

**Functional Medicine Comprehensive Patient History**  
**Red Rock Chiropractic Center Kyle J. Pankonin, D.C.**

Patient name	
Date of birth	
Address	
Home phone number	
Work phone number	
Emergency contact number	
Cell phone number	
Fax number	
Email	
Preferred contact	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Email
Present occupation	
Current job duties	
Past occupation(s)	
Marital status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Number of children	
How did you hear about our office?	
<b>Symptom 1</b>	
Describe your concern in detail.	
When did it start?	
How often does it occur?	
How would you rate the severity of the symptom (mild, moderate, severe)?	
What makes it better?	
What makes it worse?	
Have you experienced this symptom in the past?	
If so, please explain.	
<b>Symptom 2</b>	
Describe your concern in detail.	
When did it start?	
How often does it occur?	
How would you rate the severity of the symptom (mild, moderate, severe)?	
What makes it better?	
What makes it worse?	
Have you experienced this symptom in the past?	
If so, please explain.	
<b>Symptom 3</b>	
Describe your concern in detail.	
When did it start?	
How often does it occur?	
How would you rate the severity of the symptom (mild, moderate, severe)?	
What makes it better?	
What makes it worse?	
Have you experienced this symptom in the past?	
If so, please explain.	
<b>Symptom 4</b>	
Describe your concern in detail.	
When did it start?	
How often does it occur?	
How would you rate the severity of the symptom (mild, moderate, severe)?	
What makes it better?	
What makes it worse?	
Have you experienced this symptom in the past?	

**Functional Medicine Comprehensive Patient History**  
**Red Rock Chiropractic Center Kyle J. Pankonin, D.C.**

If so, please explain.	
<b>Symptom 5</b>	
Describe your concern in detail.	
When did it start?	
How often does it occur?	
How would you rate the severity of the symptom (mild, moderate, severe)?	
What makes it better?	
What makes it worse?	
Have you experienced this symptom in the past?	
If so, please explain.	
List the physicians you have seen for the above concerns:	
Doctor 1	
Doctor 2	
Doctor 3	
Doctor 4	
Doctor 5	
Have you ever had a head injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please describe how the injury occurred and which part of the head sustained the injury.	
Please check all integrative medicine treatments you have received as it relates to the concerns listed.	<input type="checkbox"/> None <input type="checkbox"/> Chiropractic <input type="checkbox"/> Acupuncture <input type="checkbox"/> Iridology <input type="checkbox"/> Colonics <input type="checkbox"/> Massage <input type="checkbox"/> Chelation therapy (IV-therapy) <input type="checkbox"/> Rolfing <input type="checkbox"/> Reiki <input type="checkbox"/> Nutritional therapy <input type="checkbox"/> Yoga <input type="checkbox"/> Hypnosis <input type="checkbox"/> Biological dentistry <input type="checkbox"/> Ayurveda <input type="checkbox"/> Electromagnetic therapy <input type="checkbox"/> Environmental medicine <input type="checkbox"/> Homeopathy <input type="checkbox"/> Light therapy <input type="checkbox"/> Meditation <input type="checkbox"/> Biofeedback <input type="checkbox"/> Other _____
Have you had any of the following illnesses? If yes, when?	<input type="checkbox"/> Chicken pox _____ <input type="checkbox"/> Mononucleosis _____ <input type="checkbox"/> Measles _____ <input type="checkbox"/> Mumps _____ <input type="checkbox"/> Hepatitis _____ <input type="checkbox"/> Other _____
Have you had any of the following immunizations?	<input type="checkbox"/> Smallpox vaccination _____ <input type="checkbox"/> DPT or Tetanus _____ <input type="checkbox"/> Polio _____ <input type="checkbox"/> Mumps _____ <input type="checkbox"/> Measles _____ <input type="checkbox"/> Other (please specify) _____
Have you had any of the following surgeries? If yes, when?	<input type="checkbox"/> Tonsillectomy _____ <input type="checkbox"/> Tubes in ears _____ <input type="checkbox"/> Appendectomy _____ <input type="checkbox"/> Gall bladder _____ <input type="checkbox"/> Hernia _____ <input type="checkbox"/> Hysterectomy _____ <input type="checkbox"/> Other _____
Have you had any of the following diagnostic tests within the past 5 years?	<input type="checkbox"/> None <input type="checkbox"/> Chest x-ray <input type="checkbox"/> Mammogram <input type="checkbox"/> EKG <input type="checkbox"/> Sigmoidoscopy <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Upper GI series <input type="checkbox"/> Barium enema <input type="checkbox"/> CAT scan of brain <input type="checkbox"/> CAT scan of spine <input type="checkbox"/> MRI

