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 SYSTEMS MEDICINE QUESTIONNAIRE

**General Information**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle Name: \_\_\_\_\_\_\_\_\_\_\_\_Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:(\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_\_/\_\_\_\_/\_\_ Age: \_\_\_\_\_\_\_\_\_

Cell Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone:(\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City or town & country if not US

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_′ \_\_\_\_ ″

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care at NGI/GenMedx: Nutrition\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Medical\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weight: \_\_\_\_ Weight six months ago: \_\_\_\_\_ Weight one year ago: \_\_\_\_\_

Would you like your weight to be different? \_\_\_\_\_ If so, what? \_\_\_\_\_

1. Please check applicable box(es):

\_\_ Black \_\_ Hispanic \_\_ Mediterranean \_\_ Asian

\_\_ Native American \_\_ Caucasian \_\_ Northern European \_\_ Other

Relationship status: \_\_\_\_\_\_\_\_\_\_\_\_ Children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hours worked per week: \_\_\_\_\_\_\_\_\_\_\_\_

Biological Sex: \_\_\_\_\_ Gender Preference: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If we had a magic wand and could change three things about your current condition, what would they be?

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**Please list your current medical issues in ascending order**.

|  |  |  |  |
| --- | --- | --- | --- |
| **DESCRIBE** **PROBLEM/** **DIAGNOSIS**  | **MILD/** **MODERATE/** **SEVERE**  | **TREATMENT** **APPROACH**  | **SUCCESS?**  |
| ***Example: Allergies*** | *Moderate*  | *Zyrtec*  | *Still have seasonal issues.*  |
|  |   |   |   |
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|  |   |   |   |

 Do these health concerns interfere with (check all that apply):

□ work □ sleep □ daily routine □ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your symptoms getting progressively worse? □ Yes □ No

Is your condition: □ Constant □ Intermittent

Do you have any medical diagnoses concerning your current symptoms? □ Yes □ No

If yes, list the doctor’s name, diagnosis, and date of diagnosis.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please** **indicate any** **previous therapies or treatments and the level of success with each intervention. Success levels should be rated as 1, meaning very little effectiveness and 10 being a resolution of the issue.**

|  |  |  |
| --- | --- | --- |
| **Previous Intervention**  | **Outcome rated 1-10**  | **Are you still using this intervention?**  |
| **Medications**   |   |   |
| **Emergency room**   |   |   |
| **Surgery**   |   |   |
| **Exercise**   |   |   |
| **Supplements**   |   |   |
| **Chiropractic care**   |   |   |
| **Naturopathic care**  |   |   |
| **Acupuncture**   |   |   |
| **Nutrition**   |   |   |
| **Personal trainer**   |   |   |
| **Other:**   |   |   |

Where do you picture yourself being in the next 1 to 3 years if this problem is not taken care of?

Please be specific.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What would be different or better without this (these) problem(s)? Please be specific.

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What do you desire the most from NGI?

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Please list any other concerns and/or goals:

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Why do you feel your health is the way it is?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At what point in your life did you feel the best? What were you doing then?

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Do you sleep well? \_\_\_\_\_\_ How many hours? \_\_\_\_\_\_ Do you wake up at night? \_\_\_\_\_\_

Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any pain, stiffness or swelling? If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical and Surgical History**

Please answer the following to the best of your ability. If the condition applies to your immediate family member, ***including your child***, please indicate so in the margins. **Indicate P for Paternal for your father’s side, so PGM would be your fathers’ mother and M for maternal. MGF, Maternal grandfather and so forth.**

|  |  |  |  |
| --- | --- | --- | --- |
| **ILLNESS**  | **DATE**  | **COMMENTS**  | **PERSON AFFECTED**  |
| Anemia  |   |   |   |
| Arthritis  |   |   |   |
| Asthma  |   |   |   |
| Autism Spectrum Disorder  |   |   |   |
| Blood Disorder  |   |   |   |
| Bronchitis  |   |   |   |
| Cancer  |   |   |   |
| Chronic Fatigue Syndrome  |   |   |   |
| Covid/Long Covid |  |  |  |
| Crohn’s Disease, Ulcerative Colitis, Celiac  |   |   |   |
| Diabetes (Type 1 or 2)  |   |   |   |
| Diverticulitis/losis  |   |   |   |
| Dementia/Multi-infarct  |   |   |   |
| Ehlers-Danlos Syndrome  |   |   |   |
| Emphysema or COPD  |   |   |   |
| Epilepsy, convulsions, or seizures  |   |   |   |
| Fertility/PCOS  |   |   |   |
| Fibromyalgia  |   |   |   |
| Food sensitivities  |   |   |   |
| Gallstones  |   |   |   |
| Gout  |   |   |   |
| Heart attack/Angina (chest pain)  |   |   |   |
| Heart failure  |   |   |   |
| Hepatitis  |   |   |   |
| High blood fats (cholesterol, triglycerides)  |   |   |   |
| High blood pressure (hypertension)  |   |   |   |
| Hypotension  |   |   |   |
| IBS (constipation or diarrhea)  |   |   |   |
| IgE Food Allergies  |   |   |   |
| Kidney stones/Prostate issues  |   |   |   |
| Marfan’s or other connective tissue disease  |   |   |   |
| Mast Cell Activation Disorder  |   |   |   |
| Mononucleosis (kissing disease/EBV)  |   |   |   |
| Osteoporosis  |   |   |   |
| Parathyroid Disease  |   |   |   |
| Pneumonia  |   |   |   |
| Rheumatic fever (Scarlet fever/scarletina)  |   |   |   |
| RA/SLE/MS  |   |   |   |
| Sinusitis  |   |   |   |
| Sleep apnea  |   |   |   |
| Speech/Hearing problems  |   |   |   |
| Stroke  |   |   |   |
| Thyroid disease  |   |   |   |
| Others (Lyme/Mycoplasma, EDS, etc.)  |   |   |   |

