525 Main Street, #200
New Brighton, MN 55112
p. (651) 797-4822
f. (651) 796-0209
FrontDesk@NourishFamilyWellness.com

Welcome!

We are thankful that you have chosen our office for your family's care.

The care we provide acknowledges that your health is affected by many different aspects of life. This whole-person approach allows us to better care for your body's internal healing mechanisms. We ask you to think about all aspects of your health prior to your visit so that we can have a meaningful and productive conversation during your appointment.

Taking the time now to record the details of your health helps us to be thorough and saves time during the appointment so that we have more time to address your specific concerns.

We recognize that it takes time to complete these forms. We encourage you to see this as an opportunity to reflect upon your health and your life. This is the first step towards health and energy replenishment.

Please complete and bring the following with you to your appointment:

- ☐ New Client Paperwork
- ☐ Health Questionaire - Please bring all medication and supplement bottles
- ☐ Candida Questionaire
- ☐ Hormone Questionaire
- ☐ Scheduling and Payment Policy - Review and sign
- ☐ Detox Questionaire

Also included in this packet is information about services, pricing, directions, and parking. Please arrive 10 minutes prior to your appointment to allow time for check- in. If you have questions about any of the forms, please contact us at 651-797-4822.

We look forward to partnering with you in true health.

Warm Thanks,

The Team @ Nourish Family Wellness

PRINTED NAME_____

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist(s) who now or in the future treat me.

I understand that methods of treatment may include, but are not limited to, acupuncture, Chinese herbal medicine, and nutritional counseling. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment, which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

(Or Patient Representative)
PATIENT SIGNATURE:_____Date_____

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Billing Codes

Service	Billing Codes
Consultation for Health & Exam	Billed as routine office visit: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, & 99215
Spinal Chiropractic Adjustments	98940, 98941, 98942
Extremity Chiropractic Adjustments	98943, 98943-59
Acupuncture	97810-52
Nutrition Consultation	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, & 99215
Exercise Instruction	97110
NMS Re-ed	97112
Manual Therapy	97140-59
Massage	97124
Supplements/Orthotics	99070-D
Splinting/Taping	97504
Heat/Cryo Therapy	97010

HEALTH HISTORY

Name _____ Date of Birth _____ Today's Date _____

Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____

Marital Status: ❑ Single ❑ Partner ❑ Married ❑ Separated ❑ Divorced ❑ Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit: Date began:

_____ _____

_____ _____

Date of last physical exam _____ Practitioner name and phone number _____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

_____

Outcome _____

What types of therapy have you tried for this problem(s):

❑ diet modification ❑ fasting ❑ vitamins/minerals ❑ herbs ❑ homeopathy ❑ chiropractic ❑ acupuncture ❑ conventional drugs

❑ other _____

List current health problems for which you are being treated: _____

_____

Current medications (prescription or over-the-counter): _____

_____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: ❑ underweight ❑ overweight ❑ just right Your weight today _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, farmer, miner)?

_____

❑ Corrective lenses ❑ Dentures ❑ Hearing aid ❑ Medical devices/prosthetics/implants, describe: _____

Recent changes in your ability to: ❑ see ❑ hear ❑ taste ❑ smell ❑ feel hot/cold sensations

❑ move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)

Strong like for any of the following flavors: ❑ sour ❑ bitter ❑ sweet ❑ rich/fatty ❑ spicy/pungent ❑ salty

Strong dislike for any one of the following flavors: ❑ sour ❑ bitter ❑ sweet ❑ rich/fatty ❑ spicy/pungent ❑ salty

Do you: ❑ Prefer warmth (i.e., food, drinks, weather, etc.) ❑ Prefer cold (i.e., food, drinks, weather, etc.) ❑ No preference

Is your sleep disturbed at the same time each night? _____ If yes, what time? _____

Time of day you feel the most energy or the least symptoms:

❑ 7 a.m. - 9 a.m. ❑ 9 a.m. - 11 a.m. ❑ 11 a.m. - 1 p.m.
❑ 1 p.m. - 3 p.m. ❑ 3 p.m. - 5 p.m. ❑ 5 p.m. - 7 p.m.
❑ 7 p.m. - 9 p.m. ❑ 9 p.m. - 11 p.m. ❑ 11 p.m. - 1 a.m.
❑ 1 a.m. - 3 a.m. ❑ 3 a.m. - 5 a.m. ❑ 5 a.m. - 7 a.m.

Time of day you feel the worst or your symptoms are aggravated:

❑ 7 a.m. - 9 a.m. ❑ 9 a.m. - 11 a.m. ❑ 11 a.m. - 1 p.m.
❑ 1 p.m. - 3 p.m. ❑ 3 p.m. - 5 p.m. ❑ 5 p.m. - 7 p.m.
❑ 7 p.m. - 9 p.m. ❑ 9 p.m. - 11 p.m. ❑ 11 p.m. - 1 a.m.
❑ 1 a.m. - 3 a.m. ❑ 3 a.m. - 5 a.m. ❑ 5 a.m. - 7 a.m.

Do you experience any of these general symptoms EVERY DAY?

❑ Debilitating fatigue	❑ Shortness of breath	❑ Insomnia	❑ Constipation	❑ Chronic pain/inflammation
❑ Depression	❑ Panic attacks	❑ Nausea	❑ Fecal incontinence	❑ Bleeding
❑ Disinterest in sex	❑ Headaches	❑ Vomiting	❑ Urinary incontinence	❑ Discharge
❑ Disinterest in eating	❑ Dizziness	❑ Diarrhea	❑ Low grade fever	❑ Itching/rash

Medical History

- ❑ Arthritis
- ❑ Allergies/hay fever
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Autoimmune disease
- ❑ Blood pressure problems
- ❑ Bronchitis
- ❑ Cancer
- ❑ Chronic fatigue syndrome
- ❑ Carpal tunnel syndrome
- ❑ Cholesterol, elevated
- ❑ Circulatory problems
- ❑ Colitis
- ❑ Dental problems
- ❑ Depression
- ❑ Diabetes
- ❑ Diverticular disease
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Epilepsy
- ❑ Emphysema
- ❑ Eyes, ears, nose, throat problems
- ❑ Environmental sensitivities
- ❑ Fibromyalgia
- ❑ Food intolerance
- ❑ Gastroesophageal reflux disease
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart disease
- ❑ Infection, chronic
- ❑ Inflammatory bowel disease
- ❑ Irritable bowel syndrome
- ❑ Kidney or bladder disease
- ❑ Learning disabilities
- ❑ Liver or gallbladder disease (stones)
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological problems (Parkinson's, paralysis)
- ❑ Sinus problems
- ❑ Stroke
- ❑ Thyroid trouble
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Sexually transmitted disease
- ❑ Seasonal affective disorder
- ❑ Skin problems
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Urinary tract infection
- ❑ Varicose veins

Other _____

_____

Medical (Men)

- ❑ Benign prostatic hyperplasia (BPH)
- ❑ Prostate cancer
- ❑ Decreased sex drive
- ❑ Infertility
- ❑ Sexually transmitted disease

Other _____

_____

Medical (Women)

- ❑ Menstrual irregularities
- ❑ Endometriosis
- ❑ Infertility
- ❑ Fibrocystic breasts
- ❑ Fibroids/ovarian cysts
- ❑ Premenstrual syndrome (PMS)
- ❑ Breast cancer
- ❑ Pelvic inflammatory disease
- ❑ Vaginal infections
- ❑ Decreased sex drive
- ❑ Sexually transmitted disease

Other _____

Age of first period _____

Date of last gynecological exam ____

Mammogram ❑ + ❑ –

PAP ❑ + ❑ –

Form of birth control _____

# of children _____

# of pregnancies _____

❑ C-section _____

- ❑ Surgical menopause
- ❑ Menopause

Date of last menstrual cycle _____

Length of cycle _____ days

Interval of time between cycles _____ days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____

