



|   |  |
|---|--|
| When were you last free of your current main health issue?            |  |
| When did your current main health issue start?                        |  |
| Was the onset of your symptoms fairly sudden or gradual?              |  |
| What do you believe or suspect triggered your symptoms?               |  |
| What form or work or study were you involved in at the time of onset? |  |
| Where were you living at the time of onset?                           |  |
| What hobbies did you have at the time of onset?                       |  |

**Illness precipitating factors.** Which of the following events occurred in the 6 month period prior to the initial onset of main symptoms?

|  | Tick | Explain. |
|--|------|----------|
| High levels of stress/sadness/anger/betrayal/resentment/hatred   |      |          |
| Emotionally traumatic event(s) (e.g. death of a loved one)   |      |          |
| Excessive physical &/or work activity for you  |      |          |
| Sleep deprivation (< 7 hrs/night)/sleep disruption/night shift work  |      |          |
| Medication use (e.g. antibiotics, antacids, hormones, psychiatric)   |      |          |
| Changed dose of medication (e.g. lowered thyroid hormones)   |      |          |
| Started supplement containing > 600 mcg (0.6 mg) of copper   |      |          |
| Illicit drug use or started smoking  |      |          |
| Major change in diet (e.g. crash dieting / became vegetarian)  |      |          |
| Eating disorder behavior (bulimia or anorexia)   |      |          |
| Significantly increased alcohol, coffee or diet soft drink intake  |      |          |
| Changed house/job/office/school/class room   |      |          |
| Moved into recently constructed house  |      |          |
| House/work/school renovated or repaired (inc. vinyl wall paper)  |      |          |
| House/work/school freshly painted or sprayed with pesticides   |      |          |
| Workplace near toxic industry, highways or aerial spraying   |      |          |
| New mattress/fireproof bedding/carpet/furniture/refinished furniture/rug   |      |          |
| Amalgam (silver) filling insertion/removal, root canal insertion; or developed a dental infection or gum disease which you still have    |      |          |
| Broke glass thermometer  |      |          |
| Three or more servings of fish per week (1 serve = 150 grams)  |      |          |
| Regularly eating one of the following fish - Swordfish, shark/flake, marlin, broadbill, orange roughy/sea perch or catfish               |      |          |
| New appliance fuelled by gas, wood or kerosene (e.g. heater/fridge/dryer furnace/water heater/stove/fireplace/charcoal grill/generators) |      |          |
| Water contamination (e.g. leaks/flooding) in house/work/school   |      |          |
| New or increased mold growth in your house/work/school (e.g. musty smell)  |      |          |
| Exposure to algal blooms (e.g. 'red tides')  |      |          |
| Commenced new hobby  |      |          |
| Other chemical exposure (e.g. work/home related/polluted air around home – look at your answers on page 14)                              |      |          |
| Insertion of breast implants, silicon injections, metal crowns, braces, joint/hip replacement, metals screws/pins/nails/slips, etc.      |      |          |
| New cordless phone near bed, started using electric blanket, started sleeping near a meter box, new WiFi system – see answers on page 11 |      |          |
| Food poisoning / gastroenteritis / 'intestinal flu' / parasitic infection  |      |          |
| Household member with parasitic or bacterial infection   |      |          |
| International travel, camping, wilderness activities and/or travel to parasite prone area  |      |          |
| Viral or bacterial infection (other than typical 'cold') / fever   |      |          |
| Tick, spider or animal bite  |      |          |
| Vaccination (e.g. Hepatitis B or Tetanus)  |      |          |
| Blood transfusion or donation  |      |          |
| Hospitalization  |      |          |
| Surgery (e.g. hysterectomy/appendectomy)   |      |          |
| Pregnancy/miscarriage/abortion/menopause onset   |      |          |
| Underwent counseling that examined or uncovered an abusive history   |      |          |
| Injury / concussion or head injury / stroke  |      |          |
| Unprotected sex with people of unknown STD status  |      |          |

Anything else you wish to add? Mention anything, even if it seems unrelated.

**Family History.** Have you or any blood relatives been diagnosed with the following?

| Disorder                       | Yourself? |         | Relative(s)? | Disorder                                | Yourself? |         | Relative(s)? |
|--------------------------------|-----------|---------|--------------|---|-----------|---------|--------------|
|                                | Past      | Present |              |   | Past      | Present |              |
| ADD/ADHD                       |           |         |              | Learning disability                     |           |         |              |
| Alzheimer's Disease            |           |         |              | Migraines                               |           |         |              |
| Autism Spectrum                |           |         |              | Multiple Sclerosis (MS)                 |           |         |              |
| Bipolar Disorder               |           |         |              | Neural Tube Defects (e.g. spina bifida) |           |         |              |
| B-vitamin deficiency           |           |         |              | Night blindness                         |           |         |              |
| Chronic Fatigue Syndrome       |           |         |              | Parkinson's Disease                     |           |         |              |
| Crohn's Disease                |           |         |              | Pernicious anaemia*                     |           |         |              |
| Dementia under 70              |           |         |              | Polycystic ovaries                      |           |         |              |
| Down Syndrome                  |           |         |              | Porphyria                               |           |         |              |
| Drug addiction                 |           |         |              | Rheumatoid Arthritis                    |           |         |              |
| Early heart attacks (under 50) |           |         |              | Schizophrenia/psychosis                 |           |         |              |
| Epilepsy                       |           |         |              | Systemic Lupus (SLE)                    |           |         |              |
| Fibromyalgia                   |           |         |              | Ulcerative colitis                      |           |         |              |
| Haemochromatosis (excess iron) |           |         |              | Vitiligo (pale patches on skin)         |           |         |              |

\*Anaemia requiring vitamin B12 shots or raw liver.

Do any other significant medical conditions or symptoms run in, or are present in, your family?

**Sleep.**

|  |                |    |   |   |
|--|----------------|----|---|---|
| How many hours do you <u>sleep</u> per day (not total time in bed)? Take an average from a typical week.   | ___ hr's/night |    |   |   |
| How long does it take you to fall asleep on average?   | ___ minutes    |    |   |   |
| How many minutes are you awake between the time you first fall asleep and when you get out of bed?         | ___ minutes    |    |   |   |
| On average what hours do you sleep (e.g. 11 PM – 7 AM)?  | _____          |    |   |   |
| Do you snore moderately or severely? Answer no if snore only mildly or occasionally.                       | Yes            | No |   |   |
| Do you sometimes wake up in the night with a snort, gasp or choking/breathless feeling?                    | Yes            | No |   |   |
| Has your partner heard you making gasping/choking/snorting noises or breathing pauses during the night?    | Yes            | No |   |   |
| Do you wake up feeling unrefreshed/tired & feel sleepy during the day even when sleep sufficient hours?    | Yes            | No |   |   |
| Fall asleep very easily during day (e.g. sitting reading or watching TV) even when sleep sufficient hours? | Yes            | No |   |   |
| Regularly wake up in the night with a headache or have a headache upon awakening in the morning?           | Yes            | No |   |   |
| Obesity (BMI over 30) or large neck circumference (greater than 40 cm's)?                                  | Yes            | No |   |   |
| Do you have a close family history of sleep apnea?   | Yes            | No |   |   |
| How many times do you wake up during the night?  | 3+             | 2  | 1 | 0 |
| How many times do you wake up to go to the toilet in the night?  | 3+             | 2  | 1 | 0 |
| Is your sleep often disturbed by a snoring or restless partner, a young child or noisy pets?               | Yes            | No |   |   |
| Do your legs feel jumpy/restless & do you need to continually move your legs at rest at night?             | Yes            | No |   |   |
| Has your partner told you that your legs kick around during your sleep &/or you kick your partner?         | Yes            | No |   |   |
| When you wake up have you kicked around and scattered your bed sheets?                                     | Yes            | No |   |   |
| Often feel more awake when lying in bed at night than during much of the day?                              | Yes            | No |   |   |
| Sleep much better and feel much better in the day if you go to bed late (after 12 PM) and get up late?     | Yes            | No |   |   |
| Find it easy to sleep in morning hours (e.g. 5-7 AM) but difficult during 10-12 PM?                        | Yes            | No |   |   |
| Difficulty waking up in morning plus feel much better in the evening or night / 'night owl'?               | Yes            | No |   |   |
| Regularly or periodically do night shifts, or regularly travel through different time zones?               | Yes            | No |   |   |
| Have you had a sleep study done?   | Yes            | No |   |   |

