Name:____

Sleep:

Do you have trouble falling asleep? ___Yes ___No
Do you have trouble staying asleep? ___Yes ___No

Digestion and elimination:

Do you have normal, daily bowel movements (at least one bowel movement a day)? Yes or No
Bloating Yes or No Gas Yes or No Indigestion Yes or No Reflux Yes or No

Intestinal Dysbiosis:

Have you ever been on long-term (more than 2 weeks) antibiotic therapy? ___ Yes____ No
Have you ever had vaginal yeast infections? __Yes __No
If yes, when was last infection? ________________
Do you have chronic vaginal yeast infections (more than 2 a year)? ___Yes __No
Have you taken birth control pills for more than 1 year? ___Yes___ No
Do you crave Sugar? ____ Yes ___No
Does eating sugar make your symptoms worse? __Yes __No
Do you have rectal itching after eating sugar, fruit, or a lot of starches? ___Yes ___No
Have you EVER been on prednisone or cortisone long-term (weeks)? _____Yes ___No
Have you EVER been on long term (month or more) non-steroidal anti-inflammatory medications (Vioxx, Celebrex, Naprosyn, Advil, Bextra, Mobic, etc.)? __Yes __No

Thyroid:

Please check any of the following that apply-
___ Fatigue ___High Cholesterol ___Chronic Headaches ___Cold hands/feet ___Hair loss ___Depression
___ Irregular periods ___Severe menstrual cramps ___Low blood pressure ___Fluid retention
___Frequent colds and sore throats ___Decreased memory ___Ringing in the ears ___Decreased concentration
___Infertility ___Decreased sex drive ___ Constipation __Inappropriate weight gain

Psychologic: ☐ **I DENY having any of the symptoms or problems listed below.**

☐inability to experience pleasure ☐ behavioral change ☐ convulsions ☐ memory loss
☐ anxiety ☐ bi-polar disorder ☐ depression ☐ mood change
☐ loss or change in appetite ☐ confusion ☐ insomnia

Adrenal Function:

If you skip a meal do you feel bad (have headaches, become irritable, get jittery, tired, etc.)? ___ Yes __No
Do you have low blood pressure? ___Yes ___ No __Don’t Know
Do you crave salty foods? ___Yes ___No
Does increased stress or stressful situations make your symptoms worse? ___Yes ____No
How’s your energy level? Choose 1 to 5, with 5 being the best. ______
How is your concentration and memory on a scale of 1-5, with 5 being best? ________
How do you feel in the morning? __Refreshed ___Hung over ___Exhausted___Nauseated ___Achy All Over
Are you hungry in the morning? ___Yes ___No