Family Health History (Parents and Siblings)

- ❑ Arthritis
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Heart disease
- ❑ Infertility
- ❑ Learning disabilities
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological disorders (Parkinson's, paralysis)
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Stroke
- ❑ Suicide

Other _____

Health Habits

❑ Tobacco:

Cigarettes: #/day _____

Cigars: #/day _____

❑ Alcohol:

Wine: #glasses/d or wk _____

Liquor: #ounces/d or wk _____

Beer: #glasses/d or wk _____

❑ Caffeine:

Coffee: #6 oz cups/d _____

Tea: #6 oz cups/d _____

Soda w/caffeine: #cans/d _____

Other sources _____

❑ Water: #glasses/d_____

Exercise

- ❑ 5-7 days per week
- ❑ 3-4 days per week
- ❑ 1-2 days per week
- ❑ 45 minutes or more duration per workout
- ❑ 30-45 minutes duration per workout
- ❑ Less than 30 minutes
- ❑ Walk
- ❑ Run, jog, jump rope
- ❑ Weight lift
- ❑ Swim
- ❑ Box
- ❑ Yoga

Nutrition & Diet

- ❑ Mixed food diet (animal and vegetable sources)
- ❑ Vegetarian
- ❑ Vegan
- ❑ Salt restriction
- ❑ Fat restriction
- ❑ Starch/carbohydrate restriction
- ❑ The Zone Diet
- ❑ Total calorie restriction

Specific food restrictions:

❑ dairy ❑ wheat ❑ eggs

❑ soy ❑ corn ❑ all gluten

Other _____

Food Frequency

Servings per day:

Fruits (citrus, melons, etc.) _____

Dark green or deep yellow/orange vegetables _____

Grains (unprocessed) _____

Beans, peas, legumes _____

Dairy, eggs _____

Meat, poultry, fish _____

Eating Habits

- ❑ Skip breakfast
- ❑ Two meals/day
- ❑ One meal/day
- ❑ Graze (small frequent meals)
- ❑ Food rotation
- ❑ Eat constantly whether hungry or not
- ❑ Generally eat on the run
- ❑ Add salt to food

Current Supplements

- ❑ Multivitamin/mineral
- ❑ Vitamin C
- ❑ Vitamin E
- ❑ EPA/DHA
- ❑ Evening Primrose/GLA
- ❑ Calcium, source _____
- ❑ Magnesium
- ❑ Zinc
- ❑ Minerals, describe _____
- ❑ Friendly flora (acidophilus)
- ❑ Digestive enzymes
- ❑ Amino acids
- ❑ CoQ10
- ❑ Antioxidants (e.g., lutein, resveratrol, etc.)
- ❑ Herbs - teas
- ❑ Herbs - extracts
- ❑ Chinese herbs
- ❑ Ayurvedic herbs
- ❑ Homeopathy
- ❑ Bach flowers
- ❑ Protein shakes
- ❑ Superfoods (e.g., bee pollen, phytonutrient blends)
- ❑ Liquid meals

Other _____

Would you like to:

- ❑ Have more energy
- ❑ Be stronger
- ❑ Have more endurance
- ❑ Increase your sex drive
- ❑ Be thinner
- ❑ Be more muscular
- ❑ Improve your complexion
- ❑ Have stronger nails
- ❑ Have healthier hair
- ❑ Be less moody
- ❑ Be less depressed
- ❑ Be less indecisive
- ❑ Feel more motivated
- ❑ Be more organized
- ❑ Think more clearly and be more focused
- ❑ Improve memory
- ❑ Do better on tests in school
- ❑ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- ❑ Stop using laxatives or stool softeners
- ❑ Be free of pain
- ❑ Sleep better
- ❑ Have agreeable breath
- ❑ Have agreeable body odor
- ❑ Have stronger teeth
- ❑ Get less colds and flus
- ❑ Get rid of your allergies
- ❑ Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)

MET427 7/00 Rev 1/03

HEALTH APPRAISAL QUESTIONNAIRE

Name _____ **Date** _____

DIRECTIONS

This questionnaire asks you to assess how you have been feeling **during the last four months**. This information will help you keep track of how your physical, mental and emotional states respond to changes you make in your eating habits, priorities, supplement program, social and family life, level of physical activity and time spent on personal growth. All information is held in strict confidence. Take all the time you need to complete this questionnaire.

For each question, circle the number that best describes your symptoms:

0 = No or Rarely—You have never experienced the symptom or the symptom is familiar to you but you perceive it as insignificant (monthly or less)

1 = Occasionally—Symptom comes and goes and is linked in your mind to stress, diet, fatigue or some identifiable trigger

4 = Often—Symptom occurs 2-3 times per week and/or with a frequency that bothers you enough that you would like to do something about it

8 = Frequently—Symptom occurs 4 or more times per week and/or you are aware of the symptom every day, or it occurs with regularity on a monthly or cyclical basis

Some questions require a YES or NO response: 0 = NO 8 = YES

PART I

SECTION A

	No/Rarely	Occasionally	Often	Frequently
1. Indigestion, food repeats on you after you eat	0	1	4	8
2. Excessive burping, belching and/or bloating following meals	0	1	4	8
3. Stomach spasms and cramping during or after eating	0	1	4	8
4. A sensation that food just sits in your stomach creating uncomfortable fullness, pressure and bloating during or after a meal	0	1	4	8
5. Bad taste in your mouth	0	1	4	8
6. Small amounts of food fill you up immediately	0	1	4	8
7. Skip meals or eat erratically because you have no appetite	0	1	4	8

Total points ____

SECTION B

	No/Rarely	Occasionally	Often	Frequently
1. Strong emotions, or the thought or smell of food aggravates your stomach or makes it hurt	0	1	4	8
2. Feel hungry an hour or two after eating a good-sized meal	0	1	4	8
3. Stomach pain, burning and/or aching over a period of 1-4 hours after eating	0	1	4	8
4. Stomach pain, burning and/or aching relieved by eating food; drinking carbonated beverages, cream or milk; or taking antacids	0	1	4	8
5. Burning sensation in the lower part of your chest, especially when lying down or bending forward	0	1	4	8
6. Digestive problems that subside with rest and relaxation	(0)No			(8)Yes
7. Eating spicy and fatty (fried) foods, chocolate, coffee, alcohol, citrus or hot peppers causes your stomach to burn or ache	0	1	4	8
8. Feel a sense of nausea when you eat	0	1	4	8
9. Difficulty or pain when swallowing food or beverage	0	1	4	8

Total points ____

SECTION C

	No/Rarely	Occasionally	Often	Frequently
1. When massaging under your rib cage *on your left side*, there is pain, tenderness or soreness	0	1	4	8
2. Indigestion, fullness or tension in your abdomen is delayed, occurring 2-4 hours after eating a meal	0	1	4	8
3. Lower abdominal discomfort is relieved with the passage of gas or with a bowel movement	0	1	4	8
4. Specific foods/beverages aggravate indigestion	0	1	4	8
5. The consistency or form of your stool changes (e.g., from narrow to loose) within the course of a day	0	1	4	8

SECTION C *(cont.)*

	No/Rarely	Occasionally	Often	Frequently
6. Stool odor is embarrassing	0	1	4	8
7. Undigested food in your stool	0	1	4	8
8. Three or more large bowel movements daily	0	1	4	8
9. Diarrhea (frequent loose, watery stool)	0	1	4	8
10. Bowel movement shortly after eating (within 1 hour)	0	1	4	8