*Sleep apnea*

*Sleep disturbance*

*Restless leg syndrome*

*Delayed sleep phase syndrome*

**Diet/Lifestyle.** How often do you consume the following (e.g. 2/day or 2/month)?

|                         |                          |                           |                          |
|-------------------------|--------------------------|---------------------------|--------------------------|
| Tea                     | / day with ___ tsp sugar | Coffee                    | / day with ___ tsp sugar |
| Vegetables              |                          | Soft drinks/cordial       |                          |
| Fruit                   |                          | Fruit juice               |                          |
| Whole grains/brown rice |                          | White flour/rice products |                          |
| Meat products           |                          | Sunflower/safflower oil   |                          |
| Fish/seafood            |                          | Chocolate                 |                          |
| Legumes/lentils/beans   |                          | Chips                     |                          |
| Nuts/seeds              |                          | Lollies                   |                          |
| Eggs                    |                          | Alcohol                   |                          |
| Dairy products          |                          | Cigarettes/tobacco        |                          |
| Olive oil               |                          | Illicit drugs             |                          |

|  |     |    |
|--|-----|----|
| Do you eat any aspartame (aka NutraSweet or Equal) containing products (e.g. diet soft drinks, certain confectionary products, etc.) or sucralose (Splenda)? | Yes | No |
| Are you a vegetarian, if so what type and for how long?  | Yes | No |
| Do you follow any other specific type of diet (e.g. gluten free, Atkins)?  | Yes | No |

**List typical meals.** Also list drinks consumed at meals, other than water.

|               |
|---------------|
| Breakfast:    |
| Mid-morning:  |
| Lunch:        |
| Mid-afternoon |
| Dinner:       |
| Late night:   |

**Dehydration.**

|  |   |
|--|---|
| Dark/concentrated colored urine              | • Drink ___ glasses of water/day on average |
| Decreased urination frequency (over 3 hours) |   |
| Dry mouth or dry mucous membranes in nose    |   |
| Intolerant to hot whether                    |   |
| Joint pain/discomfort                        |   |

**Physical activity.** How much and what type of physical activity do you get per week?

|  |
|--|
|  |
|--|

**Chronic infection/Immune dysregulation.** Highlight those which apply to you.

|  |  |
|--|--|
| Periodically swollen glands/lymph nodes                          | History of recurrent ear infections, tonsillitis or thrush                 |
| Frequent or ongoing elevated temperature (above 37°C / 98.6°F)   | Illness began after a viral or bacterial infection                         |
| Night sweats not related to menopause                            | Feel better/reduced symptoms while on, or after, antibiotics               |
| Ongoing sore throat  | Regular cold sores, fever blisters or warts                                |
| Swollen or discoloured (e.g. bright red) areas at back of throat | Health declined after a vaccination  |
| Elevated ESR or CRP  | Multiple tick bites in life or health decline after tick or spider bite    |
| Positive ANA on blood testing                                    | History of rickettsia (e.g. Q-Fever, Typhus, Rocky Mountain Spotted Fever) |

**Blood sugar/insulin imbalances.**

|  |  |  |
|--|--|--|
| <b>Diabetes mellitus/insulin resistance.</b> | <b>Hypoglycemia.</b> Regularly experience times in the day (e.g. between meals or if meals are missed) when have clusters of below symptoms. | Risk factors (mark or circle those which apply): <ul style="list-style-type: none"> <li>• Personal history of:                     <ul style="list-style-type: none"> <li>○ Low birth weight</li> <li>○ Gestational diabetes</li> <li>○ Giving birth to a baby weighing 9 pounds or more</li> <li>○ Fasting blood sugar above 5.5</li> <li>○ Elevated insulin levels</li> <li>○ Elevated uric acid</li> <li>○ Polycystic Ovarian Syndrome</li> </ul> </li> <li>• Family history of:                     <ul style="list-style-type: none"> <li>○ Diabetes Type 1</li> <li>○ Diabetes Type 2 ('adult onset')</li> </ul> </li> </ul> |
| Excess hunger                                | <ul style="list-style-type: none"> <li>• Faintness/lightheaded/dizziness</li> </ul>  |  |
| Fatigue                                      | <ul style="list-style-type: none"> <li>• Shakiness or trembling</li> </ul>   |  |
| Sleepiness after high carb meals             | <ul style="list-style-type: none"> <li>• Irritability/poor mood/nervousness/anxiousness</li> </ul>   |  |
| Carbohydrate/sugar cravings                  | <ul style="list-style-type: none"> <li>• Poor concentration/poor memory/confusion</li> </ul>   |  |
| Extra weight in abdominal region             | <ul style="list-style-type: none"> <li>• Headaches</li> </ul>  |  |
| High blood pressure (130/85 or more)         | <ul style="list-style-type: none"> <li>• Coldness/sweating</li> </ul>  |  |
| Frequent urination                           | <ul style="list-style-type: none"> <li>• Blurred vision</li> </ul>   |  |
| Excess thirst                                | Need for frequent meals/snacks to avoid above symptoms   |  |
| Slow wound healing or skin tags              | Symptoms are worse before meals and lessen after eating  |  |

**Essential fatty acid deficiencies.**

|  |   |
|--|---|
| Dry skin (e.g. feet/face/general)                | Dull nails - lack of surface shine            |
| Scaly or flaky skin (e.g. legs)                  | Slow growing fingernails                      |
| Cracking/peeling fingertips & skin (e.g. heels)  | Dry eyes                                      |
| Lackluster skin                                  | Dry mouth/throat                              |
| Small bumps on back of upper arms (chicken skin) | Acne  |
| Patchy dullness &/or color variation of skin     | Excessive ear wax or hard ear wax             |
| Mixed oily and dry skin ('combination' skin)     | Excessive thirst                              |
| Irregular quilted appearance of skin (e.g. legs) | Allergic (e.g. eczema/asthma/hay fever/hives) |
| Thick or cracked calluses                        | Crave fats/fatty foods                        |
| Dandruff or cradle cap                           | Stiff or painful joints                       |
| Dry, lackluster, brittle or unruly hair          | Menstrual cramps                              |
| Soft, fraying, splitting or brittle fingernails  | Premenstrual breast pain/tenderness           |

|  |     |    |
|--|-----|----|
| Do omega-3 oils (fish/flax) improve your skin/hair/nails or any other symptoms?  | Yes | No |
| <ul style="list-style-type: none"> <li>• Or does omega-3 make certain symptoms worse or have no noticeable effects?</li> </ul> | Yes | No |
| Have you tried taking evening primrose or borage oil?  | Yes | No |
| <ul style="list-style-type: none"> <li>• If so did it reduce skin/hair dryness or improve health in some other way?</li> </ul> | Yes | No |

**Copper excess.**

|   |   |
|---|---|
| Anxious/agitated  | Risk factors (mark or circle those which apply): <ul style="list-style-type: none"> <li>• Presently taking estrogen containing medication (e.g. OCP, HRT)</li> <li>• Negative reaction to estrogen (e.g. OCP/HRT)</li> <li>• Currently take multivitamin containing copper; ____ mcg/day</li> <li>• Negative reaction to supplements containing copper (e.g. multi's)</li> <li>• Regularly use copper tea kettles</li> <li>• Drinking water has metallic taste</li> <li>• Blue-green stains in bathtub, toilet or sink</li> <li>• Family history of:                     <ul style="list-style-type: none"> <li>○ Women with depression</li> <li>○ Post-partum depression</li> <li>○ ADD/ADHD/Autism</li> <li>○ Wilson's Disease</li> </ul> </li> </ul> |
| Difficulty falling asleep   |   |
| Poor concentration  |   |
| Depressed (especially premenstrually or after pregnancy/childbirth) |   |
| Tinnitus (ringing in ears)  |   |
| Frontal headaches   |   |
| Temper/tantrums   |   |
| Hyperactivity   |   |

**Magnesium deficiency.**

|  |   |
|--|---|
| Muscle cramps, spasms or pain (e.g. back ache, neck ache, leg/foot cramps) | Risk factors ( <i>mark or circle those which apply</i> ): <ul style="list-style-type: none"> <li>• High stress levels</li> <li>• Chronic occupational exposure to very loud noises (e.g. factory or traffic related)</li> <li>• High weekly levels of exercise and/or frequent strenuous exercise</li> <li>• Sweat excessively</li> <li>• High coffee intake</li> <li>• Daily alcohol use</li> <li>• Regular cola consumption</li> <li>• Frequent diarrhea or vomiting</li> <li>• Oral contraceptive use</li> <li>• Diuretic, laxative, ACE inhibitor, beta blocker or oral corticosteroid use</li> </ul> |
| Muscle tension   |   |
| Muscle twitches, tics or jerks   |   |
| Muscle weakness  |   |
| Muscle tremors   |   |
| Restless legs  |   |
| Fatigue / sighing  |   |
| Breathlessness / chest tightness   |   |
| Heart palpitations / arrhythmias / mitral valve prolapse                   |   |
| Numbness or tingling of skin or “creepy-crawly” feeling under skin         |   |
| Sensitivity to loud noises or sudden bright light                          |   |
| Headaches / migraines  |   |
| Menstrual cramps / pain  |   |
| Teeth grinding (bruxism)   |   |
| Frequent constipation or anal spasms                                       |   |
| Difficulty falling asleep or frequent nocturnal awakenings                 |   |
| Irritable, anxious, agitated or panic attacks                              |   |

