

SIGNS & SYMPTOMS

The only questionnaire of its kind designed to identify dietary deficiencies of food components (protein, carbohydrate, and fat), food enzymes (such as lipase, protease, and amylase), and coenzymes (vitamins and minerals).

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PATIENT HISTORY FORM

Name: _____ Date: _____

Sex: Male Female Age: _____ Height: _____ Weight: _____

Occupation: _____

Please complete the following questions. This will give us a detailed understanding of your present health condition. We will review this form and review it with you. If you have any questions or do not understand any portion of it, we will be happy to assist you.

CHIEF COMPLAINT – Primary reason you are seeking treatment:

SURGERY YOU HAVE HAD AND YOUR AGE AT TIME OF SURGERY:

1. _____ age: _____
2. _____ age: _____
3. _____ age: _____
4. _____ age: _____

PRESCRIPTION MEDICATIONS YOU ARE PRESENTLY TAKING:

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

SUPPLEMENTS OR OVER-THE-COUNTER MEDICATIONS YOU ARE TAKING, SUCH AS VITAMINS OR IBUPROFEN:

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

HABITS (PLEASE CHECK ALL THAT APPLY):

- ALCOHOL CHOCOLATE CIGARETTES COFFEE LAXATIVES
 SUGAR or SUGAR SUBSTITUTES TEA

YOUR PRESENT WEIGHT IS _____ LBS.

DO YOU CONSIDER YOURSELF TO BE: OVERWEIGHT AVERAGE UNDERWEIGHT

DESCRIBE YOUR ACTIVITY LEVEL: SEDENTARY LIGHT MODERATE HEAVY

ARE YOU PRIMARILY RESPONSIBLE FOR PREPARING YOUR OWN MEALS? YES NO

HOW MANY OF YOUR WEEKLY MEALS DO YOU EAT OUT? _____

HOW MANY GLASSES OF WATER DO YOU DRINK EACH DAY? _____

LIST ANY FOODS YOU CRAVE: _____

LIST ANY SPECIAL DIET OR DIETARY RESTRICTIONS: _____

ARE YOU FOLLOWING A DIETARY REGIMEN (WEIGHT WATCHERS, ETC)? YES NO

FAMILY HISTORY OF CONDITIONS (PLEASE LIST ACCORDINGLY):

	<u>MOTHER</u>	<u>FATHER</u>	<u>SIBLINGS</u>
ALLERGIES	_____	_____	_____
ASTHMA	_____	_____	_____
HEART DISEASE	_____	_____	_____
CANCER	_____	_____	_____
ARTHRITIS	_____	_____	_____
KIDNEY DISEASE	_____	_____	_____
DIABETES	_____	_____	_____
STOMACH DISORDERS	_____	_____	_____
OTHER CONDITIONS (PLEASE LIST)	_____	_____	_____

DIETARY PREFERENCES

On the following pages we have listed menu choices for the usual three meals a day. **Some of the choices are not specific and we ask you for details**; for example, do you have juice in the morning is answered “Yes” or “No”. If the answer is “Yes”, we would like you to describe what kind of juice. Also, please circle the appropriate description where choices are presented; as an example, for “Milk”, circle one of the following: “Cream/Whole/2%/1%/Skim”.

Rather than ask you to keep a detailed diary of everything you eat and drink for 3 to 7 days, we ask that you indicate your preferences - **WHAT YOU USUALLY HAVE FIVE DAYS A WEEK, NOT INCLUDING WEEKENDS**. There is room at the bottom of the pages for you to fill in those things that may not be listed.

MORNING MEAL

1. Do you usually skip breakfast (five days a week)? Yes No
- 2a. If you have breakfast, is it at home? Yes No
- 2b. If not, where? Restaurant Fast Food Cafeteria
- 3a. Do you usually use a meal substitute, such as Slim-Fast, etc.? _____
- 3b. If so, it may not be necessary to fill out the remainder of this breakfast menu.