**Functional Medicine Comprehensive Patient History**  
**Red Rock Chiropractic Center Kyle J. Pankonin, D.C.**

	<input type="checkbox"/> Liver scan
	<input type="checkbox"/> X-rays
	<input type="checkbox"/> Bone density test
	<input type="checkbox"/> Blood tests
	<input type="checkbox"/> Other (please specify) _____
<b>Chronological Past Medical History</b>	Birth to age 10 (You may need to ask family members for assistance)
Please list (to the best of your recollection) how you were feeling during each decade of your life: physically, mentally, and emotionally. If you feel comfortable, please include any physical, emotional, or substance abuse. If you do not feel comfortable listing this information here, you will have the opportunity to discuss this personally at any time while you are under care. This area should include illnesses, surgeries, injuries, and medications	
	Age 11 - 20 (Females: describe onset of menstrual cycles/history of cycles)
	Age 21 - 30
	Age 31-40
	Age 41 - present
List any problems your birth mother may have had with pregnancy(s) such as medications, spontaneous abortions, toxemia diabetes, etc.	
Please indicate all medications you are currently taking.	
Medication 1	Medication 11
Medication 2	Medication 12
Medication 3	Medication 13
Medication 4	Medication 14
Medication 5	Medication 15
Medication 6	Medication 16
Medication 7	Medication 17
Medication 8	Medication 18
Medication 9	Medication 19
Medication 10	Other medicine(s)
Please list any medication allergies you have.	
Please list all supplements (include herbal, vitamin, minerals, fish oil, etc.) you are currently taking. Please include dosage and how long you have been taking the supplement.	
Supplement 1	Supplement 11
Supplement 2	Supplement 12
Supplement 3	Supplement 13
Supplement 4	Supplement 14
Supplement 5	Supplement 15
Supplement 6	Supplement 16
Supplement 7	Supplement 17

**Functional Medicine Comprehensive Patient History**  
**Red Rock Chiropractic Center Kyle J. Pankonin, D.C.**

Supplement 8	Supplement 18
Supplement 9	Supplement 19
Supplement 10	Supplement 20
Please list any adverse reaction to vitamins, minerals, herbs, or other supplements you may have had.	
Do you consume alcohol? If yes, what type, how much, and how often?	
Who is your primary care provider?	
What was the date of your last physical examination?	
What is the date of your last blood test?	
Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Previous smoker If yes, how many years?	
What is your blood type? <input type="checkbox"/> A+ <input type="checkbox"/> B+ <input type="checkbox"/> AB+ <input type="checkbox"/> O+ <input type="checkbox"/> A- <input type="checkbox"/> B- <input type="checkbox"/> AB- <input type="checkbox"/> O-	
What is your present weight?	
What is your present height?	
How many days a week do you exercise? What type of exercise?	
Please select appropriate family members for the following questions.	
Deceased	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Maternal grandmother <input type="checkbox"/> Maternal grandfather <input type="checkbox"/> Paternal grandmother <input type="checkbox"/> Paternal grandfather
Heart attack	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Maternal grandmother <input type="checkbox"/> Maternal grandfather <input type="checkbox"/> Paternal grandmother <input type="checkbox"/> Paternal grandfather
Stroke	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Maternal grandmother <input type="checkbox"/> Maternal grandfather <input type="checkbox"/> Paternal grandmother <input type="checkbox"/> Paternal grandfather
Uterine fibroids	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Maternal grandmother <input type="checkbox"/> Maternal grandfather <input type="checkbox"/> Paternal grandmother <input type="checkbox"/> Paternal grandfather
Cancer	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Maternal grandmother <input type="checkbox"/> Maternal grandfather <input type="checkbox"/> Paternal grandmother <input type="checkbox"/> Paternal grandfather
Emphysema	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Maternal grandmother <input type="checkbox"/> Maternal grandfather <input type="checkbox"/> Paternal grandmother <input type="checkbox"/> Paternal grandfather
Arthritis	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Maternal grandmother <input type="checkbox"/> Maternal grandfather <input type="checkbox"/> Paternal grandmother <input type="checkbox"/> Paternal grandfather
Rheumatoid Arthritis	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Maternal grandmother <input type="checkbox"/> Maternal grandfather <input type="checkbox"/> Paternal grandmother <input type="checkbox"/> Paternal grandfather