**Iron deficiency.**

|  |  |
|--|--|
| Fatigue  | Risk factors ( <i>mark or circle those which apply</i> ): <ul style="list-style-type: none"> <li>• Menstruation                         <ul style="list-style-type: none"> <li>○ Heavy or long period</li> </ul> </li> <li>• Other sources of blood loss (e.g. periodic blood donation, wounds, bleeding gums, blood noses, notice blood in stool, ulcers, urinary tract bleeding or hemorrhoids)</li> <li>• Regular aspirin, ibuprofen (Nurofen) or other NSAID use</li> <li>• Regularly use antacids</li> <li>• Low meat intake</li> <li>• High tea &amp;/or coffee consumption</li> <li>• Engage in regular intense exercise</li> <li>• Pregnancy (presently or recently)</li> <li>• Frequent diarrhea or vomiting</li> <li>• History of Helicobacter pylori</li> </ul> |
| Heavy menstrual bleeding (menorrhagia)   |  |
| Impaired exercise tolerance / shortness of breath on exertion  |  |
| Intolerance to cold / cold hands and feet  |  |
| Impaired taste   |  |
| Sore or burning sensation in tongue/mouth  |  |
| Glossy “smooth” tongue &/or red tongue   |  |
| Sores at the corners of mouth  |  |
| Poor/lower appetite  |  |
| Paler skin (for you) or pale nail beds   |  |
| Blue tinge to sclerae (whites of eyes)   |  |
| History of pica (craving and consumption of non-food items, e.g. ice, soap, dirt, clay, paint, chalk, paper, glue, wood, etc.) |  |

|  |     |    |   |
|--|-----|----|---|
| History of low iron levels; ferritin below 50 or transferrin saturation below 22%? | Yes | No | ? |
| History of ferritin levels being above 200 in women or 300 in men?                 | Yes | No | ? |
| Most recent blood B12 level was under 398 pmol/L (540 pg/ml)?                      | Yes | No | ? |

\*Labs reference ranges typically state that ferritin levels above 15-30 are normal.

**Vitamin D deficiency.**

|   |  |
|---|--|
| Regular bone pain or tenderness (e.g. from applying thumb pressure to sternum/shinbone/forearm)   | Risk factors ( <i>mark or circle those which apply</i> ): <ul style="list-style-type: none"> <li>• Spend very little time in the sun</li> <li>• Covering all exposed skin when outside</li> <li>• Use sunscreen whenever outside</li> <li>• Dark skin</li> <li>• Smoker</li> <li>• Aged over 60</li> </ul> |
| Muscle aches/pain/discomfort (inc. low back pain)   |  |
| Poor balance or coordination  |  |
| Muscle weakness   |  |
| Feeling of heaviness in legs  |  |
| Symptoms worse (e.g. pain or mood) in winter  |  |
| One or more of the following - Loss of height, low bone density, prone to fractures, an auto-immune disease, high blood pressure, low blood calcium or phosphorus, elevated alkaline phosphatase (ALP) or parathyroid hormone (PTH) |  |

|   |     |    |   |
|---|-----|----|---|
| History of vitamin D levels being below 125 nmol/L? | Yes | No | ? |
|---|-----|----|---|

\*Labs reference ranges typically state above 50 nmol/L is normal.

**Zinc deficiency.**

|   |   |
|---|---|
| White spots or lines on nails   | Risk factors ( <i>mark or circle those which apply</i> ): <ul style="list-style-type: none"> <li>• Aged over 55</li> <li>• Ongoing or regularly recurring diarrhea</li> <li>• Recent pregnancy or breastfeeding</li> <li>• Birth control pill use</li> <li>• Regular aspirin use</li> <li>• Low meat consumption</li> <li>• Diuretics, antacids or steroids (e.g. prednisone)</li> <li>• Recent injury/burns/surgery</li> <li>• Use zinc containing denture cream (e.g. Fixodent or Poli-Grip)</li> </ul> |
| Stretch marks   |   |
| Acne, eczema, psoriasis or warts  |   |
| Slow wound healing (including frequent mouth ulcers or leg ulcers)                              |   |
| Rough skin  |   |
| Impaired taste acuity or sense of smell (e.g. need high levels of salt for food to taste salty) |   |
| Poor/decreased appetite   |   |
| Poor night vision   |   |
| Frequent infections   |   |
| Mental lethargy, hyperactivity, ADD or aggression/violent                                       |   |

|  |     |    |   |
|--|-----|----|---|
| History of serum zinc below 12 umol/L? | Yes | No | ? |
|--|-----|----|---|

**Pyroluria.**

|   |   |
|---|---|
| Little or no dream recall   | Risk factors ( <i>mark or circle those which apply</i> ): <ul style="list-style-type: none"> <li>• Red hair + blue eyes combination</li> <li>• Elevated zinc in hair analysis</li> <li>• Elevated manganese in hair analysis</li> <li>• Family history of:                         <ul style="list-style-type: none"> <li>○ Rapid-cycle bipolar disorder</li> <li>○ Dyslexia</li> </ul> </li> </ul> |
| White spots on finger nails   |   |
| Poor morning appetite and/or tendency to skip breakfast                 |   |
| Morning nausea  |   |
| Pale skin, poor tanning or burn easy in sun                             |   |
| Sensitivity to bright light   |   |
| Hypersensitive to loud noises   |   |
| Reading difficulties (e.g. dyslexia)                                    |   |
| Histrionic (dramatic)   |   |
| Argumentative/enjoy argument  |   |
| Mood swings or temper outbursts   |   |
| Much higher capability & alertness in the evening, compared to mornings |   |
| Anxiousness   |   |
| Preference for spicy or heavily flavored foods                          |   |
| Abnormal body fat distribution  |   |
| Significant growth after the age of 16                                  |   |

|  |     |    |
|--|-----|----|
| Do you have a foot form where the second toe is longer than the first toe?<br><i>*Associated with vitamin B6 deficiency.</i> | Yes | No |
|--|-----|----|

**Impaired liver detoxification.**

|   |  |
|---|--|
| Sensitivity or reaction to perfumes, car exhaust, gasoline fumes, paint, bleach, etc.                                       | Risk factors ( <i>mark or circle those which apply</i> ): <ul style="list-style-type: none"> <li>• Current regular use of paracetamol (Panadol), amiodarone or methotrexate</li> <li>• Regular alcohol use</li> <li>• History of hepatitis or fatty liver</li> <li>• Regular grapefruit juice consumption</li> <li>• Past use of methotrexate</li> <li>• Past use of anti-malarial drug Mefloquine (Lariam)</li> <li>• Close family history of:                     <ul style="list-style-type: none"> <li>○ Chemical sensitivities</li> <li>○ Aspirin or paracetamol intolerance</li> <li>○ Gilbert's disease</li> <li>○ Parkinson's disease</li> <li>○ Chronic fatigue syndrome (CFS)</li> </ul> </li> </ul> |
| Overly sensitive to cigarette smoke   |  |
| Overly sensitive to alcohol   |  |
| Overly sensitive to caffeine  |  |
| Overly sensitive to, react negatively to, or strange reactions (e.g. opposite) to medications (e.g. aspirin or paracetamol) |  |
| Multiple food sensitivities   |  |
| ○ React (e.g. headaches) to wine or preservatives on dried fruit  |  |
| ○ React to onions or garlic   |  |
| Frequent headaches/migraines  |  |
| Frequent nausea and/or loss of appetite   |  |
| Elevated liver enzymes in past or recent blood tests  |  |
| Yellowish tinge to skin or eyes / elevated bilirubin / Gilbert's disease  |  |

**Gluten intolerance.**

|  |  |
|--|--|
| Prone to low iron (ferritin under 50) and/or anaemia   | Risk factors ( <i>mark or circle those which apply</i> ): <ul style="list-style-type: none"> <li>• Pale skin plus red hair combination</li> <li>• Family history of:                     <ul style="list-style-type: none"> <li>○ Celiac disease/gluten intolerance</li> <li>○ Wheat allergy/intolerance</li> <li>○ Sjogren syndrome</li> <li>○ Colorectal or bowel cancer</li> <li>○ Stomach cancer</li> <li>○ Lymphoma</li> <li>○ Autism</li> <li>○ Schizophrenia</li> <li>○ Diabetes Type 1</li> <li>○ Malabsorption</li> <li>○ IgA deficiency (low blood levels of IgA)</li> </ul> </li> </ul> |
| Frequent loose/unformed stools or diarrhea   |  |
| Sensation of incomplete defecation (tenesmus)  |  |
| Abdominal bloating/discomfort  |  |
| Floating and/or oily stools  |  |
| Difficulty putting on weight / low body weight / unexplained weight loss   |  |
| Crave wheat products   |  |
| Itchy dermatitis, psoriasis or brown pigmentation of face  |  |
| Persistent fatigue   |  |
| Compulsive, ritualistic behavior   |  |
| Short stature and/or small head circumference for age/ethnicity  |  |
| Hashimoto's thyroiditis, grave's disease, sjogren syndrome, low bone density, peripheral neuropathy, ataxia or low blood levels of IgA |  |