Total points ____

SECTION D

	No/Rarely	Occasionally	Often	Frequently
1. Discomfort, pain or cramps in your colon (lower abdominal area)	0	1	4	8
2. Emotional stress and/or eating raw fruits and vegetables causes abdominal bloating, pain, cramps or gas	0	1	4	8
3. Generally constipated (or straining during bowel movements)	0	1	4	8
4. Stool is small, hard and dry	0	1	4	8
5. Pass mucus in your stool	0	1	4	8
6. Alternate between constipation and diarrhea	0	1	4	8
7. Rectal pain, itching or cramping	0	1	4	8
8. No urge to have a bowel movement	(0)No			(8)Yes
9. An almost continual need to have a bowel movement	(0)No			(8)Yes

Total points ____

PART II

	No/Rarely	Occasionally	Often	Frequently
1. When massaging under your rib cage *on your right side*, there is pain, tenderness or soreness	0	1	4	8
2. Abdominal pain worsens with deep breathing	0	1	4	8
3. Pain at night that may move to your back or right shoulder	0	1	4	8
4. Bitter fluid repeats after eating	0	1	4	8
5. Feel abdominal discomfort or nausea when eating rich, fatty or fried foods	0	1	4	8
6. Throbbing temples and/or dull pain in forehead associated with overeating	0	1	4	8
7. Unexplained itchy skin that's worse at night	0	1	4	8
8. Stool color alternates from clay colored to normal brown	0	1	4	8
9. General feeling of poor health	0	1	4	8

PART II

	No/Rarely	Occasionally	Often	Frequently
10. Aching muscles not due to exercise	0	1	4	8
11. Retain fluid and feel swollen around the abdominal area	0	1	4	8
12. Reddened skin, especially palms	0	1	4	8
13. Very strong body odor	0	1	4	8
14. Are you embarrassed by your breath?	0	1	4	8
15. Bruise easily	(0)No		(8)Yes	
16. Yellowish cast to eyes	(0)No		(8)Yes	

Total points ____

PART III

SECTION A

1. Feel cold or chilled—hands, feet or all over—for no apparent reason	0	1	4	8
2. Your upper eyelids look swollen	0	1	4	8
3. Muscles are weak, cramp and/or tremble	0	1	4	8
4. Are you forgetful?	0	1	4	8
5. Do you feel like your heart beats slowly?	0	1	4	8
6. Reaction time seems slowed down	0	1	4	8
7. In general, are you disinterested in sex because your desire is low?	0	1	4	8
8. Feel slow-moving, sluggish	0	1	4	8
9. Constipation	0	1	4	8
10. Dryness, discoloration of skin and/or hair	(0)No		(8)Yes	
11. Have you noticed recently that your voice is deepening?	(0)No		(8)Yes	
12. Thick, brittle nails	(0)No		(8)Yes	
13. Weight gain for no apparent reason	(0)No		(8)Yes	
14. Outer third of your eyebrow is thinning or disappearing	(0)No		(8)Yes	
15. Swelling of the neck	(0)No		(8)Yes	

Total points ____

SECTION B

1. Lingering mild fatigue after exertion or stress	0	1	4	8
2. Do you find that you get tired and exhaust easily?	0	1	4	8
3. Craving for salty foods	0	1	4	8
4. Sensitive to minor changes in weather and surroundings	0	1	4	8
5. Dizzy when rising or standing up from a kneeling position	0	1	4	8
6. Dark bluish or black circles under your eyes	0	1	4	8
7. Have bouts of nausea with or without vomiting	0	1	4	8
8. Catch colds or infections easily	(0)No		(8)Yes	
9. Wounds heal slowly	(0)No		(8)Yes	
10. Your body or parts of your body feel tender, sore, sensitive to the touch, hot and/or painful	0	1	4	8
11. Feel puffy and swollen all over your body	0	1	4	8
12. Skin is gradually tanning without exposure to sun or the ingestion of high levels of carotene-rich foods (e.g., daily carrot juice intake) or supplements	(0)No		(8)Yes	

Total points ____

PART IV

	No/Rarely	Occasionally	Often	Frequently

SECTION A

When you miss meals or go without food for extended periods of time, do you experience any of the following symptoms?

1. A sense of weakness	0	1	4	8
2. A sudden sense of anxiety when you get hungry	0	1	4	8
3. Tingling sensation in your hands	0	1	4	8
4. A sensation of your heart beating too quickly or forcefully	0	1	4	8
5. Shaky, jittery, hands trembling	0	1	4	8
6. Sudden profuse sweating and/or your skin feels clammy	0	1	4	8
7. Nightmares possibly associated with going to bed on an empty stomach	0	1	4	8
8. Wake up at night feeling restless	0	1	4	8
9. Agitation, easily upset, nervous	0	1	4	8
10. Poor memory, forgetful	0	1	4	8
11. Confused or disoriented	0	1	4	8
12. Dizzy, faint	0	1	4	8
13. Cold or numb	0	1	4	8
14. Mild headaches or head pounding	0	1	4	8
15. Blurred vision or double vision	0	1	4	8
16. Feel clumsy and uncoordinated	0	1	4	8

Total points ____

SECTION B

1. Frequent urination during the day and night	0	1	4	8
2. Unusual thirst—feeling like you can't drink enough water	0	1	4	8
3. Unusual hunger—eating all the time	0	1	4	8
4. Vision blurs	0	1	4	8
5. Feel itchy all over	0	1	4	8
6. Tingling or numbness in your feet	0	1	4	8
7. Sense of drowsiness, lethargy during the day not associated with missing meals or not sleeping	0	1	4	8
8. Eating starchy foods, even if they are healthy and unprocessed (like rice, corn, beans, whole wheat or oats), causes you to gain weight or prevents you from losing weight	(0)No		(8)Yes	
9. Sores heal slowly	(0)No		(8)Yes	
10. Loss of hair on your legs	(0)No		(8)Yes	

Total points ____

PART V

SECTION A

1. Feel jittery	0	1	4	8
2. First effort of the day causes pain, pressure, tightness or heaviness around the chest	0	1	4	8
3. Exhaustion with minor exertion	0	1	4	8
4. Heavy sweating (no exertion, no hot flashes)	0	1	4	8
5. Difficulty catching breath, especially during exercise	0	1	4	8
6. Heart pounding, sensation of heart beating too quickly, too slowly or irregularly	0	1	4	8
7. Swelling in feet, ankles and/or legs comes and goes for no apparent reason	0	1	4	8

Total points ____

PART V (cont.)

SECTION B

	No/Rarely	Occasionally	Often	Frequently
1. Muscle pain at rest	0	1	4	8
2. Cramp-like pains in your ankles, calves or legs	0	1	4	8
3. Numbness, tingling and prickling sensation in hands and feet	0	1	4	8
4. Cold feet and/or toes appear blue	0	1	4	8
5. Brief moments of hearing loss	0	1	4	8
6. Nausea comes and goes quickly (unrelated to eating)	0	1	4	8
7. Feel worse standing: legs get heavy and fatigued	0	1	4	8
8. Leg discomfort or fatigue relieved by elevating legs	0	1	4	8
9. Fingers and toes get numb in cold weather even when protected	0	1	4	8
10. Notice changes in your ability to feel pain or differentiate between sensations of hot or cold	(0)No			(8)Yes
11. Body hair (on arms, hands, fingers, legs and toes) is thinning or has disappeared	(0)No			(8)Yes
12. Do you notice a decline in your ability to make decisions, concentrate, focus attention or follow directions?	(0)No			(8)Yes