**Functional Medicine Comprehensive Patient History**  
**Red Rock Chiropractic Center Kyle J. Pankonin, D.C.**

Lupus	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Maternal grandmother <input type="checkbox"/> Maternal grandfather <input type="checkbox"/> Paternal grandmother <input type="checkbox"/> Paternal grandfather
Diabetes	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Maternal grandmother <input type="checkbox"/> Maternal grandfather <input type="checkbox"/> Paternal grandmother <input type="checkbox"/> Paternal grandfather
Parkinson's	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Maternal grandmother <input type="checkbox"/> Maternal grandfather <input type="checkbox"/> Paternal grandmother <input type="checkbox"/> Paternal grandfather
Alzheimer's or other dementia	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Maternal grandmother <input type="checkbox"/> Maternal grandfather <input type="checkbox"/> Paternal grandmother <input type="checkbox"/> Paternal grandfather
Osteoporosis	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Maternal grandmother <input type="checkbox"/> Maternal grandfather <input type="checkbox"/> Paternal grandmother <input type="checkbox"/> Paternal grandfather
Glaucoma	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Maternal grandmother <input type="checkbox"/> Maternal grandfather <input type="checkbox"/> Paternal grandmother <input type="checkbox"/> Paternal grandfather
Breast cancer	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Maternal grandmother <input type="checkbox"/> Maternal grandfather <input type="checkbox"/> Paternal grandmother <input type="checkbox"/> Paternal grandfather
Prostate cancer	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Maternal grandmother <input type="checkbox"/> Maternal grandfather <input type="checkbox"/> Paternal grandmother <input type="checkbox"/> Paternal grandfather
High blood pressure	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Maternal grandmother <input type="checkbox"/> Maternal grandfather <input type="checkbox"/> Paternal grandmother <input type="checkbox"/> Paternal grandfather
Skin cancer	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Maternal grandmother <input type="checkbox"/> Maternal grandfather <input type="checkbox"/> Paternal grandmother <input type="checkbox"/> Paternal grandfather
Depression	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Maternal grandmother <input type="checkbox"/> Maternal grandfather <input type="checkbox"/> Paternal grandmother <input type="checkbox"/> Paternal grandfather
Multiple sclerosis	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Maternal grandmother <input type="checkbox"/> Maternal grandfather <input type="checkbox"/> Paternal grandmother <input type="checkbox"/> Paternal grandfather
Alcohol addiction	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Maternal grandmother <input type="checkbox"/> Maternal grandfather <input type="checkbox"/> Paternal grandmother <input type="checkbox"/> Paternal grandfather
Smoking addiction	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Maternal grandmother <input type="checkbox"/> Maternal grandfather <input type="checkbox"/> Paternal grandmother <input type="checkbox"/> Paternal grandfather
Asthma	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Maternal grandmother <input type="checkbox"/> Maternal grandfather <input type="checkbox"/> Paternal grandmother <input type="checkbox"/> Paternal grandfather
Pneumonia	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Maternal grandmother <input type="checkbox"/> Maternal grandfather <input type="checkbox"/> Paternal grandmother <input type="checkbox"/> Paternal grandfather



**Functional Medicine Comprehensive Patient History**  
**Red Rock Chiropractic Center Kyle J. Pankonin, D.C.**

Age of first menses (period)	
Frequency of cycles (e.g. every 28 days)	
Average number of days of the menstrual phase (bleeding)	
Do you experience painful cycles?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you experience abnormal clotting?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last menstrual period	
Do you currently use contraception?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, which type do you use and for how long	
If you are currently NOT using contraception (hormonal)	
and have used hormonal birth control in the past, please	
indicate which type and for how long you used this type	
of birth control	
Date of last PAP test	
Please indicate normal or abnormal test results	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown
Date of last mammogram	
Please indicate normal or abnormal test results	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown
Date of last bone density test	
Please indicate normal or abnormal test results	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown
List any other female problems of concern	
<b>OBSTETRIC HISTORY</b>	
If you have never become pregnant, please check the box	
to the right and process to the next page by clicking the	<input type="checkbox"/> Never been pregnant
word NEXT at the bottom of this page.	
Are you pregnant now?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Number of pregnancies	
Number of live births	
Number of vaginal deliveries	
Number of cesareans deliveries	
Number of miscarriages	
Number of abortions	
History of toxemia due to pregnancy	<input type="checkbox"/> Yes <input type="checkbox"/> No
History of post partum depression	<input type="checkbox"/> Yes <input type="checkbox"/> No
History of gestational diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>MALE MEDICAL HISTORY (MALES ONLY)</b>	
Discharge, growth or lesions (sores) on the penis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Scrotal/testicular pain, swelling or growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty achieving or maintaining an erection (erectile	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
dysfunction)	
Difficulty with ejaculation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Have you had a PSA test (prostate blood test)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Date of last PSA test (prostate blood test)	
Please indicate normal or abnormal test results	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Unknown
Date of last prostate examination	
History of hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Infertility	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Changes in urinary function (flow and/or frequency)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rectal bleeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, how long?	
Hemorrhoids?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, how long?	
List any other male problems of concern	





Check all symptoms or conditions you are presently experiencing or have had in the past. You may select both "past" and "present," if applicable.