**Gastrointestinal abnormalities.** Highlight each of the following that you experience regularly.

|   |  |  |  |
|---|--|--|--|
| Frequent/intermittent diarrhea                | Trouble digesting red meat                           | Feel unwell/fatigued right after meals                         | Multiple food sensitivities                                |
| Loose/unformed stools                         | Undigested food in stool                             | Food (e.g. meat) or water 'sits in stomach'                    | Negative reactions to many supplements                     |
| Frequent constipation                         | Unexplained weight loss                              | Reflux and/or heartburn  | Unexplained bad breath                                     |
| Sensation of incomplete defecation (tenesmus) | Never gain weight & eat generously                   | Stomach aching/pain/discomfort or stomach bloating after meals | Feel/act better after a bowel movement                     |
| Abdominal bloating                            | Fatty foods causes loose stools                      | Burping after meals  | Feel better after pre-colonoscopy cleanse (e.g. pico-prep) |
| Abdominal discomfort/pain                     | Floating stools / sticky stools                      | Feel overly full easily / poor appetite                        | Itchy rectal/anal area                                     |
| Abdominal tenderness                          | Notice oil/fat on toilet surface                     | High fat foods (e.g. cream) cause nausea                       | Colo-rectal pain or spasms                                 |
| Excessive flatulence                          | Foul smelling stools                                 | Nausea after supplements (e.g. fish oil)                       | Yeasty or ammonia stool odor                               |
| Visible pus/mucus in stool                    | Trouble digesting raw vegetables                     | Frequent nausea or vomiting                                    | Burning/'acidic' stools                                    |
| Very noisy abdomen                            | Light, pale or white stools / yellow or green stools | Lemon juice improves digestion                                 | Increased fiber worsens gut symptoms (e.g. bloating/gas)   |
| Bowel urgency                                 | History or low iron (ferritin < 50) or B12           | Regularly use antacids   | Black/red/blood spots in stool                             |

**Food allergies and intolerances.**

|   |   |
|---|---|
| Itchy, tingly, irritated or burning tongue/lips/palate/throat during or after meals | <p>Risk factors (<i>mark or circle those which apply</i>):</p> <ul style="list-style-type: none"> <li>• Childhood history:                             <ul style="list-style-type: none"> <li>○ Colicky or recurrent croup as baby</li> <li>○ Reflux as infant</li> <li>○ Asthma/wheezy bronchitis/chesty</li> <li>○ Recurrent ear infections or glue ear</li> <li>○ Eczema or wool intolerance</li> <li>○ Hay fever</li> <li>○ Urticaria (hives)</li> <li>○ Recurrent tonsillitis</li> <li>○ Food allergies/intolerances as a child                                     <ul style="list-style-type: none"> <li>• e.g. eggs → nausea/vomiting</li> </ul> </li> <li>○ Did not tolerate milk based formulas or breast milk as an infant</li> <li>○ Health declined when introduced solid foods as an infant (e.g. eczema)</li> </ul> </li> <li>• Present:                             <ul style="list-style-type: none"> <li>○ Known food allergies/intolerances</li> <li>○ Allergy to pollen</li> <li>○ Allergy to dust</li> <li>○ Allergy to animals (e.g. cats/dogs/horses)</li> <li>○ Allergy to latex</li> <li>○ Drug allergies or aspirin intolerance</li> <li>○ Below or above normal levels of IgA (immunoglobulin A) in blood</li> </ul> </li> <li>• Close family history of:                             <ul style="list-style-type: none"> <li>○ Food allergies/intolerances</li> <li>○ Pollen allergy</li> <li>○ Dust, cat or dog allergy</li> <li>○ Frequent urticaria (hives)</li> <li>○ Eczema or wool intolerance</li> <li>○ Allergic rhinitis (hay fever)</li> <li>○ Asthma / wheezy / chesty child</li> </ul> </li> </ul> |
| Swollen lips/mouth or recurrent mouth ulcers  |   |
| Frequent hives - generally or around mouth/lips (e.g. rash or ring around mouth )   |   |
| Increased mucus production in throat / regularly clearing throat                    |   |
| Excess drooling / excess saliva production / spitting during speech                 |   |
| Irregular patches on tongue (geographic map-like) or mottled tongue                 |   |
| Puffiness or 'bags' below eyes; or puffy or swollen nose/face                       |   |
| Horizontal creases/lines/folds under eyes ('denny-morgan folds')                    |   |
| Dark circles under eyes ('allergic shiners')  |   |
| Inner corners of eyes itch or whole eyes itch / eye rubbing or scratching           |   |
| Watery, glassy or glazed eyes; or red eyes  |   |
| Itchy nose / nose rubbing or scratching ('nasal salute')                            |   |
| Nasal or sinus congestion / sinusitis / runny or snuffly nose / sneezing            |   |
| Postnasal drip (nasal mucus draining down the back of the throat)                   |   |
| Abnormally red and/or flushed appearance of cheeks or nose (e.g. red tip nose)      |   |
| Red ears / hot or 'burning' earlobes  |   |
| Eczema or wool intolerance / psoriasis or patches of depigmented dermatitis         |   |
| Itchy arms, ear canals, hands, legs or skin in general                              |   |
| Asthma or recurrent wheezy bronchitis / infection or exercise induced wheezing      |   |
| Abdominal pain, bloating or frequent vomiting                                       |   |
| Increased frequency of stools / unformed bowel movements / frequent constipation    |   |
| Sensation of incomplete defecation (tenesmus) or colo-rectal spasms                 |   |
| Feel best (e.g. energy/focus/mental clarity) when don't eat or skip meals           |   |
| Fatigue, feel sad/angry, brain fog, poor focus or look pale/red after some meals    |   |
| Strong particular food cravings and dislikes / fussy eater                          |   |
| Recurrent ear infections, fluid in ears or recurrent glue ear                       |   |
| Headaches/migraines   |   |

|   |  |
|---|--|
| List specific foods or beverages (e.g. milk) you crave.   |  |
| List foods close blood relatives are reactive to.   |  |
| List any foods you were reactive to as a child.   |  |
| List any foods you are reactive to presently, e.g. food causes bloating, headaches, fatigue, sneezing, runny or itchy nose, musculo-skeletal pain, mucus production, etc. |  |

**Gastrointestinal abnormalities.**

|   |               |     |                                   |
|---|---------------|-----|-----------------------------------|
| How often do you have bowel movements (e.g. 1 / day)?   | _____ / _____ |     |                                   |
| Born via cesarean?  | No/little     | Yes |                                   |
| Were you breast fed?  | Yes           | No  |                                   |
| Born less than 33 weeks gestation (7 or more weeks premature)?  | Yes           | No  |                                   |
| History of antibiotic use in first month of life or multiple courses of antibiotics in first 24 months of life?   | Yes           | No  |                                   |
| History of frequent oral antibiotic use (e.g. recurrent childhood ear infections / recurrent UTI's / tonsillitis)?  | Yes           | No  |                                   |
| History of long-term (greater than 2 weeks) oral antibiotic use (e.g. for acne)? How long? _____  | Yes           | No  | <i>Intestinal dysbiosis/yeast</i> |
| Gut has never been the same since a specific course of antibiotics?   | Yes           | No  |                                   |
| Apply <u>mild</u> pressure to the area 2 cm's right, then 2 cm's down from umbilicus. Is this area tender?  | Yes           | No  |                                   |
| History of daily use of antacids?   | Yes           | No  |                                   |
| Appendix removed?   | Yes           | No  |                                   |
| Taken prolonged courses of steroids (e.g. prednisone)?  | Yes           | No  |                                   |
| Past history of Helicobacter pylori or live with person(s) found to have Helicobacter pylori infection?   | Yes           | No  |                                   |
| Gut has never been the same since bout of food poisoning/gastro?  | Yes           | No  | <i>Intestinal infection</i>       |
| When taking antibiotics since illness onset, symptoms reduce during or after antibiotics?   | Yes           | No  |                                   |
| Some fruits (e.g. apples or pears) causes one or more of the following - Abdominal bloating/discomfort, loose stools, diarrhea, flatulence, constipation or nausea?     | Yes           | No  | <i>Fructose malabsorption</i>     |
| One or more of - Fatty liver, raised liver enzymes, low blood sugar, floating or oily stools? Circle which.   | Yes           | No  |                                   |
| Does eating dairy products cause bloating, stomach cramps, loose stools, nausea or flatulence?  | Yes           | No  | <i>Lactose intolerance</i>        |
| Close family history of lactose intolerance?  | Yes           | No  |                                   |
| Eating higher in protein (e.g. red meat) causes one or more of the following - Brain fog, 'toxic' feeling, slurred speech, disorientation, headaches or incoordination? | Yes           | No  | <i>Excess ammonia</i>             |
| Ammonia smell to stool or urine at times? Circle which.   | Yes           | No  |                                   |
| High carbohydrate/sugar intake causes slurred speech, incoordination or disturbance of manner of walking?   | Yes           | No  | <i>D-lactic acidosis</i>          |
| Negative reaction to probiotic supplements?   | Yes           | No  |                                   |
| Tonsils or gallbladder removed, section of intestines/bowel removed or gastric surgery? Circle which.   | Yes           | No  |                                   |