Total points ____

PART VI

SECTION A

	No/Rarely	Occasionally	Often	Frequently
1. Family, friends, work, hobbies or activities you hold dear are no longer of interest	0	1	4	8
2. Do you cry?	0	1	4	8
3. Does life look entirely hopeless?	0	1	4	8
4. Would you describe yourself as feeling miserable and sad, unhappy or blue?	0	1	4	8
5. Do you find it hard to make the best of difficult situations?	0	1	4	8
6. Sleep problems—too much or too little sleep	0	1	4	8
7. Changes in your appetite and weight	(0)No			(8)Yes
8. Lately you've noticed an inability to think clearly or concentrate	(0)No			(8)Yes
9. Difficulty making decisions and/or clarifying and achieving your goals	(0)No			(8)Yes

Total points ____

SECTION B

	No/Rarely	Occasionally	Often	Frequently
1. Does worrying get you down?	0	1	4	8
2. Does every little thing get on your nerves and wear you out?	0	1	4	8
3. Would you consider yourself a nervous person?	0	1	4	8
4. Do you feel easily agitated?	0	1	4	8
5. Do you shake and tremble?	0	1	4	8
6. Are you keyed up and jittery?	0	1	4	8
7. Do you tremble or feel weak when someone shouts at you?	0	1	4	8
8. Do you become scared at sudden movements or noises at night?	0	1	4	8
9. Do you find yourself sighing a lot?	0	1	4	8
10. Are you awakened out of your sleep by frightening dreams?	0	1	4	8
11. Do frightening thoughts keep coming back in your mind?	0	1	4	8

SECTION B (cont.)

	No/Rarely	Occasionally	Often	Frequently
12. Do you become suddenly scared for no reason?	0	1	4	8
13. Do you break out in a cold sweat?	0	1	4	8
14. "Butterflies in your stomach," nausea and/or diarrhea	0	1	4	8

Total points ____

SECTION C

1. Do you feel pent up and ready to explode?	0	1	4	8
2. Are you prone to noisy and emotional outbursts?	0	1	4	8
3. Do you do things on impulse?	0	1	4	8
4. Are you easily upset or irritated?	0	1	4	8
5. Do you go to pieces if you don't control yourself?	0	1	4	8
6. Do little annoyances get on your nerves and make you angry?	0	1	4	8
7. Does it make you angry to have anyone tell you what to do?	0	1	4	8
8. Do you flare up in anger if you can't have what you want right away?	0	1	4	8

Total points ____

PART VII

1. Eyes water or tear	0	1	4	8
2. Mucus discharge from the eyes	0	1	4	8
3. Ears ache, itch, feel congested or sore	0	1	4	8
4. Discharge from ears	0	1	4	8
5. Is your nose continually congested?	0	1	4	8
6. Are you prone to loud snoring?	(0)No			(8)Yes
7. Does your nose run?	0	1	4	8
8. Nosebleeds	(0)No			(8)Yes
9. Hoarse voice	0	1	4	8
10. Do you have to clear your throat?	0	1	4	8
11. Do you feel a choking lump in your throat?	0	1	4	8
12. Do you suffer from severe colds?	(0)No			(8)Yes
13. Do frequent colds keep you miserable all winter?	(0)No			(8)Yes
14. Flu symptoms last longer than 5 days	(0)No			(8)Yes
15. Do infections settle in your lungs?	(0)No			(8)Yes
16. Chest discomfort or pain	0	1	4	8
17. Do you experience sudden breathing difficulties?	0	1	4	8
18. Do you struggle with shortness of breath?	0	1	4	8
19. Difficulty exhaling (breathing out)	0	1	4	8
20. Breathlessness followed by coughing during exertion, no matter how slight	0	1	4	8
21. Inability to breathe comfortably while lying down	0	1	4	8
22. Do you cough up lots of phlegm?	0	1	4	8
23. Can you hear noisy rattling sounds when breathing in and out?	0	1	4	8
24. Are you troubled with coughing?	0	1	4	8
25. Do you wheeze?	0	1	4	8
26. Do you have severe soaking sweats at night?	0	1	4	8
27. Do your lips and/or nails have a bluish hue?	0	1	4	8
28. Are you sleepy during the day?	0	1	4	8

PART VII (cont.)

	No/Rarely	Occasionally	Often	Frequently
29. Do you have difficulty concentrating?	0	1	4	8
30. Eyes, ears, nose, throat and lung symptoms seem associated with specific foods like dairy or wheat products	(0)No		(8)Yes	
31. Eyes, ears, nose, throat and lung symptoms are associated with seasonal changes	(0)No		(8)Yes	

Total points ____

PART VIII

1. Involuntary loss of urine when you cough, lift something or strain during an activity	0	1	4	8
2. Mild lower back ache or pain	0	1	4	8
3. Abdominal achiness or pain	0	1	4	8
4. Pain or burning when urinating	0	1	4	8
5. Rarely feel the urge to urinate	0	1	4	8
6. Feel the need to urinate less than every two hours during the day or night	0	1	4	8
7. Strong smelling urine	0	1	4	8
8. Back or leg pains are associated with dripping after urination	0	1	4	8
9. Sore or painful genitals	0	1	4	8
10. Urine is a rose color	0	1	4	8
11. Sudden urge to void causes involuntary loss of urine	0	1	4	8
12. Generalized sense of water retention throughout your body	0	1	4	8

Total points ____

PART IX

SECTION A

1. Bones throughout your entire body ache, feel tender or sore	0	1	4	8
2. Localized bone pain	0	1	4	8
3. Hands, feet or throat get tight, spasm or feel numb	0	1	4	8
4. Difficulty sitting straight	0	1	4	8
5. Upper back pain	0	1	4	8
6. Lower back pain	0	1	4	8
7. Pain when sitting down or walking	0	1	4	8
8. Find yourself limping or favoring one leg	0	1	4	8
9. Shins hurt during or after exercise	0	1	4	8

Total points ____

SECTION B

1. Are you stiff in the morning when you wake up?	0	1	4	8
2. Difficulty bending down and picking up clothing or anything from the floor	0	1	4	8
3. Joint swelling, pain or stiffness involving one or more areas (fingers, hands, wrists, elbows, shoulders, toes, arches, feet, ankles, knees or ankles)	0	1	4	8
4. Joints hurt when moving or when carrying weight	0	1	4	8
5. A routine exercise program, like daily walking, causes your knees to swell or hurt	0	1	4	8
6. Difficulty opening jars that were previously easy to open	0	1	4	8
7. Discomfort, numbness, prickling or tingling sensation, or pain in neck, shoulder or arm	0	1	4	8

	No/Rarely	Occasionally	Often	Frequently
SECTION B *(cont.)*				
8. Intermittent pain or ache on one side of head spreading to cheek, temple, lower jaw, ear, neck and shoulder	0	1	4	8
9. Difficulty chewing food or opening mouth	0	1	4	8
10. Difficulty standing up from a sitting position	0	1	4	8
11. Shooting, aching, tingling pain down the back of leg	0	1	4	8
12. Is it difficult to reach up and get a 5-pound object like a bag of flour from just above your head?	(0)No		(8)Yes	
13. Injure, strain or sprain easily	(0)No		(8)Yes	

Total points ____

SECTION C

1. Muscles stiff, sore, tense and/or achy	0	1	4	8
2. Burning, throbbing, shooting or stabbing muscle pain	0	1	4	8
3. Muscle cramps or spasms (involuntary or after exertion/exercise)	0	1	4	8
4. Is muscle pain or stiffness greater in the morning than other times of the day?	0	1	4	8
5. Specific points on body feel sore when pressed	0	1	4	8
6. Feel unrefreshed upon awakening	0	1	4	8
7. Headaches	0	1	4	8
8. Pain at the sides of your head or in your face especially when awakening	0	1	4	8
9. Your jaw clicks or pops	0	1	4	8
10. Muscle twitch or tremor—eyelids, thumb, calf muscle	0	1	4	8
11. Irresistible urge to move legs	0	1	4	8
12. Legs move during sleep	0	1	4	8
13. Unpleasant crawling sensation inside calves when lying down	0	1	4	8
14. Hand and wrist numbness or pain (e.g., interferes with writing or with buttoning or unbuttoning your clothes)	0	1	4	8
15. Feeling of "pins and needles" in your thumb and first three fingers	0	1	4	8
16. Pain in forearm and sometimes in shoulder	0	1	4	8

Total points ____

PART X

SECTION A

1. Head feels heavy	0	1	4	8
2. Dizziness	0	1	4	8
3. Difficulty bending over, standing up from sitting, rolling over in bed and/or turning your head from side to side	0	1	4	8
4. Your hands tremble, ever so slightly, for no apparent reason	0	1	4	8
5. You feel like you're wearing heavy weights on your feet when walking	0	1	4	8
6. Bump into things, trip, stumble and feel clumsy	0	1	4	8
7. Difficulty breathing	0	1	4	8
8. Difficulty swallowing	0	1	4	8
9. People tell you to speak up because they have trouble hearing you	0	1	4	8
10. Speaking and forming words does not feel automatic	0	1	4	8
11. Need 10-12 hours of sleep to feel rested	0	1	4	8

PART X (cont.)