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| **INJURIES**  | **DATE**  | **COMMENTS**  |
|  Back injury  |   |   |
|  Broken bones (describe)  |   |   |
|  Head injury  |   |   |
|  Neck injury  |   |   |
|  Other (describe)  |   |   |

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| **DIAGNOSTIC TESTS**  | **DATE**  | **COMMENTS**  | **RESULTS**  |
|  Barium Enema  |   |   |   |
|  Bone Scan (DEXA)  |   |   |   |
|  CAT (Scan of Abdomen)  |   |   |   |
|  CAT (Scan of Brain)  |   |   |   |
|  CAT (Scan of Spine)  |   |   |   |
|  Chest X-ray  |   |   |   |
|  Colonoscopy  |   |   |   |
|  EKG  |   |   |   |
|  EMG/SSEP/NCV  |   |   |   |
|  Liver scan  |   |   |   |
|  Neck X-ray  |   |   |   |
|  Nerve Biopsy  |   |   |   |
|  NMR/MRI  |   |   |   |
|  Sigmoidoscopy  |   |   |   |
|  Sweat Electrode test (POTS test)  |   |   |   |
|  Tilt Table Test  |   |   |   |
|  Upper GI Series/ Endoscopy  |   |   |   |
|  Vaso-Vagal (Dysautonomia/Neurology)  |   |   |   |
| Tryptase  |   |   |   |
| Bone marrow biopsy  |   |   |   |
| Urinary N-methylhistamine  |   |   |   |
| Urinary 2,3-dinor 11-beta prostaglandin F2 alpha  |   |   |   |
| Other (describe)  |   |   |   |

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| **OPERATIONS**  | **DATE**  | **COMMENTS**  |
|  Appendectomy  |   |   |
|  Dental Surgery  |   |   |
|  Diverticulitis/resection  |   |   |
|  Gall Bladder  |   |   |
|  Hernia  |   |   |
|  Hysterectomy  |   |   |
|  Tonsillectomy/ Adenoidectomy  |   |   |
| **HOSPITILIZATIONS**  | **WHEN/DURATION**  | **COMMENTS**  |
|  Birth/C-section |   |   |
|  Other (describe)  |  |  |  |
|  Other (describe)  |   |   |  |
|  |   |   |  |

**Medications and Supplements:**

|  |
| --- |
|  |

**PLEASE LIST ALL DRUG AND HERBAL ALLERGIES, INCLUDING THINGS LIKE RED DYE, SULFA DRUGS, etc.:**

|  |
| --- |
| **PLEASE LIST ALL FOOD ALLERGIES:** |

|  |
| --- |
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**PLEASE LIST ALL FOOD SENSITIVITES:**

**Please list ALL vitamins, mineral and herbal supplements. Please consider the teas you might drink or energy beverages and multivitamins.**

|  |  |  |  |
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| **Vitamin/Supplement (including the brand)**  | **Date Started**  | **Dosage/Regimen**  | **Why are you** **taking the supplement?**  |
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**Please list all medications. Please bring** **all of your medications and supplements with you to your first appointment.**

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| **Medication**  | **Date Started/Ordering** **MD**  | **Dosage/Regimen**  | **Why are you taking the medication?**  |
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**In the following charts, please** **indicate if you have the sign or symptom currently, or if you have had the issue in the past, please** **indicate when and how/why the issue was resolved if known.**

|  |  |  |  |
| --- | --- | --- | --- |
| **HEAD/EYES/EARS**  | **MILD**  | **MODERATE**  | **SEVERE**  |
| Conjunctivitis  |   |   |   |
| Distorted sense of smell  |   |   |   |
| Distorted taste  |   |   |   |
| Ear fullness  |   |   |   |
| Ear noise  |   |   |   |
| Ear pain  |   |   |   |
| Ear ringing/buzzing  |   |   |   |
| Eye crusting  |   |   |   |
| Eye pain  |   |   |   |
| Headache  |   |   |   |
| Hearing loss  |   |   |   |
| Hearing problems  |   |   |   |
| Lid margin redness  |   |   |   |
| Migraine  |   |   |   |
| Sensitivity to loud noise  |   |   |   |
| Vision problems  |   |   |   |