**Intestinal yeast.**

|   |
|---|
| Genital thrush in the past 6 months or history of recurrent genital thrush  |
| Vaginal itching or redness, vaginitis or "jock itch" in the past 3 months – often scratching/itching at genital area  |
| White coating on your tongue, white patches in mouth or stringy bits in saliva  |
| Nasal congestion or stuffiness, swelling of the nasal membranes or sinusitis  |
| Previously noticed a decline in your health following antibiotics or since onset of illness antibiotics exacerbate your health problem                              |
| History of appearance or exacerbation of thrush or allergic symptom(s) (e.g. eczema/hives/asthma, etc.) following the use of antibiotics                            |
| Fungus infections on skin (e.g. athletes foot/peeling or splitting of skin between toes/ringworm) or nails (discolored yellow/brown/black)                          |
| Eating sugar makes you feel worse/worsens certain symptoms (e.g. gut symptoms)  |
| Negative reaction to certain dietary yeasts/molds (e.g. vinegar, mushrooms, fermented foods, brewers/bakers yeast, aged cheeses, vegemite, beer, etc.)              |
| Lower abdominal bloating (felt below the bellybutton)   |
| Bloating or flatulence after eating rice or potatoes  |
| Gas, frequent constipation, abdominal pain, loose/unformed stools, frequent diarrhea, foul smelling stools, mucus/pus in stool or 'yeasty' odor to stools or breath |
| Itchy rectal/anal area or red ring immediately around anus  |
| Anus burns when pass stool / 'acidic' or burning stools   |
| Chemical sensitivities (e.g. car exhaust, petrol, cigarette smoke or perfumes)  |
| Multiple food sensitivities   |
| Feel 'spaced out' &/or 'brain fogged'   |
| Attention problems  |
| Skin rashes including eczema, rash between skin folds, psoriasis or hives   |

**Intestinal parasites.**

|   |  |
|---|--|
| Current illness began with diarrhea/food poisoning  | <p>Risk factors (<i>mark or circle those which apply</i>):</p> <ul style="list-style-type: none"> <li>• Previously diagnosed with parasitic infection (e.g. Giardia, Cryptosporidium, Blastocystis, Dientamoeba, etc.)</li> <li>• Person living in the same house as you and/or partner diagnosed with intestinal parasite</li> <li>• Regularly drank/drink water from wells, streams, rivers or lakes</li> <li>• Known occurrence of becoming sick in the past from probable water contamination</li> <li>• Have traveled to parasite endemic areas (e.g. Mexico, India, South America, Africa, Israel, Tropical Islands, Egypt, Middle-East)</li> <li>• Gastrointestinal (e.g. diarrhea/vomiting) or other symptoms (e.g. fatigue) after/during international travel</li> <li>• Have dogs or cats...                             <ul style="list-style-type: none"> <li>○ ... Kissing/licking your dogs/cats</li> <li>○ ... Your pets have had worms</li> </ul> </li> <li>• Have children in day care centers</li> <li>• Have eaten raw/under-cooked meat or often use a microwave to cook raw meat</li> <li>• Often eat from street vendors or salad bars</li> <li>• You or your partner works in an area at high risk for infections (e.g. nursing homes, day care/child care centers, sanitation; work with fresh food or animals)</li> </ul> |
| Gut symptoms started suddenly rather than gradually |  |
| Abdominal bloating                                  |  |
| Abdominal discomfort/pain                           |  |
| Multiple food sensitivities                         |  |
| Frequent constipation                               |  |
| Loose/unformed stools                               |  |
| Foul smelling stools                                |  |
| Excessive flatulence                                |  |
| Frequent nausea                                     |  |
| Itchy anal/rectal area                              |  |
| Visible mucus or pus in stools                      |  |
| Frequent or intermittent diarrhea                   |  |
| Difficulty gaining weight                           |  |
| Teeth grinding while sleeping (bruxism)             |  |
| Hives, psoriasis, eczema, skin ulcers or skin rash  |  |
| Fatigue/weakness                                    |  |
| Steroid medications worsen symptoms                 |  |

**Electromagnetic field (EMF) exposure and sensitivity.**

|   |   |            |
|---|---|------------|
| Sleep with electric blanket or electric heating pad   |   |            |
| Use a heated water bed  |   |            |
| Meter box or refrigerator on the other side of the wall from your bed head  |  | Example 1. |
| Or computer, television or washing machine on the opposite side of the wall from your bed head which is often operating while you are in bed  |   |            |
| Within 65 cm's of your body while in bed (e.g. by bed or under bed) there is an electric alarm clock, a cordless phone or a power adapter (power adapter not regular power plug)  |  | Example 2. |
| During the day sit 65 cm's or less from an operating electric heater, electric lamp or photocopier  |   |            |
| House is within 40 meters horizontally of large electrical pylons or the lines which extend between them  |  | Example 3. |
| Regular power lines are less than 5 metres horizontally from an area you spend periods of time in (e.g. bed, office, home computer, etc.)   |   |            |
| Close proximity (< 50 m) of television transmitter, microwave tower, radio tower or mobile phone towers to home, school or work space   |   |            |
| Live near (< 50 m) a power transformer  |   |            |
| Live near (< 50 m) a power generating station   |   |            |
| Live near (< 50 m) a electric distribution substation   |   |            |
| Have your mobile phone under your pillow while in bed   |   |            |
| Spend long periods (greater than 20 minutes in total) talking on your mobile or cordless phone most days  |   |            |
| WiFi base station in bedroom or on/under a desk where you spend significant time  |   |            |
| In floor electrical heating   |   |            |
| Occupational electromagnetic exposures (e.g. electrician, welder, machinist, power line worker, etc.)   |   |            |
| Any other electromagnetic exposure that come to mind? _____   |   |            |
| Physical or mental health is worse before or during a storm (including thunderstorms)   |   |            |
| Electromagnetic exposures (e.g. mobile phones, transformers, microwave ovens, TV, wireless, LCD watches, toasters, high tension wires, computers, those listed above or others) produce symptoms such as the following – Pain, tingling, fatigue, sleep problems, headache, dizziness, concentration problems, nausea, breathing problems, etc. <i>*Reference: William J. Rea, MD, FACS. Journal of Bioelectricity, 1991.</i> |   |            |

**Sick building syndrome.**

|   |
|---|
| Frequent/ongoing coughing   |
| Discomfort, stinging or burning sensation of throat or mouth        |
| Throat hoarseness / changed voice (e.g. raspy/weak)                 |
| Frequent metallic taste in mouth                                    |
| Wheezing, irritated lungs, burning sensation of lungs or bronchitis |
| Shortness of breath / chest tightness                               |
| Irritated, sore or burning eyes                                     |
| Red or watery/tearing eyes  |
| Sensitivity to bright light   |
| Nasal congestion / running or stuffy nose / nose bleeds             |
| Irritated, stinging or burning nose or nasal passage                |
| Sinusitis / sinus pressure, discomfort or pain                      |
| Stinging, burning or itchy skin / skin sensitivity to light touch   |
| Spaciness / light headed  |
| Headaches / 'ice pick' or 'lightening bolt' pains                   |

**Chemical toxicity (e.g. mercury).**

|  |
|--|
| Tinnitus (ringing in ears)   |
| Frequent headaches or migraines  |
| Fine tremor of protruded tongue, lips or fingers (e.g. poor handwriting) |
| Excessive flow of saliva   |
| Profound fatigue / fibromyalgia  |
| Tendency to be irritable, anxious, overly excitable or depressed         |
| Short term memory loss / poor concentration / brain fog                  |
| Dizziness / light headedness / vertigo                                   |
| Frequent metallic taste in mouth   |
| Twitching of facial muscles (e.g. eyelids)                               |
| Redness to the skin in hands and feet                                    |
| Numbness, tingling, burning or prickling in hands/feet or skin           |

**Chemical sensitivity.**

|   |
|---|
| Odor sensitivity* (e.g. perfume/car exhaust/gasoline/newsprint/cigarette smoke/natural gas/new paint) or lack of sense of smell |
| Sensitive to anesthetics (slow to recover following surgery and pregnancies)  |
| Sensitive to many foods   |
| Feel worse indoors and better outdoors  |
| Become ill near spraying of chemicals, refineries or chemical plants  |
| Recurring infections (e.g. upper respiratory, sinus or bladder)   |
| Function better in the mountains, near the seashore and other less polluted environments  |
| Cyclic edema (swelling from fluid accumulation in body tissues)   |
| Tingling, numbness, neuropathy or seizures  |
| Unilateral (on one side) pain or weakness   |
| Symptoms and signs favor one side of the body more than the other   |
| Alcohol intolerance   |
| Sensitive to medications  |
| Pallor (pale skin for you)  |
| Flushing, itching, excessive sweating, difficulty sweating, bruising or small (1-2mm) red or purple spots on body               |

\*Odor sensitivity = Can detect presence of chemical others cannot or sensation of disgust or aversion to the smell of volatile chemical agents, at a level of exposure which the majority of the population would find innocuous. (Reference: Killing Us Softly by Dr. Mark Donohoe)