	No/Rarely	Occasionally	Often	Frequently
SECTION A *(cont.)*				
12. Lack strength (your grip is weak, holding your head or picking your arms up takes effort)	0	1	4	8
13. Hands get tired when you write and your handwriting is less legible and smaller than it used to be	(0)No		(8)Yes	
14. Muscles in arms and legs seem softer and smaller	(0)No		(8)Yes	
15. Is your eyesight, sense of smell and taste or ability to hear not as sharp as it used to be?	(0)No		(8)Yes	
16. Do you find yourself moving slower than you used to?	(0)No		(8)Yes	
Total points				
SECTION B				
1. Difficulty absorbing new information	0	1	4	8
2. Tend to forget things	0	1	4	8
3. Trouble thinking or concentrating	0	1	4	8
4. Easily distracted	0	1	4	8
5. Do you have a tendency to become frustrated quickly?	0	1	4	8
6. Inability to sit still for any length of time, even at mealtime	0	1	4	8
7. Finishing tasks is easier said than done	0	1	4	8
8. Do you have more trouble solving problems or managing your time than usual?	0	1	4	8
9. Low tolerance for stress and otherwise ordinary problems	0	1	4	8
Total points				

PART XI

Men Only

1. Sensation of not emptying your bladder completely	0	1	4	8
2. Need to urinate less than 2 hours after you have finished urinating	0	1	4	8
3. Find yourself needing to stop and start again several times while urinating	0	1	4	8
4. Find it difficult to postpone urination	0	1	4	8
5. Have a weak urinary stream	0	1	4	8
6. Need to push or strain to begin urinating	0	1	4	8
7. Dripping after urination	0	1	4	8
8. Urge to urinate several times a night	0	1	4	8
Total points				

PART XII

Women Only

(Menopausal women should skip to Sections E and F)

SECTION A

Do you persistently experience any of these symptoms within three days to two weeks *prior to menstruation?*

	No/Rarely	Occasionally	Often	Frequently
[A]				
1. Anxious, irritable or restless	(0)No		(8)Yes	
2. Numbness, tingling in hands and feet	(0)No		(8)Yes	
3. Easy to anger, resentful	(0)No		(8)Yes	
4. Aggressive or hostile toward family/friends	(0)No		(8)Yes	
SECTION A *(cont.)*				
[B]				
5. Abdominal bloating, feeling swollen (e.g., feet)	(0)No		(8)Yes	
6. Temporary weight gain	(0)No		(8)Yes	
7. Breast tenderness, swelling	(0)No		(8)Yes	
8. Appearance of breast lumps	(0)No		(8)Yes	
9. Discharge from nipples	(0)No		(8)Yes	
10. Nausea and/or vomiting	(0)No		(8)Yes	
11. Diarrhea or constipation	(0)No		(8)Yes	
12. Aches and pains (back, joints, etc.)	(0)No		(8)Yes	
[C]				
13. Craving for sweets	(0)No		(8)Yes	
14. Increased appetite or binge eating	(0)No		(8)Yes	
15. Headaches	(0)No		(8)Yes	
16. Being easily overwhelmed, shaky or clumsy	(0)No		(8)Yes	
17. Heart pounding	(0)No		(8)Yes	
18. Dizziness or fainting	(0)No		(8)Yes	
[D]				
19. Confused and forgetful to the point that work suffers	(0)No		(8)Yes	
20. Overwhelmed with feelings of sadness and worthlessness	(0)No		(8)Yes	
21. Difficulty sleeping or falling asleep	(0)No		(8)Yes	
22. Engaging in self-destructive behavior	(0)No		(8)Yes	
Total points				

SECTION B

Do you experience any of these symptoms *during your period?*

1. Cramping in lower abdomen or pelvic area	(0)No		(8)Yes	
2. Lower abdominal pain is sharp and/or dull or intermittent	(0)No		(8)Yes	
3. Bloating and sense of abdominal fullness	(0)No		(8)Yes	
4. Diarrhea or constipation	(0)No		(8)Yes	
5. Nausea and/or vomiting	(0)No		(8)Yes	
6. Low back and/or legs ache	(0)No		(8)Yes	
7. Headaches	(0)No		(8)Yes	
8. Unusual fatigue (take naps) resulting in missed work	(0)No		(8)Yes	
9. Painful and/or swollen breasts	(0)No		(8)Yes	
10. Scanty blood flow	(0)No		(8)Yes	
Total points				

SECTION C

1. Painful or difficult sexual intercourse	0	1	4	8
2. Low abdominal, back and vaginal pain throughout the month	0	1	4	8
3. Pelvic pressure or pain while sitting down or standing up, relieved by lying down	0	1	4	8
4. Vaginal bleeding other than during your period	0	1	4	8
5. Painful bowel movements	0	1	4	8
6. Difficult (straining) urination	0	1	4	8
7. Abnormal vaginal discharge	0	1	4	8
8. Offensive vaginal discharge	0	1	4	8
9. Vaginal itching or burning with or without intercourse	0	1	4	8
10. Pain during periods is getting progressively worse	(0)No		(8)Yes	
11. Profuse or prolonged menstrual bleeding	(0)No		(8)Yes	
12. Unable to get pregnant	(0)No		(8)Yes	
Total points				

PART XII (cont.)

SECTION D

	No/Rarely	Occasionally	Often	Frequently
1. Absence of periods for six months or longer	(0)No			(8)Yes
2. Periods occur irregularly (e.g., 3 to 6 times a year)	(0)No			(8)Yes
3. Profuse heavy bleeding during periods	0	1	4	8
4. Menstrual blood contains clots and tissue	0	1	4	8
5. Bleeding between periods can occur anytime	0	1	4	8
6. Periods occur greater than every 35 days	(0)No			(8)Yes
7. Intense upper stomach pain, lasting several hours at the time you ovulate (approximately day 14 of your cycle)	0	1	4	8
8. Bleeding occurs at ovulation (approximately day 14 of your cycle)	0	1	4	8
9. Monthly abdominal pain without bleeding	0	1	4	8
10. Abundant cervical mucus	0	1	4	8
11. Acne and/or oily skin	0	1	4	8
12. Overwhelming urges for sexual intercourse	0	1	4	8
13. Aggressive feelings	0	1	4	8
14. Increased growth of dark facial and/or body hair	(0)No			(8)Yes
15. Poor sense of smell	(0)No			(8)Yes
16. Voice is becoming deeper	(0)No			(8)Yes
17. Breasts seem to be getting smaller	(0)No			(8)Yes
18. Receding hairline	(0)No			(8)Yes
Total points				