Symptom	Past	Present	Symptom	Past	Present	Symptom	Past	Present
Abdominal pain/cramps	<input type="checkbox"/>	<input type="checkbox"/>	Absence of menstrual cycles (amenorrhea)	<input type="checkbox"/>	<input type="checkbox"/>	Aching ankles, knees, wrists, or shoulders	<input type="checkbox"/>	<input type="checkbox"/>
Acid reflux/GERD	<input type="checkbox"/>	<input type="checkbox"/>	Acne	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol cravings	<input type="checkbox"/>	<input type="checkbox"/>
Allergies and sensitivities (food and other substances)	<input type="checkbox"/>	<input type="checkbox"/>	Alternating diarrhea and constipation	<input type="checkbox"/>	<input type="checkbox"/>	Anal fissures	<input type="checkbox"/>	<input type="checkbox"/>
Anger easily	<input type="checkbox"/>	<input type="checkbox"/>	Angina pain	<input type="checkbox"/>	<input type="checkbox"/>	Anorexia	<input type="checkbox"/>	<input type="checkbox"/>
Antacid/proton pump inhibitor use	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Backaches	<input type="checkbox"/>	<input type="checkbox"/>	Bad breath (chronic)	<input type="checkbox"/>	<input type="checkbox"/>
Becomes ill when illness comes around (catch everything)	<input type="checkbox"/>	<input type="checkbox"/>	Bedwetting	<input type="checkbox"/>	<input type="checkbox"/>	Behavior/ADHD/Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>
Bitter taste in the mouth in the morning	<input type="checkbox"/>	<input type="checkbox"/>	Black or tarry stools	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding after intercourse	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding between periods/frequent spotting	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding/swollen gums	<input type="checkbox"/>	<input type="checkbox"/>	Bloating 1 to 2 hours after eating	<input type="checkbox"/>	<input type="checkbox"/>
Bloating/bloating and gas	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Blood sugar up and down	<input type="checkbox"/>	<input type="checkbox"/>	Blood, mucus, or pus in stool	<input type="checkbox"/>	<input type="checkbox"/>	Bloodshot eyes	<input type="checkbox"/>	<input type="checkbox"/>
Blurry vision	<input type="checkbox"/>	<input type="checkbox"/>	Body odor	<input type="checkbox"/>	<input type="checkbox"/>	Bowel urgency/increase frequency (several to many times per day)	<input type="checkbox"/>	<input type="checkbox"/>
Brain fog/fatigue after eating	<input type="checkbox"/>	<input type="checkbox"/>	Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	Breast soreness during menstrual period	<input type="checkbox"/>	<input type="checkbox"/>
Bruising easily	<input type="checkbox"/>	<input type="checkbox"/>	Bumps on the back of arms	<input type="checkbox"/>	<input type="checkbox"/>	Bumps on the front thighs	<input type="checkbox"/>	<input type="checkbox"/>
Burning mouth and lips	<input type="checkbox"/>	<input type="checkbox"/>	Burning or pain with urination	<input type="checkbox"/>	<input type="checkbox"/>	Burning sensation when eating citrus foods	<input type="checkbox"/>	<input type="checkbox"/>
Burning, stinging eyes	<input type="checkbox"/>	<input type="checkbox"/>	Burping/belching	<input type="checkbox"/>	<input type="checkbox"/>	Burst of energy at night	<input type="checkbox"/>	<input type="checkbox"/>
Canker sores (mouth/tongue sores)	<input type="checkbox"/>	<input type="checkbox"/>	Carpal tunnel syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
Cervical dysplasia	<input type="checkbox"/>	<input type="checkbox"/>	Change in habits of bowel movements	<input type="checkbox"/>	<input type="checkbox"/>	Changes of seasons makes symptoms worse	<input type="checkbox"/>	<input type="checkbox"/>
Changes in hair texture and hair growth	<input type="checkbox"/>	<input type="checkbox"/>	Changes in size and color of moles	<input type="checkbox"/>	<input type="checkbox"/>	Chapped dry lips	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy past or present	<input type="checkbox"/>	<input type="checkbox"/>	Chronic digestive symptoms (GERD, IBS, IBD)	<input type="checkbox"/>	<input type="checkbox"/>	Chronic ear infections	<input type="checkbox"/>	<input type="checkbox"/>
Chronic intestinal infections (yeast/parasitic)	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain in lower neck and upper back	<input type="checkbox"/>	<input type="checkbox"/>	Chronic stomach/abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>
Chronic stress	<input type="checkbox"/>	<input type="checkbox"/>	Chronic systemic (all over) pain	<input type="checkbox"/>	<input type="checkbox"/>	Clothes dry-cleaned	<input type="checkbox"/>	<input type="checkbox"/>
Coated tongue (white, yellow or dark)	<input type="checkbox"/>	<input type="checkbox"/>	Cold hands and feet	<input type="checkbox"/>	<input type="checkbox"/>	Cold sweats	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Confusion	<input type="checkbox"/>	<input type="checkbox"/>	Constant clearing of throat	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Constipation (chronic)	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Coughing	<input type="checkbox"/>	<input type="checkbox"/>	Cracks in corner of mouth	<input type="checkbox"/>	<input type="checkbox"/>	Cravings for sweets	<input type="checkbox"/>	<input type="checkbox"/>
Croup as a baby	<input type="checkbox"/>	<input type="checkbox"/>	Dandruff	<input type="checkbox"/>	<input type="checkbox"/>	Dark circles under eyes	<input type="checkbox"/>	<input type="checkbox"/>
Decreased cognitive function (brain fog) most of the time	<input type="checkbox"/>	<input type="checkbox"/>	Dental bone loss	<input type="checkbox"/>	<input type="checkbox"/>	Dependent on sugar and/or alcohol	<input type="checkbox"/>	<input type="checkbox"/>