MENU ITEM	YES	NO	DESCRIBE
Eggs or Egg Beaters			
Cheese			
Bacon-Ham-Sausage			
Potatoes			
Hot Cereal			Sugar/Sweetener
Cold Cereal			
Pancakes-French Toast			Syrup or Jelly/Jam/Honey
Toast or English Muffin			Butter/Margarine
Bagel or Croissant			Butter/Margarine/Cream Cheese
Doughnuts			
Sweet Rolls or Danish			Butter/Margarine
Milk			Cream/Whole/2%/1%/Skim
Yogurt			
Fresh Fruit			
Water			
Juice			
Coffee			Creamer/Sweetener
How many cups per day?			Regular/Decaf
Tea			Regular/Decaf/Herbal?
Soft Drink			Diet/Regular

Additional Items: _____

MID-DAY MEAL

1. Do you usually (five days a week) skip lunch? Yes No
- 2a. Do you eat lunch at home? Yes No
- 2b. If not, where? Carry Lunch Restaurant Fast Food Cafeteria
- 3a. Do you usually use a meal substitute, such as Slim-Fast, etc.? _____
- 3b. If so, it may not be necessary to fill out the remainder of this lunch menu.

LUNCH ITEM	YES	NO	DESCRIBE
Meat or Burger			
Pizza			
Soup & Sandwich			
Soup & Salad Bar			Favorite dressing
Vegetable			
Pasta/Noodles			
Potato or Fries			
Bread or Rolls			
Dessert or Milk Shake			
Yogurt			
Water			
Juice			
Coffee			Creamer - Milk/Artificial
How many cups per day?			Sugar/Sweetener
Tea			
Herbal Tea			
Soft Drink			Diet or Regular
Milk			Whole/2%/1%/Skim
Buttermilk-Chocolate Milk			
Beer-Wine-Mixed Drink			

Additional Items: _____

EVENING MEAL

1. Do you usually (five days a week) skip the evening meal? Yes No
- 2a. If you have supper, is it at home? Yes No
- 2b. If not, where? Restaurant Fast Food Cafeteria
- 3a. Do you use a meal substitute, such as Slim-Fast, etc.? _____
- 3b. If so, it may not be necessary to fill out the remainder of this supper menu.

DINNER ITEM	YES	NO	DESCRIBE
Meat or Fish			
Soup			
Vegetables			
Salad			
Potato			
Rice			
Bread or Rolls			Butter/Margarine
Dessert			
Water			
Juice			
Coffee			Creamer - Milk/Artificial Sweetener
Tea			
Herbal Tea			Creamer/Sweetener
Soft Drink			Diet or Regular
Milk			Whole/2%/1%/Skim
Buttermilk-Chocolate Milk			
Beer-Wine-Mixed Drink			

Additional Items: _____

SNACKS

1a. Do you chew gum? Yes No

1b.. Do you use breath mints? Yes No

WHEN DO YOU SNACK?	YES	NO	DESCRIBE
Mid-Morning			
Mid-Afternoon			
Evening			
Bedtime			
SNACK ITEM	YES	NO	WHAT KIND
Chips			
Popcorn			
Candy			
- Chocolate			
- Hard Candy			
Cookies			
Ice Cream			
BEVERAGE ITEM			
Water			
Juice			
Coffee			Creamer - Milk/Artificial Sweetener
Tea			
Herbal Tea			Creamer/Sweetener
Soft Drink			Diet or Regular
Milk			Whole/2%/1%/Skim
Buttermilk-Chocolate Milk			

Additional Items: _____

SIGNS & SYMPTOMS SURVEY

Please score each question as follows:

3 = if this is a **MAJOR** problem for you (severe or happens frequently).

1 = if this is a **MINOR** problem for you (not severe or happens infrequently).

Blank = if you **NEVER** have this problem.

If you do not understand a question, please circle it and discuss it with us.

SECTION ONE

Group A

- History of spinal disc problems or back surgery
- Cannot tolerate stress, i.e. unable to make decisions
- Irritated or receding gums, loose teeth
- Colds hands and feet
- Clicking jaw or TMJ pain

Group B

- History of speech impediment, stuttering, or stammering
- Dry, itchy eyes or dry mouth
- Poor memory
- Inability to relax, become serene, or meditate
- Frequent sore or irritated throat, sores on tongue or in mouth

Group C

- History of frequent canker sores, cold blisters, or boils
- Muscle and tendon weakness, pain in low back and buttocks
- Slow morning starter, writer's cramp, or stiffness after sitting
- Dry skin, dandruff, hair falling out
- Painful ribs, pleurisy, pain on inhalation, or sharp chest or shoulder pain