SECTION E

	No/Rarely	Occasionally	Often	Frequently
1. Vaginal discharge	0	1	4	8
2. Vaginal secretions are watery and thin	0	1	4	8
3. Vaginal dryness	0	1	4	8
4. Sexual intercourse is uncomfortable	0	1	4	8

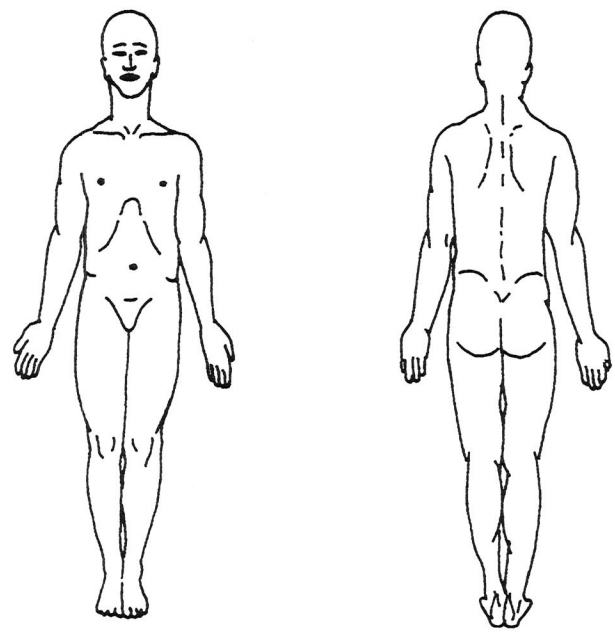
SECTION E (cont.)

	No/Rarely	Occasionally	Often	Frequently
5. Interest in having sex is low	0	1	4	8
6. Engorged breasts	0	1	4	8
7. Breast tenderness, soreness	0	1	4	8
8. Difficulty with orgasm	0	1	4	8
9. Vaginal bleeding after sexual intercourse	0	1	4	8
10. Do you skip periods?	(0)No			(8)Yes
11. The length (number of days) of your period varies month to month, with the number of days of bleeding getting fewer	(0)No			(8)Yes
Total points				

SECTION F

	No/Rarely	Occasionally	Often	Frequently
1. Sense of well-being fluctuates throughout the day for no apparent reason	0	1	4	8
2. Sudden hot flashes	0	1	4	8
3. Spontaneous sweating	0	1	4	8
4. Chills	0	1	4	8
5. Cold hands and feet	0	1	4	8
6. Heart beats rapidly or feels like it is fluttering	0	1	4	8
7. Numbness, tingling or prickling sensations	0	1	4	8
8. Dizziness	0	1	4	8
9. Mental fogginess, forgetful or distracted	0	1	4	8
10. Inability to concentrate	0	1	4	8
11. Depression, anxiety, nervousness and/or irritability	0	1	4	8
12. Difficulty sleeping	0	1	4	8
13. Conscious of new feelings of anger and frustration	0	1	4	8
14. Skin, hair, vagina and/or eyes feel dry	0	1	4	8
15. Stopped menstruating around six months ago, yet still experience some vaginal bleeding	(0)No			(8)Yes
Total points				

Please mark an "X" to indicate areas where you feel pain, swelling or discomfort, or areas of your skin that have changed color or texture (e.g., moles, rashes, etc.). Describe what you feel or observe in your own words. Write anywhere in this area.



Candida Questionnaire — Adult

In Section A circle the score for each **YES** answer. For Sections B and C score as indicated. Record total scores at the end of the questionnaire. Add the totals to get your **GRAND TOTAL SCORE.**

Section A — History

1. Have you taken tetracyclines (Sumycin, Panmycin, Vibramycin, Minocin, etc.) or other antibiotics for acne for one month or longer? 35
2. Have you ever taken other "broad spectrum" antibiotics for urinary, respiratory, or other infections for two months or longer, or in shorter courses four or more times in a one year period? 35
3. Have you ever taken a "broad spectrum" antibiotic drug? 6
4. Have you ever been bothered by persistent prostatitis, vaginitis, or other reproductive organ problems? 25
5. Have you been pregnant: two or more times? 5
   1 time? 3
6. Have you taken birth control pills for more than two years? 15
   For six months to two years? 8
7. Have you taken prednisone, Decadron, or other cortisone-type drugs for more than two weeks? 15
   For two weeks or less? 6
8. Does exposure to perfumes, insecticides, fabric shop odors, and other chemicals provoke:
   Moderate to severe symptoms? 20
   Mild symptoms? 5
9. Are symptoms worse on damp, muggy days or in moldy places? 20
10. Have you had athlete's foot, ring worm, "jock itch," or other chronic fungous infections of the skin or nails?
    Severe or persistent 20
    Mild to moderate? 10
11. Do you crave sugar? 10
12. Do you crave breads? 10
13. Do you crave alcoholic beverages? 10
14. Does tobacco smoke ***really*** bother you? 10

Section B — Major Symptoms

Enter the appropriate score for each symptom below.

If a symptom is ***occasional*** or ***mild***	Score 3 points
If a symptom is ***frequent*** or ***moderately severe***	Score 6 points
If a symptom is ***severe*** or ***disabling***	Score 9 points

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

Section C — Other Symptoms

Enter the appropriate score for each symptom below.

If a symptom is ***occasional*** or ***mild***	Score 1 points
If a symptom is ***frequent*** or ***moderately severe***	Score 2 points
If a symptom is ***severe*** or ***disabling***	Score 3 points

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

Scores: Section A _____ Section B _____ Section C _____

GRAND TOTAL SCORE _____

The **GRAND TOTAL SCORE** will help determine if your health problems are yeast connected. Scores in women will run higher because more questions apply only to women than to men.

Yeast connected health problems are almost **CERTAINLY PRESENT** in women with scores over 180, and in men with scores over 140.

Yeast connected problems are **PROBABLY PRESENT** in women with scores over 120 and in men with scores over 90.

Yeast connected problems are **POSSIBLY PRESENT** in women with scores over 60 and in men with scores over 40.

Scores less than 60 in women and 40 in men: yeasts are less apt to cause health problems.

Detoxification Questionnaire

Patient Name: _____ **Date:** _____

Rate each of the following symptoms based on your typical health profile for the specified duration:

❒ Past month ❒ Past week ❒ Past 48 hours

Point Scale: **0**—*Never or almost never* have the symptom **1**—*Occasionally* have it, effect is *not severe* **2**—*Occasionally* have it, effect is *severe*
3—*Frequently* have it, effect is *not severe* **4**—*Frequently* have it, effect is *severe*