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| --- | --- | --- | --- |
| **MOOD/NERVES**  | **MILD**  | **MODERATE**  | **SEVERE**  |
| Agoraphobia  |   |   |   |
| Anxiety  |   |   |   |
| Panic Attacks  |   |   |   |
| Auditory hallucinations  |   |   |   |
| Black outs  |   |   |   |
| Depression  |   |   |   |
| Difficulty Concentrating  |   |   |   |
| Specifically, with:  |   |   |   |
|  - Thinking  |   |   |   |
|  - Judgment  |   |   |   |
|  - Speech  |   |   |   |
|  - Memory  |   |   |   |
| Dizziness (spinning)  |   |   |   |
| Fainting  |   |   |   |
| Fearfulness  |   |   |   |
| Irritability  |   |   |   |
| Light-headedness  |   |   |   |
| Other:  |   |   |   |
| Any other salient symptoms from any category:    |

|  |  |  |  |
| --- | --- | --- | --- |
| **GENERAL**  | **MILD**  | **MODERATE**  | **SEVERE**  |
| Cold hand and feet  |   |   |   |
| Cold intolerance  |   |   |   |
| Daytime sleepiness  |   |   |   |
| Difficulty falling asleep  |   |   |   |
| Early waking  |   |   |   |
| Fatigue  |   |   |   |
| Fever  |   |   |   |
| Flushing  |   |   |   |
| Heat intolerance  |   |   |   |
| Night Waking  |   |   |   |
| Nightmares  |   |   |   |
| No dream recalls  |   |   |   |

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| **MUSCULOSKELETAL**  | **MILD**  | **MODERATE**  | **SEVERE**  |
| Back muscle spasm  |   |   |   |
| Calf cramps  |   |   |   |
| Chest tightness  |   |   |   |
| Foot cramps  |   |   |   |
| Dislocations/subluxations  |   |   |   |
| Joint pain  |   |   |   |
| Joint redness  |   |   |   |
| Joint stiffness  |   |   |   |
| Muscle pain  |   |   |   |
| Muscle spasms  |   |   |   |
| Muscle stiffness  |   |   |   |
| Muscle twitches:  |   |   |   |
|  -Around the eyes  |   |   |   |
|  -In the arms in Legs  |   |   |   |
| Muscle weakness  |   |   |   |
| Neck muscle spasm  |   |   |   |
| Tendonitis  |   |   |   |
| Tension headaches  |   |   |   |
| TMJ problems  |   |   |   |
| Others  |   |   |   |

**For women only:**

Have you ever been pregnant? □ Yes □ No

Number of miscarriages \_\_\_\_\_\_ Number of terminations \_\_\_\_\_\_

Number of premature births \_\_\_\_\_\_ Number of term/live births \_\_\_\_\_\_

Birth weight of largest baby \_\_\_\_\_\_ Weight of smallest baby \_\_\_\_\_\_

Did you develop pre-eclampsia or eclampsia (high blood pressure)? □ Yes □ No Are there any additional complications regarding fertility or pregnancy? □ Yes □ No If yes, please describe.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last Pap Smear \_\_\_\_\_\_\_\_\_ Normal/Abnormal

Date of last Mammogram \_\_\_\_\_\_\_\_ Normal/Abnormal

Age of first period \_\_\_\_\_ Are your periods regular? \_\_\_\_\_

Average length of menstruation? \_\_\_\_\_\_\_

Date of last period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What is your average cycle length? \_\_\_\_\_

Would you consider your periods to be heavy or light? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you experience painful cramps or moodiness during menstruation? Please explain.

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Do you spot in between your periods? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you experience increased stool frequency or diarrhea at the onset of your period? □ Yes □ No

Do you currently use contraception? □ Yes □ No

Current birth controlled used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What birth control have you used in the past? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you experience yeast infections or urinary tract infections? Please explain.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reached or approaching menopause? Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, age of last period. \_\_\_\_\_\_\_\_\_

If you are menopausal, are you having symptoms? Please explain?

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Are you using hormone replacement therapy? □ Yes □ No

If yes, which type and dosages?

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How long have you been using hormone replacement therapy (if applicable)?

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Do you have any of the following currently or in the past (circle all that apply)?

Hot flashes ● PMS ● Cramps ● Tender breasts ● Infertility ● PCOS ● Endometriosis

Uterine polyps ● Uterine fibroids ● Breast/ovarian/uterine cancer ● Facial hair growth ● Hypothyroidism ●Migraines ● Hysterectomy

**For Men Only**

For men, please indicate any issues with urinary frequency or erectile dysfunction.