Group D

- History of diabetes in your family
- Blood sugar problems, either hypoglycemia or diabetes
- Unable to control appetite
- Desire to lose weight
- Need a meal replacement

SECTION TWO

Group A

- History of diabetes in yourself or family
- High blood pressure
- High blood triglyceride levels
- Dizziness or light-headedness when changing positions
- Pain on the side of the head or in the temples

Group B

- History of gallbladder stones or surgery
- Loss of appetite, especially for meat
- Frequent sour taste in the mouth, intolerance of fats or spicy foods
- Frequent constipation with light colored stool
- Discomfort or soreness under the right rib cage after eating

Group C

- History of ulcers or gastritis
- Frequent heartburn or indigestion with nausea and pain
- Acid reflux after eating
- Frequent use of antacids
- Pain or burning in the stomach that is relieved by eating

Group D

- History of lactose intolerance or gluten intolerance
- Craving or thirst for cold liquids or foods
- Intolerance of dairy products, grains, or sugar
- Sensitive to air pollutants, such as perfumes, smoke, etc.
- Discomfort or soreness under the left rib cage after eating

Group E

- History of chronic indigestion
- Unusual fullness after eating
- Lower bowel gas
- Undigested food, capsules, or tablets found in the stool
- Frequent abdominal cramping after eating

Group F

- History of pernicious anemia
- Loss of taste for meat
- Strong desire to eat when not hungry
- Indigestion, particularly 2 to 3 hours after eating
- Flatulence, lower bowel gas

Group G

- Painful gas
- Bloating after eating dairy
- Diarrhea after eating dairy

SECTION THREE**Group A**

- History of chronic sinus problems
- Loss of sense of smell, or an obstruction to nasal breathing
- Bothered by thick mucous discharges from nose
- Frequent nosebleeds
- Facial pain or paralysis

Group B

- History of anemia or other blood disorder, or taking medication
- Fatigued, tired most of the time
- Pale skin, lips, and nails
- Low resistance (frequent colds and infections)
- Sleepy after eating

Group C

- History of hepatitis, jaundice, or other liver disorder
- History of high blood pressure and/or medication
- Water retention, swelling of hands and feet
- Varicose veins and/or hemorrhoids
- Shoulder and neck stiffness and/or soreness

Group D

- History of chronic or frequent yeast infections
- Foul odor to stool or urine
- Unusually large appetite, i.e. cannot control urge to eat
- Frequent or prolonged use of antibiotics
- Constipation with hard, dry stool

Group E

- History of skin problems, such as acne
- Dermatitis, eczema, or psoriasis
- Have many warts or moles
- Frequent episodes of hives due to food allergies
- Excessive perspiration or lack of perspiration

Group F

- _____ Always tired, i.e. unable to meet daily requirements
- _____ Loss of appetite or feel better if you don't eat
- _____ Restless sleep, gnawing of teeth
- _____ Thin and have difficulty gaining weight
- _____ Itching around rectum and groin

SECTION FOUR**Group A**

- _____ History of reactive hypoglycemia
- _____ Suffer from airborne allergies
- _____ Dark circles under the eyes
- _____ Nausea or vomiting-type of indigestion or morning sickness
- _____ Muscular lower back pain

Group B

- _____ History of constipation with infrequent bowel movements
- _____ Frequent use of laxatives or enemas
- _____ Hard, painful stools
- _____ Lower abdominal gas
- _____ Less than one bowel movement a day

Group C

- _____ History of colitis or other disorder of the large intestine
- _____ Diarrhea with mucus or blood in the stool
- _____ Frequent or soft bowel movements
- _____ Left lower bowel pain
- _____ Painful bowel movements

Group D

- _____ History of frequent bladder infections
- _____ Frequent urination, urgency, or loss of control
- _____ Pass small amounts of urine at each voiding.
- _____ Dry skin, flaking, and dandruff
- _____ Pain or discomfort over the bladder

SECTION FIVE**Group A**

- _____ Would you describe yourself as a Type A personality; for example, driven and aggressive?
- _____ Tendency to have problems with indigestion and constipation
- _____ Stiff joints, especially after rest, i.e. loss of mobility
- _____ Sensitive to sudden sounds, i.e. startle easily
- _____ Headaches in back of the head and neck

Group B

- _____ History of thyroid gland disorders or medication
- _____ Fast heart beat, i.e. heart racing
- _____ Swollen or painful breasts
- _____ Moist warm skin, i.e. sweat easily
- _____ Neck, shoulder, arm or hand pain