I. Medical Symptoms Questionnaire (MSQ)

HEAD	_____	Headaches	
	_____	Faintness	
	_____	Dizziness	
	_____	Insomnia	**TOTAL** _____
EYES	_____	Watery or itchy eyes	
	_____	Swollen, reddened or sticky eyelids	
	_____	Bags or dark circles under eyes	
	_____	Blurred or tunnel vision	**TOTAL** _____
EARS	_____	Itchy ears	
	_____	Earaches, ear infections	
	_____	Drainage from ear	
	_____	Ringing in ears, hearing loss	**TOTAL** _____
NOSE	_____	Stuffy nose	
	_____	Sinus problems	
	_____	Hay fever	
	_____	Sneezing attacks	
	_____	Excessive mucus formation	**TOTAL** _____
MOUTH/ THROAT	_____	Chronic coughing	
	_____	Gagging, frequent need to clear throat	
	_____	Sore throat, hoarseness, loss of voice	
	_____	Swollen or discolored tongue, gums, lips	
	_____	Canker sores	**TOTAL** _____
SKIN	_____	Acne	
	_____	Hives, rashes, dry skin	
	_____	Hair loss	
	_____	Flushing, hot flashes	
	_____	Excessive sweating	**TOTAL** _____
HEART	_____	Chest pain	
	_____	Irregular or skipped heartbeat	
	_____	Rapid or pounding heartbeat	**TOTAL** _____
LUNGS	_____	Chest congestion	
	_____	Asthma, bronchitis	
	_____	Shortness of breath	
	_____	Difficulty breathing	**TOTAL** _____
DIGESTIVE TRACT	_____	Nausea, vomiting	
	_____	Diarrhea	
	_____	Constipation	
	_____	Bloated feeling	
	_____	Belching, passing gas	
	_____	Heartburn	
	_____	Intestinal/stomach pain	**TOTAL** _____
JOINTS/ MUSCLE	_____	Pain or aches in joints	
	_____	Arthritis	
	_____	Stiffness or limitation of movement	
	_____	Feeling of weakness or tiredness	
	_____	Pain or aches in muscles	**TOTAL** _____
WEIGHT	_____	Binge eating/drinking	
	_____	Craving certain foods	
	_____	Excessive weight	
	_____	Water retention	
	_____	Underweight	
	_____	Compulsive eating	**TOTAL** _____
ENERGY/ ACTIVITY	_____	Fatigue, sluggishness	
	_____	Apathy, lethargy	
	_____	Hyperactivity	
	_____	Restlessness	**TOTAL** _____
MIND	_____	Poor memory	
	_____	Confusion, poor comprehension	
	_____	Difficulty in making decisions	
	_____	Stuttering or stammering	
	_____	Slurred speech	
	_____	Learning disabilities	
	_____	Poor concentration	
	_____	Poor physical coordination	**TOTAL** _____
EMOTIONS	_____	Mood swings	
	_____	Anxiety, fear, nervousness	
	_____	Anger, irritability, aggressiveness	
	_____	Depression	**TOTAL** _____
OTHER	_____	Frequent illness	
	_____	Frequent or urgent urination	
	_____	Genital itch or discharge	**TOTAL** _____
GRAND TOTAL			**TOTAL** _____

II. Xenobiotic Tolerability Test (XTT)

1. Are you presently using prescription drugs?
❒ Yes (1 pt.)
If yes, how many are you currently taking? ____ (1 pt. each)
❒ No (0 pt.)

2. Are you presently taking one or more of the following over-the counter drugs?
❒ Cimetidine (2 pts.)
❒ Acetaminophen (2 pts.)
❒ Estradiol (2 pts.)

3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them:
❒ Experience side effects, drug(s) is (are) efficacious at lowered dose(s) (3 pts.)
❒ Experience side effects, drug(s) is (are) efficacious at usual dose(s) (2 pts.)
❒ Experience no side effects, drug(s) is (are) usually not efficacious (2 pts.)
❒ Experience *no* side effects, drug(s) is (are) usually efficacious (0 pt.)

4. Do you currently use or within the last 6 months had you regularly used tobacco products?
❒ Yes (2 pts.) ❒ No (0 pt.)

5. Do you have strong negative reactions to caffeine or caffeine containing products?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

6. Do you commonly experience "brain fog," fatigue, or drowsiness?
❒ Yes (1 pt.) ❒ No (0 pt.)

7. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

8. Do you feel ill after you consume even small amounts of alcohol?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

10. Do you have a personal history of
❒ Environmental and/or chemical sensitivities (5 pts.)
❒ Chronic fatigue syndrome (5 pts.)
❒ Multiple chemical sensitivity (5 pts.)
❒ Fibromyalgia (3 pts.)
❒ Parkinson's type symptoms (3 pts.)
❒ Alcohol or chemical dependence (2 pts.)
❒ Asthma (1 pt.)

11. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?
❒ Yes (1 pt.) ❒ No (0 pt.)

12. Do you have an adverse or allergic reaction when you consume sulfite containing foods such as wine, dried fruit, salad bar vegetables, etc?
❒ Yes (1 pt.) ❒ No (0 pt.) ❒ Don't know (0 pt.)

GRAND TOTAL: _____

For Practitioner Use Only:

OVERALL SCORE TABULATION

Recommended protocols based on new detoxification questionnaire (MSQ and XTT)

MSQ SCORE _____ (High >50; moderate 15-49: Low <14)

XTT SCORE _____ (High >10; moderate 5-9: Low <4)

MSQ Score	XTT Score	Description	Functional Medicine Protocol		
			Medical Food	Diet	Additional Nutraceutical Support
50 or >	10 or >	High level of general symptoms and indicated symptoms of elevated toxic load	Medical food for imbalanced detoxifiers	28-day elimination diet	Bifunctional, antioxidant, and chlorophyllin nutraceuticals
15-49	5-9	Moderate level of general symptoms with moderate symptoms of toxic load	Medical food for imbalanced detoxifiers	10-day elimination diet	Consider bifunctional, antioxidant, and chlorophyllin nutraceuticals
14 or <	4 or <	Low level of general symptoms and minimal indicators of toxic load			Maintenance

Additional Symptom-Specific Support

Symptom	Nutraceutical Support
Water retention and/or frequent or urgent urination	Kidney support nutraceuticals
Heartburn and/or intestinal/stomach pain	Functional dyspepsia nutraceuticals
Diarrhea, constipation, and/or intestinal/stomach pain	Probiotics

Note: Patients with high MSQ but low XTT may be exhibiting pathology that is not related to toxic load. Other mechanisms should be considered such as inflammation/immune/allergic gastrointestinal dysfuntion, oxidative stress, hormonal/neurotransmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.

PILLARS OF GI HEALTH

Patient Name: _____

Date: _____

Questionnaire

Understanding key contributors to gastrointestinal (GI) health will help identify the best course of action for recovery of GI function. After reviewing this questionnaire with your health care provider, please refer to the Pillars of GI Health Patient Handbook for dietary, lifestyle and nutrient therapy recommendations.

Please list your top 3 major health concerns in order of importance:

1. _____
2. _____
3. _____

Diet and Gastrointestinal Health

- Do you consume at least five servings of fruits and vegetables per day? Y N
- Do you drink at least eight 8 oz glasses of water every day? Y N
- Do you regularly consume soft drinks or fruit juices? Y N
- Have you ever been diagnosed with a chronic GI condition? Y N

Digestion and Absorption

- Do you experience frequent heartburn, burping, gas or bloating during or immediately after meals? Y N
- Have you ever been diagnosed with anemia or any other nutrient deficiency? Y N
- Have you ever been placed on a heartburn medication (proton pump inhibitor [PPI] or H2 blocker)? Y N
- Do you frequently experience indigestion? Y N

Elimination and Detoxification

- Do you regularly have less than one or more than three bowel movements per day? Y N
- Do you take a laxative more than twice a month? Y N
- Are you sensitive to smells or fragrances? Y N
- Do you have regular exposure to exhaust fumes, tobacco smoke, pesticides, commercial chemicals, paint, cleaning chemicals or volatile fumes? Y N

Microbial Balance

- Have you used antibiotics within the past two years? Y N
- Do you experience abdominal bloating, pain, gas, constipation or diarrhea? Y N
- Have you ever been diagnosed with chronic fatigue syndrome, fibromyalgia or irritable bowel syndrome? Y N
- Do you experience poor memory, difficulty concentrating or brain fog? Y N

Barrier Function

- Have you ever been diagnosed with depression, anxiety, ADD or ADHD? Y N
- Do you suffer from multiple food sensitivities? Y N
- Do you experience skin issues such as acne, rosacea or eczema? Y N
- Do you have seasonal allergies, asthma or an autoimmune disease? Y N

PILLARS OF GI HEALTH

Patient Name: _____

Date: _____

Implementation Plan

Key area(s) to be addressed:

- ☐ Diet and Gastrointestinal Health
- ☐ Digestion and Absorption
- ☐ Microbial Balance
- ☐ Elimination and Detoxification
- ☐ Barrier Function

Functional Lab Testing:

_____

_____

_____

_____

_____

_____

_____

Lifestyle Recommendations:

_____

_____

_____

_____

_____

_____

_____

Nutrient Solutions

Formulation	Dose (capsules, tablets or scoops)	Frequency Per Day

BEFORE YOU DETOX

Patient Name: _____ **Date:** _____

Before you begin the Core Restore detoxification program, it is important to first evaluate your current health state. This questionnaire will help identify signs of toxic burden. You will take this questionnaire again in 7 days to evaluate your progress. This will help you and your healthcare provider evaluate your success and continued improvement.