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Do you get regular prostate exams? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any history of elevated PSA? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any issues with infertility? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had a vasectomy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Covid Assessment**

Have you been infected with Covid and if so please list dates of infections: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been vaccinated for Covid and if so please list dates, lot number and manufacturer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you answered yes to either of the above, did you have any side effects from either or are you experiencing any long term impacts that you would like to discuss? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Digestive Symptoms/Food Patterns

Are you following a special diet (please check all that apply)?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Ovo-Lacto vegetarian  |   | Vegetarian  |   | Vegan  |   |
| Dairy-free  |   | Gluten-free  |   | Diabetic/Low sugar  |   |
| Low sodium/DASH  |   | Low histamine  |   | Low salicylate  |   |
| Low oxalate  |   | Low sulfur  |   | Low FODMAP  |   |
| Ketogenic/Keto-adapted  |   | Atkins  |   | Yeast/Mold  |   |
| Specific Carbohydrate  |   | Paleo  |   | Autoimmune Paleo  |   |
| Other, please describe  |   |  |
| How long have you been on the diet?  |   |  |

If you could change one thing about your diet to improve your health, what would it be?

**Food Allergy Assessment**

|  |  |  |  |
| --- | --- | --- | --- |
| **Food** **Allergy/Sensitivity**  | **Anaphylaxis? Yes or No**  | **Other Reactions**  | **Last Exposure**  |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |

Specify any *major* food dislikes/aversions:

Do you eat breakfast? □ Yes □ No If so, what do you typically eat for breakfast?

Do you snack? □ Yes □ No If yes, what do you usually snack on?

Describe what you typically drink during the day.

The “healthiest” three foods you eat during the week are:

1.

2.

3.

The “worst” three foods you eat during the week are:

1.

2.

3.

How often do you skip meals? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 How do you feel when you have skipped a meal? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you ravenous or can you take it in stride? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **How do you feel after eating?**  | **Better**  | **Worse**  | **No Difference or Not Applicable**  |
| High fat foods  |   |   |   |
| High protein foods  |   |   |   |
| High carbohydrate foods (pasta, bread, potatoes)  |   |   |   |
| Refined sugar/Junk Food  |   |   |   |
| Fried Foods  |   |   |   |
| 1 to 2 alcoholic beverages  |   |   |   |

Have you ever had a food that you craved or really “binged” on for a period of time?

□ Yes □ No

If yes, what food(s)? (Food craving may be an indicator that you may be allergic to that food.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Do you ever feel that you have lost control of what or how much you are eating?

 If so, how often does this happen and what particular food(s) is involved?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you eat when you are: Stressed? Bored? Upset? Tired?

Do you cook? \_\_\_\_

What percentage of your food is home-cooked? \_\_\_\_

Where do you get the rest from? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Will family and/or friends be supportive of your desire to make food and/or lifestyle changes?

Yes, or no? Explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please** **indicate whether you have any of the following diseases/conditions:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Anemia**  |   | **GERD**  |   |
| **Celiac Disease**  |   | **High Blood Fats**  |   |
| **Crohn’s Disease**  |   | **Hypertension**  |   |
| **Diabetes, Type 1**  |   | **IBS (constipation, diarrhea)**  |   |
| **Diabetes, Type 2**  |   | **IgE Food Allergies**  |   |
| **Diverticulitis**  |   | **SIBO**  |   |
| **Gallstones**  |   | **Ulcerative Colitis**  |   |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  | **Stool Analysis**  |  |
|  | **Frequency**  |  | **Color**  |  | **Consistency**  |
| • • • • •  | More than 3 x/day 1-3 x/day 4-6 x/day 2-3 x/week 1 or fewer x/week  | • • • • •  | Medium brown consistently Very dark or black Greenish color Blood is visible Dark brown consistently • Varies a lot  | • • • • •  | Soft, well-formed, and easy to pass; surface may be smooth or slightly cracked Floats Difficult to pass Diarrhea Thin, long, and narrow, ribbon-like  |
|  |  |  |  | •  | Small and hard  |
|  |  |  |  | •  | Loose, but not watery  |
|  |  |  |  | •  | Alternating between hard and loose/watery  |

|  |
| --- |
| **Symptoms & Patterns: Please answer to the best of your knowledge**  |
| Do you remember *really* disliking a particular food from childhood, particularly because it made you sick? If yes, what food(s) and what were your symptoms?  |   |
| Do you currently have any symptoms after eating a particular food? Like gassiness or urgency for the restroom? If yes, please describe and note food(s).  |   |
| Do any foods give you hives, runny nose, burning mouth, blisters in your mouth, ringing or redness in your ears, or make you feel hot or dizzy?  |   |
| Do you ever flush on your chest or cheeks and then have diarrhea?  |   |
| Do you find that you tolerate cooked produce better than uncooked produce?  |   |
| Do you have seasonal allergies? (Mold/pollen/trees/grasses/pet dander/latex)  |   |
| Do you have issues with swelling or water retention?  |   |
| Sometimes there are delayed allergy responses, up to 24-72 hours after the consumption of the offending food item;  |   |