Group C

- _____ History of low blood pressure problems
- _____ Awake after sleeping a few hours and cannot go back to sleep
- _____ Suffer from frequent periods of depression or inability to think clearly
- _____ Become light-headed when meals are missed
- _____ Suffer from frequent nightmares or panic attacks

Group D (MALE)

- _____ History of prostate disorders or medication
- _____ Frequent night urination
- _____ Dribbling
- _____ Loss of sexual urge
- _____ Pain radiating into groin or testes

Group E (FEMALE)

- _____ History of hysterectomy or estrogen replacement therapy
- _____ Vaginal discharge
- _____ Excessive menstruation flow
- _____ Lack of menstruation, scanty flow, irregular periods
- _____ Painful periods and/or symptoms of PMS

Group F

- _____ History of bone disorders, spurs, and/or osteoporosis
- _____ Muscle soreness and weakness
- _____ Loose teeth or poor fitting dentures
- _____ Hyper irritability, insomnia, and/or restlessness
- _____ Low back pain, weak joints or ligaments, fallen arches

Group G

- _____ Generally tired and lack of ambition or purpose
- _____ Frequent lack of motivation, inability to get started
- _____ Fatigued, easily tired
- _____ Failure to meet ordinary requirements of daily activities
- _____ Failure to respond to specific nutritional schedules

SECTION SIX**Group A**

- _____ History of cataracts, glaucoma, or poor vision
- _____ Frequent head colds, runny nose, and/or watery eyes
- _____ Bruise easily, slow healing of cuts, sore or bleeding gums, gingivitis
- _____ Frequent redness in the eyelids or "sand" in your eyes
- _____ Frequent headaches associated with eye strain or pain when moving your eyes

Group B

- _____ History of heart disease, taking medication, etc
- _____ Irregular heart beat or skipped beats
- _____ Dryness of skin and hair, itching due to dryness
- _____ Have varicose veins and/or hemorrhoids
- _____ Shoulder or chest pain on exertion

Group C

- _____ History of asthma, emphysema, bronchitis, or pneumonia
- _____ Difficulty breathing, shortness of breath
- _____ Frequent cough (dry or productive)
- _____ Wheezing or having difficulty breathing when lying on your back
- _____ Shoulder pain or bursitis

Group D

- _____ History of injury to tail bone
- _____ Restlessness or insomnia
- _____ Inability to concentrate, frequent day dreaming or nightmares
- _____ Unresolved health problems
- _____ Painful tail bone, hurts to sit down

Group E

- _____ History of muscle weakness and/or atrophy
- _____ Inability to tolerate potassium-rich foods such as molasses, olives, vegetable juices, bananas, oranges, etc.
- _____ Frequent writer's cramp or stiffness especially after rest
- _____ Muscle soreness and pain resulting from exercise
- _____ Loss of joint range of motion, painful "stretching"

Group F

- _____ History of deep bone or joint pain, painful weak teeth
- _____ Frequent anxiety (in need of tranquilizers)
- _____ Frequent infections (regular use of antibiotics)
- _____ Symptoms of edema, such as swelling of feet and ankles
- _____ Recent acute traumatic incident/accident

Group G

- _____ History of osteoarthritis or gout
- _____ Musculoskeletal pain, difficulty walking, etc.
- _____ Bone and joint pain in spine, hips, knees, feet, or hands
- _____ Inflammation, i.e. fever, redness, swelling, and/or pain
- _____ Stiff joints/sore muscles or diagnosed with Fibromyalgia

Group H

- _____ History of chronic herpes-type skin eruptions (frequent canker sores, cold blisters, and boils)
- _____ Raised and red skin eruptions such as hives, strong reaction to food or chemicals
- _____ Strong reactions to mosquito or insect bites
- _____ Frequent histamine reactions, such as sneezing attacks, etc.
- _____ Painful skin irritations such as sunburn, diaper rash, or chapped lips

**Thank you for taking the time to fill out your portion accurately and honestly.
Your answers will assist us in making a more thorough examination of your health and
enable us to make a more complete identification of your health issues.**

For educational purposes only. These recommendations are for the reduction of stress only. They are not intended as treatment or prescription for any disease, or as a substitute for regular medical care.

Taken from 21st Century Nutrition