**Mark any substances which you have symptoms from.**

|                       |                  |                |             |               |
|-----------------------|------------------|----------------|-------------|---------------|
| Overstuffed furniture | Photocopy paper  | Disinfectants  | Pesticides  | Potted plants |
| Fireplace             | Varnish          | Plastic        | Herbicides  | Cosmetics     |
| Old home              | Solvents         | Dyes           | Grain dust  | Nail polish   |
| Linoleum              | Lacquer          | Turpentine     | Dog inside  | Perfumes      |
| New carpet            | Furniture polish | Diesel fumes   | Cat inside  | Wooden floors |
| Old carpet            | Floor wax        | Exhaust fumes  | Bird inside | Dry cleaning  |
| Rugs                  | Incense          | Gasoline fumes | Tar         | Rubber        |

**Toxic environment.**

|   |     |    |
|---|-----|----|
| Do any other people who live/work/school in the same building as you also have symptoms/signs present in the 'sick building' column above? Or do they share any other symptoms with you (e.g. chronic fatigue)? Specify which _____   | Yes | No |
| Did you change house/work/office/school/class room/furnace/second hand air conditioner shortly before the onset or exacerbation of your symptoms?   | Yes | No |
| Have you noticed a negative change in your health since you moved into the home you currently live in?  | Yes | No |
| If you leave your house, work place or school for several days or more (or even several hours), do any of your symptoms reduce? e.g. feel a lot more energetic and clear headed while camping or sleeping somewhere else, or feel much better on holidays away from work/school. And/or do you feel worse while at home/work/school?      | Yes | No |
| Do you tend to have worse symptoms/health problems in the cold portion of the year when regularly using gas heating?  | Yes | No |
| Do you feel worse in certain area of your home, work or school (e.g. a particular room or basement)?  | Yes | No |
| Noticeable mold/mildew (e.g. in bathroom, under sinks, laundry, basement, attic, cellar, crawl space, inside cabinets/closets, windowsills, old moldy books, in or under fridges, drainage tray under fridge, etc.) in your house/workplace/school/car? Mold grows in areas of dampness (past or present). <u>Look carefully.</u>         | Yes | No |
| Musty/moldy/mildewy odor in your house/work/school (e.g. musty basement/cellar/crawl space/attic/old books/air con/air system)?   | Yes | No |
| Have previously had water contamination (e.g. leaks/flooding/leaky pipes) in your house/workplace/school, e.g. "water intrusion through leaky roofs, windows or doors; wicking of water along a concrete slab or saturation of carpets; and pooling of surface water in basements", attics or under kitchen sink? [Dr. Ritchie Shoemaker] | Yes | No |
| Do you have areas of water stained walls, ceilings or ceiling tiles in your house/workplace/school? e.g. blistered, peeling or stained wallpaper or paint, or salt deposit on walls? Have a look around, you may not have noticed it before.  | Yes | No |
| Do you have a generally damp, clammy or humid home/work/school or a damp area (e.g. basement/cellar/crawl space/condensation inside windows or on walls/around air conditioner vents/ceiling tiles/attic) in your home/work/school?   | Yes | No |
| Do you have rising damp in your home/work/school?   | Yes | No |
| Do you have ceilings which are bowing from previous water damage?   | Yes | No |
| Is the area under your house wet?   | Yes | No |
| Do you sleep or work in a basement?   | Yes | No |
| Do you have vinyl wallpaper in your home?   | Yes | No |

**Inhalant allergies.**

| <b>Dust allergy.</b>                                     | <b>Pollen allergy.</b>                       | <b>Mold sensitivity.</b>   |
|--|--|--|
| Known or suspected dust allergy                          | Known or suspected pollen allergies          | Known or suspected mold sensitivity  |
| Nasal symptoms (e.g. sneezing/runny/itchy nose)          | Watering, itching or redness of eyes         | Worse outdoors between 4:30 & 8:30 PM  |
| Worse during or after sweeping/dusting/vacuuming         | Worse in October → January ('pollen season') | Certain symptoms (e.g. headaches, stuffy nose, cough or joint pain) are worse in wet/humid weather |
| Worse in dusty areas                                     | Worse outdoors                               | Worse after sundown  |
| Worse within 30 minutes of going to bed                  | Worse on windy days                          | Worse in damp places or low places in road   |
| Worse indoors and better outdoors                        | Worse on clear/sunny days                    | Cool evening air increases your symptoms   |
| Symptoms get worse each year with return of cold weather | Better on rainy days                         | Symptoms appear, or worsen, after being around mold/mildew or smelling mold odor                   |
| Your house is dustier than other houses                  | Worse outdoors from 7 to 11 AM               | Worse when mowing or playing on the grass  |

\*Worse = Worse allergy symptoms (e.g. itchy nose/eyes, watery eyes, red eyes, sneezing/runny nose, coughing/wheezing, asthma), fatigue, mood or any other symptom.

**Amalgam fillings.**

|   |       |       |
|---|-------|-------|
| How many amalgam ('silver') fillings do you currently have?   | _____ | 0     |
| How many amalgam ('silver') fillings have you had removed previously?                               | _____ | 0     |
| Did you experience any negative symptoms around the time of inserting or removing amalgam fillings? | Yes   | No/NA |
| Black staining in gums in area around existing amalgam fillings?                                    | Yes   | No/NA |

\*Amalgam fillings are approximately 50% mercury.

**Metal sensitivity.**

|  |     |    |
|--|-----|----|
| Does skin contact with certain metals cause a skin rash? For example one of the following (circle which if known):   |     |    |
| <ul style="list-style-type: none"> <li>• Nickel in earrings and watches</li> <li>• Gold in jewellery such as rings and earrings</li> <li>• Titanium dioxide in cosmetics, sunscreen, body piercings &amp; rings/watches</li> </ul> | Yes | No |
| Do you have nickel, gold, palladium or titanium in your mouth (e.g. gold crowns) or other areas of your body (e.g. metals screws/pins)?  | Yes | No |

**Chemical exposure history.** Tick appropriate boxes and circle sections which apply.

|  | Present | Past |
|--|---------|------|
| <b>Work.</b>   |         |      |
| • Fire-fighter, using furnaces, doing controlled burns or other regular exposure to smoke  |         |      |
| • Factory worker, refineries, machinist, around machines emitting fumes or any source of fumes   |         |      |
| • Mine worker, coal burning, metal worker, soldering or welder   |         |      |
| • Funeral home worker or dry cleaner   |         |      |
| • Orchard, vineyard, market garden, florist, nursery, golf course worker or any job working around pesticides  |         |      |
| • Carpet cleaner, installer, carpet factory or rug store   |         |      |
| • Military or was in the Gulf, Vietnam, Iraq or other war with known chemical exposures  |         |      |
| • Dentist or dental assistant/technician   |         |      |
| • Electrician or carpenter   |         |      |
| • Exterminator   |         |      |
| • Beautician, work around cosmetics, hair dresser or similar   |         |      |
| • Photograph developing equipment or art supplies  |         |      |
| • Construction materials, tar, etc. or involved in the demolition of buildings   |         |      |
| • Work regularly using paints, spray paints, paint thinners, glues or epoxies  |         |      |
| • Radiator repair, battery stores or regular hand contact with bullets/gun powder  |         |      |
| • Spent years working on a farm  |         |      |
| • Involved in sheep dipping  |         |      |
| • Work in a chicken farm, sheep market, poultry/egg rearing or around animals which involve use of chemical sprays   |         |      |
| • Work with laboratory and/or medical related chemicals  |         |      |
| • Printing industry / printing shops   |         |      |
| • Mechanic or plumber  |         |      |
| • Work with pressed or treated wood products (hardwood, plywood, pressed board, wall paneling, particleboard, fiberboard)  |         |      |
| • Pilot or airline worker  |         |      |
| • Jeweler or glass maker   |         |      |
| • Work adjacent to frequently used photocopier/printer with poor ventilation   |         |      |
| • Office area has no, or very poor, ventilation/air flow and has poor air quality  |         |      |
| • Workplace near toxic industry, highways or aerial spraying   |         |      |
| <b>Home.</b>   |         |      |
| • Regular commercial chemical treatments for pests in your house or pesticides/insecticides sprayed in your yard   |         |      |
| • Pesticides/insecticides sprayed around home by tractor, helicopter or spray drift (inc. drifting from adjacent homes)  |         |      |
| • Spray paints or other chemical sprays (other than pesticides) are often used in your home (e.g. basement)  |         |      |
| • Live on or adjacent to farm  |         |      |
| • History of using well water, river, lake or similar as key source of drinking/cooking water  |         |      |
| • Live near coal burning plants or a power station   |         |      |
| • Live on or in very close proximity to an orchard, vineyard, market garden, nursery, golf course or dry cleaner   |         |      |
| • Exposed to considerable amount of construction materials / major home renovations exposing self to old paint   |         |      |
| • Live in smoggy/polluted area, near smoke stacks, industrial plant, dump, land fill area or airport   |         |      |
| • Down wind from chemical factory or incinerator   |         |      |
| • Use kerosene, wood, oil, coal, formaldehyde, phenol or pentachlorophenol for heating/cooking/cleaning  |         |      |
| • Use an unvented/unflued gas/kero heater/stove/furnace or other appliance   |         |      |
| • Use very old or poor condition gas heater, stove or furnace  |         |      |
| • Gas heater or furnace in bedroom, bathroom, toilet, sauna or caravan   |         |      |
| • Frequently used garage directly below bedroom or frequently used attached garage which opens into the house  |         |      |
| • Gas water heater or gas tank in basement   |         |      |
| • Carpet with strong chemical smell  |         |      |
| • Air circulation system recycles air rather than inputting fresh outdoor air  |         |      |
| • Live in a trailer  |         |      |
| • Have formaldehyde insulation in house  |         |      |
| • Use mothballs in home (contains naphthalene)   |         |      |
| • People smoke in your home or car   |         |      |
| • Have wooden decking/fencing/poles, etc. treated with copper chrome arsenic (CCA) - e.g. green tinge on wood  |         |      |
| • Often notice chemical odors/smells in your home (e.g. natural gas)   |         |      |
| • What other countries have you lived in for significant periods of time (1+ year)?  |         |      |
| <b>Personal/general.</b>   |         |      |
| • Eat fish highest in mercury (swordfish, shark/flake, marlin, broadbill, orange roughy/sea perch, catfish)  |         |      |
| • Use aluminium containing cookware, coffee pots, containers, foil, deodorants/antiperspirants, antacids, salt containing anti-caking agent 554 or baking powder containing sodium aluminum sulphate |         |      |
| • Regularly hang up freshly dry cleaned clothes in bedroom   |         |      |
| • Use flame retardant materials (e.g. bedding, mattresses, furniture, clothing, carpets, rugs, etc.)   |         |      |
| • History of sniffing/inhaling paints/glues etc. for recreational purposes   |         |      |