|  |  |
| --- | --- |
| Do you think that some of your symptoms might be due to delayed food sensitivities when viewed through this lens?  |  |
| Do you have intestinal gas? If yes, indicate which of the following apply: daily, occasionally, excessive, present with pain, little odor, foul smelling  |   |
| Have you lost your taste for meat?  |   |
| Do you experience a sense of excess fullness after meals?  |   |
| Describe appetite (low, extreme, etc.)  |   |
| Is there undigested food in stool?  |   |
| Are you aggravated by spicy or sour foods (have sour burps, sour smell)?  |   |
| Do you experience pain between shoulder blades?  |   |
| Do you experience gallbladder attacks?  |   |
| Do you have a bitter taste in your mouth, especially after meals?  |   |
| Any pain under right side of rib cage?  |   |
| Abdominal bloating 1-2 hours after eating?  |   |
| Does your pulse speed up after eating?  |   |
| Is there a coating on your tongue?  |   |
| Does your anus itch?  |   |
| Do you have bad breath or strong body odor?  |   |
| Do you experience cramping in the lower abdominal region?  |   |
| Do you crave sweets, breads, rolls, cookies, pasta, pizza, or chips?  |   |
| Do you crave coffee or sugar in the afternoon?  |   |
| Do you get sleepy in the afternoon?  |   |
| Is fatigue relieved by eating?  |   |
| When you eat snacks/sweets, do you eat them, get a temporary boost of energy and  |   |
| mood, and later crash?  |  |
| Do you ever experience heart palpitations after eating sweets?  |   |
| Do you have frequent thirst?  |   |
| Do you urinate often?  |   |
| Do you experience any of the following: wired, increased aches in muscles and joints, anxiety, palpitations, sweating, dizziness when using caffeine?  |   |
| Have a negative reaction when you consume foods containing MSG, sulfites, or other preservatives  |   |

|  |
| --- |
| Immediately after or within 30 minutes of eating, do you experience:  |
|  Indigestion?  |   |
|  Burping?  |   |
|  Bloating?  |   |
|  Sneezing?  |   |
|  Hives?  |   |
|  Sleepiness/Fatigue?  |   |
| Heartburn or acid reflux symptoms  |   |
| Do you regularly experience nausea?  |   |
|  Mornings  |   |
|  Evenings  |   |
|  At other times (please specify):  |   |

**Environmental & Lifestyle Intake**

What type of home do you currently live in (single family home, apartment/condo, mobile home, etc.)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What type of work environment do you currently work in (home, office building, factory, restaurant, shops, etc.)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approximately what year was your home built? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Do you have any pets or farm animals? If yes, what kind and where do they live? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your home had any previous water or fire damage? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the current water source for your home (well, public water, bottled, etc.)? \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To your knowledge have you been exposed to toxic metals in your job or at home? \_\_\_\_\_\_\_\_\_\_ If yes, which one(s) (lead, arsenic, aluminum, cadmium, mercury) and how long were you exposed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do odors or chemicals affect you? If so, which ones (smoke, perfume, cleaning products, etc.)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ In your work or home environment, are you (or have you been) exposed to any of the following regularly:

\_\_\_\_ Chemicals \_\_\_\_ Electromagnetic radiation \_\_\_\_ Mold

\_\_\_\_ Dry cleaning \_\_\_\_ Automobile exhaust \_\_\_\_ Aerosols

\_\_\_\_ Radio tower \_\_\_\_ Paint fumes \_\_\_\_ Smoke

\_\_\_\_ Landfill/dump \_\_\_\_ Hydro tower \_\_\_\_ Herbicides

\_\_\_\_ Heavy metals \_\_\_\_ Organic solvents \_\_\_\_ Pesticides

\_\_\_\_ Harsh chemicals (varnish, gas, glue, acid, cleaning) \_\_\_\_ Airplane travel

\_\_\_\_ Farm/industrial/power plant/lines \_\_\_\_ Modeling clay

\_\_\_\_ Photo developing/dark room

Do you have regular exposure at home or work to:

|  |  |
| --- | --- |
| \_\_\_\_ Forced air heat  |  \_\_\_\_ Renovations  |
| \_\_\_\_ Basement cracks/dirt floors  |  \_\_\_\_ Damp basement/crawl space  |
| \_\_\_\_ Wet windows  |  \_\_\_\_ Visible mold  |
| \_\_\_\_ Crumbling pipe insulation  |  \_\_\_\_ Crumbling wall/ceiling insulation  |
| \_\_\_\_ Old or cracking paint  |  \_\_\_\_ Old/cracked ceiling tiles/flooring  |
| \_\_\_\_ Carpets or rugs  |  \_\_\_\_ Stagnant or stuffy air  |
| \_\_\_\_ Gas or propane stove (or other gas)  |  \_\_\_\_ Coal or wood stove  |
| \_\_\_\_ Crumbling wall/ceiling insulation  |  \_\_\_\_Water leaks (ceiling/walls/floors)  |