POINT SCALE: 0 = Never 1 = Occasionally 2 = Frequently

Digestive
0 1 2 Bowel movements less than once per day
0 1 2 Bloated feeling
0 1 2 Belching and/or gas
0 1 2 Heartburn
____ **Total**

Head
0 1 2 Headaches
0 1 2 Pressure
0 1 2 Dizziness
0 1 2 Faintness
____ **Total**

Emotions
0 1 2 Mood swings
0 1 2 Feelings of fear and/or nervousness
0 1 2 Anger and/or irritability
0 1 2 Feelings of sadness
____ **Total**

Mind
0 1 2 Poor memory and/or confusion
0 1 2 Difficulty concentrating
0 1 2 Poor coordination
0 1 2 Difficulty making decisions
____ **Total**

Energy & Activity
0 1 2 Fatigue and/or sluggishness
0 1 2 Hyperactivity
0 1 2 Restlessness
0 1 2 Occasional sleeplessness
____ **Total**

Ears
0 1 2 Itchy ears
0 1 2 Earaches
0 1 2 Drainage from ear
0 1 2 Ringing in ears and/or hearing loss
____ **Total**

Eyes
0 1 2 Watery and/or itchy eyes
0 1 2 Swollen and/or reddened eyelids
0 1 2 Dark circles under the eyes
0 1 2 Blurred vision (excluding near- or far-sightedness)
____ **Total**

Nose
0 1 2 Stuffy nose
0 1 2 Sinus congestion
0 1 2 Sneezing
0 1 2 Mucus
____ **Total**

Lungs
0 1 2 Shortness of breath
0 1 2 Difficulty breathing
0 1 2 Chest congestion
____ **Total**

Mouth & Throat
0 1 2 Coughing
0 1 2 Gagging and/or frequent need to clear throat
0 1 2 Hoarseness and/or loss of voice
0 1 2 Dental problems
____ **Total**

Skin
0 1 2 Acne
0 1 2 Hair loss and/or hair thinning
0 1 2 Body odor
0 1 2 Excessive sweating
____ **Total**

Joints & Muscles
0 1 2 Pain or aches in joints and/or lower back
0 1 2 Stiffness and/or limitation in movement
0 1 2 Pain or aches in muscles
0 1 2 Feelings of weakness and/or tiredness
____ **Total**

Heart
0 1 2 Skipped heartbeats
0 1 2 Rapid heartbeats
0 1 2 Chest discomfort
____ **Total**

Weight
0 1 2 Underweight
0 1 2 Overweight
0 1 2 Difficulty losing weight
0 1 2 Crave certain foods
____ **Total**

Other
0 1 2 Food sensitivities
0 1 2 Chemical and/or environmental sensitivities
0 1 2 Frequent and/or urgent urination
0 1 2 Bloating and/or mood swings before menstruation
____ **Total**

Please add the totals from each section and write the section total in the spaces provided. Then, add all the section totals together and put that total in the space below.

GRAND TOTAL _____

INTERPRETING YOUR TOXICITY SCORE:

10 or lower: You have a **low** level of toxic burden
11 to 30: You have a **moderate** level of toxic burden
31 or higher: You have a **high** level of toxic burden

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AFTER YOU DETOX

Patient Name: _____ **Date:** _____

Congratulations on completing the 7-day Core Restore detoxification program! Hopefully you are feeling more energized and have made a commitment to eating right and making healthier lifestyle choices. Let's evaluate your progress using Core Restore. Your health care professional may use this as a tool to help determine if you should continue with a longer detoxification protocol.

POINT SCALE: 1 = Better 0 = No Change -1 = Worse

Digestive
1 0 -1 Bowel movements less than once per day
1 0 -1 Bloated feeling
1 0 -1 Belching and/or gas
1 0 -1 Heartburn
____ **Total**

Head
1 0 -1 Headaches
1 0 -1 Pressure
1 0 -1 Dizziness
1 0 -1 Faintness
____ **Total**

Emotions
1 0 -1 Mood swings
1 0 -1 Feelings of fear and/or nervousness
1 0 -1 Anger and/or irritability
1 0 -1 Feelings of sadness
____ **Total**

Mind
1 0 -1 Poor memory and/or confusion
1 0 -1 Difficulty concentrating
1 0 -1 Poor coordination
1 0 -1 Difficulty making decisions
____ **Total**

Energy & Activity
1 0 -1 Fatigue and/or sluggishness
1 0 -1 Hyperactivity
1 0 -1 Restlessness
1 0 -1 Occasional sleeplessness
____ **Total**

Ears
1 0 -1 Itchy ears
1 0 -1 Earaches
1 0 -1 Drainage from ear
1 0 -1 Ringing in ears and/or hearing loss
____ **Total**

Eyes
1 0 -1 Watery and/or itchy eyes
1 0 -1 Swollen and/or reddened eyelids
1 0 -1 Dark circles under the eyes
1 0 -1 Blurred vision (excluding near- or far-sightedness)
____ **Total**

Nose
1 0 -1 Stuffy nose
1 0 -1 Sinus congestion
1 0 -1 Sneezing
1 0 -1 Mucus
____ **Total**

Lungs
1 0 -1 Shortness of breath
1 0 -1 Difficulty breathing
1 0 -1 Chest congestion
____ **Total**

Mouth & Throat
1 0 -1 Coughing
1 0 -1 Gagging and/or frequent need to clear throat
1 0 -1 Hoarseness and/or loss of voice
1 0 -1 Dental problems
____ **Total**

Skin
1 0 -1 Acne
1 0 -1 Hair loss and/or hair thinning
1 0 -1 Body odor
1 0 -1 Excessive sweating
____ **Total**

Joints & Muscles
1 0 -1 Pain or aches in joints and/or lower back
1 0 -1 Stiffness and/or limitation in movement
1 0 -1 Pain or aches in muscles
1 0 -1 Feelings of weakness and/or tiredness
____ **Total**

Heart
1 0 -1 Skipped heartbeats
1 0 -1 Rapid heartbeats
1 0 -1 Chest discomfort
____ **Total**

Weight
1 0 -1 Underweight
1 0 -1 Overweight
1 0 -1 Difficulty losing weight
1 0 -1 Crave certain foods
____ **Total**

Other
1 0 -1 Food sensitivities
1 0 -1 Chemical and/or environmental sensitivities
1 0 -1 Frequent and/or urgent urination
1 0 -1 Bloating and/or mood swings before menstruation
____ **Total**

Please add the totals from each section and write the section total in the spaces provided. Then, add all the section totals together and put that total in the space below.

GRAND TOTAL _____

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INTERPRETING YOUR SCORE:

10 or higher: You have made steady improvements and reduced your toxic burden. To maintain these positive changes, set a time with your health care provider to detox again. My next scheduled detox will be ___/___/_____.

0 to 10: You have made moderate improvements to your toxic burden. Your healthcare provider may recommend that you continue the detoxification for an additional period of time (Level 2 detoxification).

0 or lower: Your healthcare provider may utilize additional nutritional supplementation based on their assessment, and may recommend further testing to uncover any hidden GI conditions.