**Neurotransmitter imbalances.** Circle every symptom/sign which applies to you. Adapted from The Edge Effect and Younger You by Dr. Eric Braverman and The Mood Cure by Julia Ross, M.A.

|   |  |
|---|--|
| <p style="text-align: center;"><b><u>LOW SEROTONIN</u></b></p> <ul style="list-style-type: none"> <li>• Depressed</li> <li>• Nervous/anxious</li> <li>• Worrier</li> <li>• Fears/phobias</li> <li>• Negative/pessimistic</li> <li>• Irritable/impatient/edgy</li> <li>• Obsessive compulsive tendency</li> <li>• Think about the same things over &amp; over again</li> <li>• Self destructive, masochistic or suicidal thoughts/plans</li> <li>• Low self esteem/confidence</li> <li>• Sleep problems/light sleeper</li> <li>• Mood is worse in and dislike dark weather</li> <li>• Prone to anger/rage/explosive behavior</li> <li>• Crave sugar/carbohydrates/alcohol/marijuana                             <ul style="list-style-type: none"> <li>○ Use these substances to improve mood &amp; relax</li> </ul> </li> <li>• Chronic pain (e.g. headaches, backaches, fibromyalgia, TMJ)</li> <li>• PMS</li> <li>• Family history of depression/completed suicide/violent suicide attempts/anxiety/OCD/eating disorders</li> </ul>                     | <p style="text-align: center;"><b><u>LOW ENDORPHINS</u></b></p> <ul style="list-style-type: none"> <li>• Very emotionally sensitive</li> <li>• Cry easily (e.g. from sentimental TV commercials)</li> <li>• Emotional pain really gets to you</li> <li>• Find it hard to get through losses or grieving</li> <li>• Depressed</li> <li>• Difficulty experiencing pleasure</li> <li>• Been through a lot of physical or emotional pain</li> <li>• Use alcohol, chocolate or codeine (in mersyndol) for relaxation, numbing or comfort</li> <li>• Low pain tolerance</li> <li>• Physical pain really gets to you</li> <li>• Chronic pain (e.g. back pain, tension headaches, migraines)</li> </ul>  |
| <p style="text-align: center;"><b><u>LOW DOPAMINE/NORADRENALINE</u></b></p> <ul style="list-style-type: none"> <li>• Reduced ability to feel pleasure</li> <li>• Flat, bored, apathetic and low enthusiasm</li> <li>• Depressed</li> <li>• Low drive and motivation</li> <li>• Difficulty getting through a task even when interesting</li> <li>• Procrastinator/little urgency</li> <li>• Difficulty paying attention and concentrating</li> <li>• Slowed thinking and/or slow to learn new ideas</li> <li>• Crave uppers (e.g. caffeine/nicotine/diet soft drinks)                             <ul style="list-style-type: none"> <li>○ Use these to improve energy/motivation/mood</li> </ul> </li> <li>• Prone to addictions (e.g. alcohol)/addictive personality</li> <li>• Shy/introvert</li> <li>• Low libido or impotence</li> <li>• Mentally fatigued easily and physically fatigued easily</li> <li>• Sleep too much and trouble getting out of bed</li> <li>• Put on weight easily</li> <li>• Family history of alcoholism/ADD/ADHD</li> </ul> | <p style="text-align: center;"><b><u>HIGH DOPAMINE</u></b></p> <ul style="list-style-type: none"> <li>• Anxiety</li> <li>• Novelty seeking behavior</li> <li>• Extravert</li> <li>• Overly intense or driven</li> <li>• Impulsive</li> <li>• Above average libido</li> <li>• Insomnia</li> <li>• Hyperactive tendency</li> <li>• Tendency for suspicion or paranoia</li> <li>• Family history of psychosis or bipolar disorder</li> </ul> <p style="text-align: center;"><b><u>HIGH GLUTAMATE</u></b></p> <ul style="list-style-type: none"> <li>• Sensitivity/reaction to eating MSG</li> <li>• Unusually or excessively excitable</li> <li>• Anxiety and/or panic disorder</li> <li>• Insomnia</li> <li>• History of seizures or psychosis</li> </ul>  |
| <p style="text-align: center;"><b><u>LOW GABA</u></b></p> <ul style="list-style-type: none"> <li>• Feel stressed/pressured/overwhelmed</li> <li>• Sweaty, clammy hands</li> <li>• Butterflies in stomach</li> <li>• Lump in throat</li> <li>• Have trouble relaxing/loosening up</li> <li>• Low stress tolerance</li> <li>• Body tends to be tense/stiff/uptight</li> <li>• Trembling/twitching/shaking</li> <li>• Anxious/nervous/jumpy/'on edge'</li> <li>• Feel panicky/panic attacks</li> <li>• Heart palpitations or fast resting heart rate (over 85)</li> <li>• Sleep problems or chronic pain</li> <li>• Use alcohol/food/cigarettes to relax</li> <li>• Family history of anxiety, panic attacks or seizures</li> </ul>  | <p style="text-align: center;"><b><u>LOW ACETYLCHOLINE</u></b></p> <ul style="list-style-type: none"> <li>• Difficulty remembering names and faces after meeting people</li> <li>• Difficulty remembering peoples birthdays and numbers</li> <li>• Difficulty remembering lists, directions or instructions</li> <li>• Forgetting common facts</li> <li>• Trouble understanding spoken or written language</li> <li>• Forget where I put things (e.g. keys)</li> <li>• Making simple mistakes at work</li> <li>• Slowed and/or confused thinking</li> <li>• Difficulty finding the right words before speaking</li> <li>• Disorientation</li> <li>• Prefer to do things alone than in groups / social withdrawal</li> <li>• Rarely feel passionate</li> <li>• Feel despair and lack joy</li> <li>• Lost some of my creativity / lack imagination</li> <li>• Dry mouth</li> </ul> |

|   |     |    |
|---|-----|----|
| History of regular use of ecstasy, amphetamines, cocaine, codeine, methadone, darvon or heroin? Circle Which. | Yes | No |
| Have tried antidepressants, 5-HTP, tryptophan, st john's wort, valium, xanax or avitan? Circle Which.         | Yes | No |
| Do you sleep markedly better after taking an anti-inflammatory (e.g. Nurofen)?                                | Yes | No |

**Hyperventilation syndrome.**

Nijmegen questionnaire. Respondents are asked to ring the score that best describes the frequency with which they experienced the symptoms listed

| Symptom   | Never | Seldom | Sometimes | Often | Very often    |
|---|-------|--------|-----------|-------|---------------|
| Chest pain                                      | 0     | 1      | 2         | 3     | 4             |
| Feeling tense                                   | 0     | 1      | 2         | 3     | 4             |
| Blurred vision                                  | 0     | 1      | 2         | 3     | 4             |
| Dizziness                                       | 0     | 1      | 2         | 3     | 4             |
| Confusion or loss of touch with reality         | 0     | 1      | 2         | 3     | 4             |
| Fast or deep breathing                          | 0     | 1      | 2         | 3     | 4             |
| Shortness of breath                             | 0     | 1      | 2         | 3     | 4             |
| Tightness across chest                          | 0     | 1      | 2         | 3     | 4             |
| Bloated sensation in stomach                    | 0     | 1      | 2         | 3     | 4             |
| Tingling in fingers and hands                   | 0     | 1      | 2         | 3     | 4             |
| Difficulty in breathing or taking a deep breath | 0     | 1      | 2         | 3     | 4             |
| Stiffness or cramps in fingers and hands        | 0     | 1      | 2         | 3     | 4             |
| Tightness around the mouth                      | 0     | 1      | 2         | 3     | 4             |
| Cold hands or feet                              | 0     | 1      | 2         | 3     | 4             |
| Palpitations in the chest                       | 0     | 1      | 2         | 3     | 4             |
| Anxiety   | 0     | 1      | 2         | 3     | 4             |
|   |       |        |           |       | TOTAL = _____ |