Have you ever worked at a job or hobby in which you came in contact with any of the following by breathing, touching, or ingesting (swallowing)? If yes, please check or circle the name.

|  |  |
| --- | --- |
| \_\_\_\_ Acids \_\_\_\_ Alcohols (industrial)  | \_\_\_\_ Alkalis  |
| \_\_\_\_ Ammonia \_\_\_\_ Arsenic  | \_\_\_\_ Asbestos  |
| \_\_\_\_ Benzene \_\_\_\_ Beryllium  | \_\_\_\_ Cadmium  |
| \_\_\_\_ Carbon tetrachloride \_\_\_\_ Chlorinated naphthalene  | \_\_\_\_ Chloroform  |
| \_\_\_\_ Chloroprene Chromates \_\_\_\_ Coal dust  | \_\_\_\_ Dichlorobenzene  |
| \_\_\_\_ Ethylene dibromide \_\_\_\_ Ethylene dichloride  | \_\_\_\_ Fiberglass Halothane  |
| \_\_\_\_ Isocyanates \_\_\_\_ Ketones  | \_\_\_\_ Lead or Mercury  |
| \_\_\_\_ Methylene chloride \_\_\_\_ Nickel  | \_\_\_\_ PBBs  |
| \_\_\_\_ PCBs \_\_\_\_ Perchloroethylene  | \_\_\_\_ Pesticides  |
| \_\_\_\_Phenol \_\_\_\_ Phosgene  | \_\_\_\_ Radiation  |
| \_\_\_\_ Rock dust \_\_\_\_ Silica powder  | \_\_\_\_ Solvents  |
| \_\_\_\_ Styrene \_\_\_\_ Talc  | \_\_\_\_ Toluene  |
| \_\_\_\_ TDI or MDI \_\_\_\_ Trichloroethylene  | \_\_\_\_ Trinitrotoluene  |
| \_\_\_\_ Vinyl chloride \_\_\_\_ Welding fumes  | \_\_\_\_ X-rays  |

Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you live next to or near an industrial plant, commercial business, dump site, highway, or nonresidential property?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which of the following do you have in your home? (circle those that apply)

Air conditioner Air purifier Central heating (gas or oil?) Gas stove

Fireplace Wood stove Humidifier Water filters

Have you recently acquired new furniture or carpet, refinished furniture, or remodeled your home? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you weatherized your home recently? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are pesticides or herbicides (bug or weed killers; flea and tick sprays, collars, powders, or shampoos) used in your home or garden, or on pets? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you work on your car? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever changed your residence because of a health problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have mercury amalgam fillings? If so, for how long have you had them? \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any artificial joints or implants? If so, for how long have you had them?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel worse at certain times of the year? If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lifestyle**

Have you lived or traveled outside of the United States? If so, when, and where? Did you get sick?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever used alcohol? □ Yes □ No If yes, how often do you now drink alcohol (Please circle)?

No longer drinking alcohol ● Average 1-3 drinks per week ● Average 4-6 drinks per week

Average 7-10 drinks per week ● Average >10 drinks per week

Have you ever had a problem with alcohol? □ Yes □ No

 If yes, please indicate time period (month/year): From \_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_.

Have you ever used recreational drugs? □ Yes □ No

If yes, please indicate what types\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever used tobacco? □ Yes □ No

If yes, number of years as a nicotine user: \_\_\_\_\_\_. Amount per day: \_\_\_\_. Year quit: \_\_\_\_.

If yes, what type(s) of nicotine have you used (circle all that apply)?

Cigarette ● Smokeless ● Cigar ● Pipe ● Patch/gum

Have you ever been exposed to secondhand smoke regularly? □ Yes □ No

How many caffeinated beverages do you consume per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list your personal care products used on a daily basis:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sleep**

Average number of hours you sleep per night: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What time do you go to sleep? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Wake up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you sleep with any lights or sounds on? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check if you have any of the following:

 \_\_\_\_Trouble falling asleep \_\_\_\_ Feeling unrested or tired after waking

 \_\_\_\_ Wake during the night \_\_\_\_ Snoring or sleep apnea

 \_\_\_\_ Strange dreams or nightmares \_\_\_\_ Night sweats

**Emotional Health/Stress**

What do you feel is the major cause of your stress (for example — spouse, family, friends, work, finances, wedding, pregnancy, legal, commute)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How do you cope with stress?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a scale of 1-10, please answer the following questions. 1 is never and 10 is always.

|  |  |
| --- | --- |
| How often do you feel you have something that must be done?  | How often do you feel overwhelmed?  |
| How often do you have difficulty falling into deep, restful sleep?  | Do you ever feel paranoid?  |
| How often do you feel sad or down for no reason?  | Have you lost your enthusiasm for your favorite activities?  |
| Have you ever had self-destructive thoughts?  | How often do you have an inability to handle stress?  |
| How often do you prefer to isolate yourself from others?  | Do you find it difficult to finish tasks?  |
| Do you feel like your libido has decreased?  | Do you ever feel anxious or panicked for no reason?  |
| How difficult is it to turn your mind off when you want to relax?  | How stressful is your life?  |

Have you ever been diagnosed with any of the following?

