting type headache
243. 0 1 2 3 Memory failing
244. 0 1 Tolerate sugar, feel fine when eating sugar (0=no, 1=yes)
245. 0 1 Height under 4' 10" (0=no, 1=yes)
246. 0 1 2 3 Decreased libido
247. 0 1 2 3 Excessive thirst
248. 0 1 2 3 Weight gain around hips or waist
249. 0 1 2 3 Menstrual disorders
250. 0 1 Delayed sexual development (after age 13) (0=no, 1=yes)
251. 0 1 2 3 Tendency to ulcers or colitis

KEY: 0=No, symptom does not occur
1=Yes, minor or mild symptom, rarely occurs (monthly)
2=Moderate symptom, occurs occasionally (weekly)
3=Severe symptom, occurs frequently (daily)

©2003 Nutritional Therapy Association, Inc.® All Rights Reserved.

Section 11 – Thyroid

252. 0 1 2 3 Sensitive/allergic to iodine
253. 0 1 2 3 Difficulty gaining weight, even with large appetite
254. 0 1 2 3 Nervous, emotional, can't work under pressure
255. 0 1 2 3 Inward trembling
256. 0 1 2 3 Flush easily
257. 0 1 2 3 Fast pulse at rest
258. 0 1 2 3 Intolerance to high temperatures
259. 0 1 2 3 Difficulty losing weight
260. 0 1 2 3 Mentally sluggish, reduced initiative
261. 0 1 2 3 Easily fatigued, sleepy during the day
262. 0 1 2 3 Sensitive to cold, poor circulation (cold hands and feet)
263. 0 1 2 3 Constipation, chronic
264. 0 1 2 3 Excessive hair loss and/or coarse hair
265. 0 1 2 3 Morning headaches, wear off during the day
266. 0 1 2 3 Loss of lateral 1/3 of eyebrow
267. 0 1 2 3 Seasonal sadness

Section 12 – Men Only

268. 0 1 2 3 Prostate problems
269. 0 1 2 3 Difficulty with urination, dribbling
270. 0 1 2 3 Difficult to start and stop urine stream
271. 0 1 2 3 Pain or burning with urination
272. 0 1 2 3 Waking to urinate at night
273. 0 1 2 3 Interruption of stream during urination
274. 0 1 2 3 Pain on inside of legs or heels
275. 0 1 2 3 Feeling of incomplete bowel evacuation
276. 0 1 2 3 Decreased sexual function

Section 13 – Women Only

277. 0 1 2 3 Depression during periods
278. 0 1 2 3 Mood swings associated with periods (PMS)
279. 0 1 2 3 Crave chocolate around periods
280. 0 1 2 3 Breast tenderness associated with cycle
281. 0 1 2 3 Excessive menstrual flow
282. 0 1 2 3 Scanty blood flow during periods
283. 0 1 2 3 Occasional skipped periods
284. 0 1 2 3 Variations in menstrual cycles
285. 0 1 2 3 Endometriosis
286. 0 1 2 3 Uterine fibroids
287. 0 1 2 3 Breast fibroids, benign masses
288. 0 1 2 3 Painful intercourse (dysparenia)
289. 0 1 2 3 Vaginal discharge
290. 0 1 2 3 Vaginal dryness
291. 0 1 2 3 Vaginal itchiness
292. 0 1 2 3 Gain weight around hips, thighs and buttocks
293. 0 1 2 3 Excess facial or body hair
294. 0 1 2 3 Hot flashes
295. 0 1 2 3 Night sweats (in menopausal females)
296. 0 1 2 3 Thinning skin

Section 14 – Cardiovascular

297. 0 1 2 3 Aware of heavy and/or irregular breathing
298. 0 1 2 3 Discomfort at high altitudes
299. 0 1 2 3 "Air hunger" or sigh frequently
300. 0 1 2 3 Compelled to open windows in a closed room
301. 0 1 2 3 Shortness of breath with moderate exertion
302. 0 1 2 3 Ankles swell, especially at end of day
303. 0 1 2 3 Cough at night
304. 0 1 2 3 Blush or face turns red for no reason
305. 0 1 2 3 Dull pain or tightness in chest and/or radiate into right arm, worse with exertion
306. 0 1 2 3 Muscle cramps with exertion

Section 15 – Kidney and Bladder

307. 0 1 2 3 Pain in mid-back region
308. 0 1 2 3 Puffy around the eyes, dark circles under eyes
309. 0 1 History of kidney stones (0=no, 1=yes)
310. 0 1 2 3 Cloudy, bloody or darkened urine
311. 0 1 2 3 Urine has a strong odor

Section 16 – Immune system

312. 0 1 2 3 Runny or drippy nose
313. 0 1 2 3 Catch colds at the beginning of winter
314. 0 1 2 3 Mucus producing cough
315. 0 1 2 3 Frequent colds or flu (0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year)
316. 0 1 2 3 Other infections (sinus, ear, lung, skin, bladder, kidney, etc.) (0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year)
317. 0 1 2 3 Never get sick (0 = sick only 1 or 2 times in last 2 years, 1 = not sick in last 2 years, 2 = not sick in last 4 years, 3 = not sick in last 7 years)
318. 0 1 2 3 Acne (adult)
319. 0 1 2 3 Itchy skin (Dermatitis)
320. 0 1 2 3 Cysts, boils, rashes
321. 0 1 2 3 History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue Syndrome, Hepatitis or other chronic viral condition (0 = no, 1 = yes in the past, 2 = currently mild condition, 3 = severe)

KEY: 0=No, symptom does not occur
1=Yes, minor or mild symptom, rarely occurs (monthly)
2=Moderate symptom, occurs occasionally (weekly)
3=Severe symptom, occurs frequently (daily)

©2003 Nutritional Therapy Association, Inc.® All Rights Reserved.