\*A total symptom score of  $\geq 23$  has been reported as showing a sensitivity of 91% and a specificity of 95% as a screening instrument in patients with diagnosed hyperventilation syndrome. BMJ 2001;322:1098-1100 (5 May)

**Stress/Emotional Health.**

|  |       |    |
|--|-------|----|
| Rate your current stress levels from 0 to 10, where 0 = No stress and 10 = Extremely high stress levels. Answer how stressed you <i>feel</i> , not how stressful you or other people would rate your life situation.   | _____ |    |
| Does one or more current life situation cause you significant levels of stress, anger, resentment or sadness: e.g. work stress, relationship stress, family stress, responsibility for others, stress about your health or financial worries? Circle those which apply to you. | Yes   | No |
| Does one or more past event still regularly cause you significant levels of upset, anger or sadness: e.g. grief/loss, guilt, trauma-related stress, physical/sexual abuse, emotional abuse, betrayal or abandonment? Circle those which apply to you.                          | Yes   | No |
| Did you have an abusive or traumatic childhood?  | Yes   | No |
| Do you associate the onset of a particular health problem with a specific upsetting event? e.g. your first migraine occurred during an argument with a relative, or your first episode of allergies occurred while being punished?   | Yes   | No |
| Do certain symptoms (e.g. headaches) often arise or greatly worsen during, or at the thought of, a particular issue (e.g. thinking about a particular situation, person or past event)?  | Yes   | No |

**Adrenal and thyroid insufficiency.**

| Hypo-adrenal.  | Hypo-thyroid.  | Risk factors ( <i>mark or circle those which apply</i> ): <ul style="list-style-type: none"> <li>• Personal history:                             <ul style="list-style-type: none"> <li>○ Health issue started after a viral infection</li> <li>○ Health issues started around puberty or pregnancy</li> <li>○ Regularly use statins, calcium channel blockers, lithium or amiodarone</li> <li>○ Thyroid, adrenal or pituitary surgery</li> <li>○ Red hair</li> </ul> </li> <li>• Family history:                             <ul style="list-style-type: none"> <li>○ Hypothyroidism</li> <li>○ Hashimoto's Thyroiditis</li> <li>○ Hyperthyroidism (inc. Grave's Disease)</li> <li>○ Addison's Disease</li> <li>○ Cushing's Syndrome</li> </ul> </li> </ul> |
|--|--|--|
| Fatigue/lethargy not relieved by sleep   | Fatigue / weakness   |  |
| Trouble getting up in the morning  | Weight gain / hard to lose weight  |  |
| Feel weak and shaky  | Tendency for constipation  |  |
| Low blood pressure   | Tendency to feel depressed   |  |
| Light-headed or dizzy when getting up to stand from lying down or sitting                          | High intolerance to cold / cold hands and feet or purple toes/fingers                      |  |
| Feel unwell during/after emotional stress e.g. exhausted, shaky, trembling, pain or confused       | Coarse, brittle or lusterless hair / head, pubic or armpit hair loss or thinning           |  |
| Decreased ability to handle stress/pressure  | Dry, scaling/flaking or course skin (e.g. cracked heels)                                   |  |
| Crave salt or salty food   | Brittle, splitting, curved or ridged nails   |  |
| Decreased tolerance for cold / frequently feel cold  | Rounded puffy face   |  |
| Poor exercise tolerance  | Puffy around eyes or droopy/baggy eyelids  |  |
| Tendency for low blood sugar e.g. irritable or shaky when hungry; or need frequent meals           | Thinning or loss of outer third of eyebrows or poor hair growth on lower legs              |  |
| Increased frequency or severity of allergies e.g. asthma, hay fever or food/chemical sensitivities | Teeth imprints (scalloping) around tongue's edge or swollen/thick tongue                   |  |
| Crave sugar  | Faint yellow/orange tinge in soles of feet or palms noticed after applying finger pressure |  |
| Light sensitivity  | Fungal infection (yellow/brown/black) in nails or peeling/splitting of skin between toes   |  |
| Increased time to recover from infection   | Redness to skin on front of neck   |  |
| Increased susceptibility to infections (e.g. the flu)  | Swollen/puffy ankles or legs   |  |
| Anxious or panic attacks / easily startled   | Slow resting heart rate (less than 65)   |  |

|  |     |    |   |
|--|-----|----|---|
| Past history of prednisone/cortisone or thyroid hormone use? Circle Which.                                       | Yes | No |  |
| Last time thyroid stimulating hormone (TSH) was tested it was above 2.5?   | Yes | No |   |
| Do you have a swollen feeling in the thyroid gland area (See image to right)?                                    | Yes | No |   |
| Press a fingernail until the underlying skin turns white. Does it take more than 2 seconds for return of colour? | Yes | No |   |

**Basal temperature.** Use a non-digital thermometer. Shake it down and leave it by the bed side the night before. Immediately after waking up and before getting out of bed take your axillary (armpit) temperature. Place the thermometer under your armpit and press your arm against your body to hold the thermometer in position. Make sure the thermometer is held there for 10 minutes. For women measurements should be taken during the first 2 weeks of your menstrual cycle and not done during ovulation (mid-cycle; day 14 in a 28 day cycle). Make sure temperature readings are taken at the same time each day. Avoid using electric blankets or water bed heaters and do not take measurements during an acute infection (e.g. cold/flu).

|             | Day 1 | Day 2 | Day 3 | Day 4 | Day 5 | Day 6 | Day 7 | Average |
|-------------|-------|-------|-------|-------|-------|-------|-------|---------|
| Temperature |       |       |       |       |       |       |       |         |

**Female: Sex hormone imbalances.**

| Progesterone Deficiency        | Estrogen Excess                       | Estrogen Deficiency               | Androgen dominance            | Risk factors ( <i>mark or circle those which apply</i> ):<br><ul style="list-style-type: none"> <li>• Take the OCP</li> <li>• Take HRT</li> <li>• Take statins</li> <li>• Hysterectomy</li> <li>• Post-menopausal Tubal ligation</li> </ul> |
|--------------------------------|---------------------------------------|-----------------------------------|-------------------------------|---|
| PMS                            | Breast tenderness/pain                | Hot flashes                       | Acne                          |   |
| Decreased libido               | Large/swollen breasts                 | Night sweats                      | Excess hair above lip         |   |
| Cyclical headaches             | Water/fluid retention                 | Breasts have lost fullness        | Darkening of facial hair      |   |
| Tender or painful breasts      | Puffiness and bloating                | Loss of libido                    | Excess hair on arms           |   |
| Breasts with lumps/cysts       | Pelvic cramps                         | Vaginal dryness                   | Head hair loss or thinning    |   |
| Heavy or frequent periods      | Excess weight gain around hips/thighs | Painful intercourse               | Aggressiveness or anger       |   |
| Infrequent period or no period |                                       | Symptoms worse week before period | History of polycystic ovaries |   |
| Migraine headaches             |                                       |                                   | Voice deepening               |   |

**Male: Sex hormone imbalances.**

| Testosterone deficiency   | Estrogen/DHT excess   | Risk factors ( <i>mark or circle those which apply</i> ):<br><ul style="list-style-type: none"> <li>• Low-normal testosterone on blood test</li> <li>• High stress levels</li> <li>• Increased abdominal fat</li> <li>• Smoker</li> <li>• Heavy alcohol use</li> <li>• Fasting blood sugar above 5.5</li> <li>• Hemochromatosis or liver disease</li> <li>• Statin, ketoconazole (nizoral), cimetidine (tagamet) or glucocorticoid (cortisone/prednisone/prednisolone) use</li> <li>• Use testosterone cream applied to groin area</li> <li>• Diagnosed with hypogonadism</li> <li>• Testicular surgery or trauma</li> </ul> |
|---|-----------------------|--|
| Lower sex drive/libido  | Breast enlargement    |  |
| Difficulty achieving an erection                                      | Pear shaped body type |  |
| Softer erections  | Elevated PSA          |  |
| Takes longer to achieve orgasm  | Prostate enlargement  |  |
| Decreased ejaculate volume  | Puffiness/bloating    |  |
| Less sexual enjoyment/satisfaction                                    | Hair loss             |  |
| Increased abdominal fat   | Headaches             |  |
| Loss of muscle mass/strength  | Weight gain           |  |
| Tendency to feel depressed or irritable                               |                       |  |
| Decreased memory  |                       |  |
| Fatigue / lower stamina   |                       |  |
| Slowed growth or reduction of hair on face, chest, legs or pubic area |                       |  |
| Reduction or absence of voice deepness                                |                       |  |

|  |     |    |
|--|-----|----|
| Loss of height, low bone density or easy fracture? Circle which. | Yes | No |
| History of infertility?  | Yes | No |

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