□ Depression □ Anxiety □ bipolar disorder □ ADD/ADHD □ OCD □ Schizophrenia □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does anyone in your family suffer from any kind of mental illness, including depression, bipolar disorder, schizophrenia, anxiety, or seasonal affective disorder? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking an anti-depressant or other psychiatric medicine? □ Yes □ No

If yes, which medication(s) are you taking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had psychotherapy or counseling? Yes\_\_\_\_ No\_\_\_\_ Currently? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previously? \_\_\_\_\_ If previously, from \_\_\_\_\_\_ to \_\_\_\_\_\_\_.

What type of therapy?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What is the attitude of those close to you about your illness? Are they supportive or nonsupportive? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you or your family recently experienced any major life changes or losses? Yes\_\_ No\_\_

If yes, please comment

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much time have you lost from work or school in the past year?

1. \_\_\_\_\_ 0-2 days
2. \_\_\_\_\_ 3 –14 days
3. \_\_\_\_\_ > 15 days

Previous jobs:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you find joy in your job or jobs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you witnessed or experienced any physical or emotional trauma that could be impacting your health or wellbeing? If so, have you sought counseling for these traumatic events? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How important is religion (or spirituality) for you and your family’s life?

1. \_\_\_\_\_ not at all important
2. \_\_\_\_\_ somewhat important
3. \_\_\_\_\_ extremely important

Do you currently practice any form of meditation, breathing exercises, stretching, qi gong, tai chi, yoga, Pilates, etc.? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hobbies and leisure activities:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Where do you find emotional support?

 \_\_\_\_ Spouse \_\_\_\_ Family \_\_\_\_ Friends \_\_\_\_ Pets

 \_\_\_\_ Religious/Spiritual \_\_\_\_ Other

 **Exercise/Recreation**

Do you exercise? □ Yes □ No

If yes, please describe your exercise frequency:

Daily ● 5 to 6X per week ● 3 to 5X/week ● 1 to 3X per week

What type(s) of exercise do you participate in (circle all that apply)?

Cardiovascular (walk, bike, run) ● Strength training ● Pilates ● Yoga ● Flexibility ● Group exercise ● Personal training ● Martial arts ● Boxing/kickboxing ● Basketball ● Baseball ● Tennis ● Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When you exercise, how long is each session?

15 minutes or less ● 16 to30 minutes ● 31 to 45 minutes

46 to 60 minutes ● 61 to 90 minutes ● more than 90 minutes

 **Readiness to Change**

Will family and/or friends be supportive of your desire to make food and/or lifestyle changes?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you willing to change what you believe about health and the body to improve your health? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any patterns in childhood or adulthood that have contributed to your health problems?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything else you would like to share?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Questionnaire:**

**Read the following questions and rate them based on how you have been feeling in the past 30 days.**

**Fill in the number that applies on the form below:**

**KEY: 0 (or leave blank) =** **No or never or almost never occurs**

1. **= Occasionally occurs, effect is not severe**
2. **= Occasionally occurs, effect is severe**
3. **= Frequently occurs, effect is not severe**
4. **= Frequently occurs, effect is severe**

**Gastrointestinal:**

\_\_\_\_\_ Belching or gas (gurgles)

\_\_\_\_\_Flatulence; foul smelling

\_\_\_\_\_ Heartburn or acid reflux

\_\_\_\_\_ Bloating or abdominal discomfort shortly after eating

\_\_\_\_\_ Bad breath (halitosis)

\_\_\_\_\_ Aggravated by spicy foods

\_\_\_\_\_ Frequent Diarrhea

\_\_\_\_\_ Undigested food in stool

\_\_\_\_\_ Constipation/hard stools

\_\_\_\_\_ Nausea or vomiting

\_\_\_\_\_ Fewer than one bowel movement a day

\_\_\_\_\_ Stools are loose and unformed

\_\_\_\_\_ Stools are light in color

\_\_\_\_\_History of parasite

\_\_\_\_\_History of Celiac or Crohn’s disease

 \_\_\_\_\_\_\_\_\_\_\_ TOTAL

**Liver:**

\_\_\_\_\_Wine or beer makes you sick (histamine/ALD)

\_\_\_\_\_ Easily intoxicated if drinking alcohol

\_\_\_\_\_ Hangovers after drinking alcohol

\_\_\_\_\_ Sensitive to chemicals (perfume, solvents, exhaust)

\_\_\_\_\_ Sensitive to tobacco smoke (puffy eyes/congestion)

\_\_\_\_\_ Surface of abdomen is uneven and distended

\_\_\_\_\_ Use over the counter or prescription pain medications

\_\_\_\_\_ Chronic fatigue or Fibromyalgia

\_\_\_\_\_ Caffeine sensitivity

\_\_\_\_\_ Sweat has a strong odor

\_\_\_\_\_Occupational exposure to pesticides, insecticides, etc. (Farmer, mill or mine worker, landscaper, golfer)

\_\_\_\_\_Previous drug reactions to lidocaine, erythromycin, cyclosporine, ketoconazole, testosterone, estradiol, cortisone, alfentanil, alfuzosin, almotriptan, alprazolam, amiodarone, amitriptyline, amlodipine, anastrozole, aprepitant, aripiprazole, astemizole, atazanavir, atorvastatin, bepridil, bexarotene (CYP3A4)

 \_\_\_\_\_\_\_\_\_\_\_ TOTAL

**Musculoskeletal:**

\_\_\_\_\_Bilateral pain or swelling in joints

\_\_\_\_\_ Muscles become easily fatigued

\_\_\_\_\_ Muscle aches/pain

\_\_\_\_\_ Arthritic pain

\_\_\_\_\_ Joints are painful upon waking (bed fighting)

\_\_\_\_\_ Joint pain after mild exertion

\_\_\_\_\_ Joint pain experienced after eating certain foods

\_\_\_\_\_Joints are hypermobile

\_\_\_\_\_History of tendonitis or carpal tunnel syndrome.

\_\_\_\_\_Muscle twitching

\_\_\_\_\_\_\_\_\_\_\_ TOTAL

**Skin**

\_\_\_\_\_ Experience hives, cysts, boils, rashes

\_\_\_\_\_ Cold sores, fever blisters, or herpes lesions

\_\_\_\_\_ Dry flaky skin and/or dandruff

\_\_\_\_\_ Fragile skin

\_\_\_\_\_Atrophic scars

\_\_\_\_\_ Acne/oily skin

\_\_\_\_\_ Itchy skin / dermatitis

\_\_\_\_\_ Dull colored skin, yellowish, pale, or grayish

\_\_\_\_\_ Pale complexion

\_\_\_\_\_Low vitamin D

\_\_\_\_\_Makeup use (non-organic)

\_\_\_\_\_Beauty/skin product use

\_\_\_\_\_\_\_\_\_\_\_ TOTAL

**Cardiovascular/Pulmonary:**

\_\_\_\_Irregular or skipped beat

\_\_\_\_Rapid or pounding heartbeat

\_\_\_\_Angina/ Chest pain

\_\_\_\_High blood pressure

\_\_\_\_ Hypotension/POTS

\_\_\_\_Edema/swelling

\_\_\_\_Congestive heart failure

\_\_\_\_Stroke

\_\_\_\_Asthma

\_\_\_\_COPD/emphysema

\_\_\_\_Fast breathing rate

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TOTAL

**Mitochondrial/Energy:**

\_\_\_\_Easily fatigued

\_\_\_\_Exercise intolerance

\_\_\_\_Unrefreshed sleep

\_\_\_\_Restlessness

\_\_\_\_Hyperactivity/mania

\_\_\_\_ Daytime sleepiness

\_\_\_\_Brain fog

\_\_\_\_Insomnia

\_\_\_\_\_\_\_\_\_\_\_\_\_\_TOTAL

**Cognition:**

\_\_\_\_Difficulty with word recall

\_\_\_\_Brain fog

\_\_\_\_Anxiety

\_\_\_\_Depression

\_\_\_\_Mood swings

\_\_\_\_Poor memory

\_\_\_\_Difficulty concentrating

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TOTAL

**Kidney:**

\_\_\_\_History of UTI’s

\_\_\_\_History of kidney stone

\_\_\_\_Hematuria/Blood in the urine

\_\_\_\_Chronic white blood cells in urine culture

\_\_\_\_Muscle wasting

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TOTAL

Thank you for trusting the Nutritional Genomics Institute and GenMedx with this exciting and revolutionary advancement in your health. In the following weeks we will discover detailed information about your specific genome, epigenes and health condition. This highly individualized information is unique only to you and is followed by explanations and specific instructions on how to follow up with your primary care physician or specialist. In this process you will most likely be required to make several lifestyle modifications and take several nutritional supplements. If you could please indicate your willingness for change on a scale of 1-10, with 1 being not willing at all and 10 being very willing. Please rate the following questions.

1. Taking several nutritional supplements, some of which may be expensive (We have no vested interest in any supplement company)?

1. Changing your diet by giving up some of your favorite foods, especially if your testing deems it warranted?

1. Making your lifestyle a priority and more congruent with a healthy, less stressful environment, to include things like meditation or prayer and exercise on a regular basis?

1. Work with your physician to continue to have functional and conventional laboratory tests so that we may treat and work on the premise of preventative medicine rather than reactionary medicine?

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