Depression	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes, metabolic syndrome, insulin resistance	<input type="checkbox"/>	<input type="checkbox"/>	Diagnosed as having irritable bowel syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Diagnosed with a vitamin D deficiency	<input type="checkbox"/>	<input type="checkbox"/>	Diagnosed with an autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>	Diagnosed with iron deficiency	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea (chronic)	<input type="checkbox"/>	<input type="checkbox"/>	Difficult time concentrating	<input type="checkbox"/>	<input type="checkbox"/>
Difficult time gaining weight	<input type="checkbox"/>	<input type="checkbox"/>	Difficult time managing stress	<input type="checkbox"/>	<input type="checkbox"/>	Difficult to sweat	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing solids or liquids	<input type="checkbox"/>	<input type="checkbox"/>	Dilated capillaries on face (redness)/Rosacea	<input type="checkbox"/>	<input type="checkbox"/>
Diminished sex drive	<input type="checkbox"/>	<input type="checkbox"/>	Discharge from penis	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Dizzy when getting up quickly	<input type="checkbox"/>	<input type="checkbox"/>	Dizzy, irritable if you go without food for several hours	<input type="checkbox"/>	<input type="checkbox"/>	Drink beverages and cook in plastic containers	<input type="checkbox"/>	<input type="checkbox"/>
Drink tap water	<input type="checkbox"/>	<input type="checkbox"/>	Drink unfiltered well water	<input type="checkbox"/>	<input type="checkbox"/>	Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>
Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	Dry, rough, flaky skin	<input type="checkbox"/>	<input type="checkbox"/>	Easily intoxicated by alcohol	<input type="checkbox"/>	<input type="checkbox"/>
Easily startled	<input type="checkbox"/>	<input type="checkbox"/>	Eat out a lot	<input type="checkbox"/>	<input type="checkbox"/>	Eat sushi and/or undercooked food	<input type="checkbox"/>	<input type="checkbox"/>
Eczema, psoriasis, dermatitis	<input type="checkbox"/>	<input type="checkbox"/>	Elevated homocysteine	<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged prostate	<input type="checkbox"/>	<input type="checkbox"/>	Erectile dysfunction/impotence	<input type="checkbox"/>	<input type="checkbox"/>	Excess ear wax	<input type="checkbox"/>	<input type="checkbox"/>
Excessive facial hair (women)	<input type="checkbox"/>	<input type="checkbox"/>	Excessive gas and bloating	<input type="checkbox"/>	<input type="checkbox"/>	Excessive sighing	<input type="checkbox"/>	<input type="checkbox"/>
Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>	Excessive urination	<input type="checkbox"/>	<input type="checkbox"/>	Exposed to toxins at home and workplace	<input type="checkbox"/>	<input type="checkbox"/>
Extremities are cold or clammy	<input type="checkbox"/>	<input type="checkbox"/>	Face twitch/tics	<input type="checkbox"/>	<input type="checkbox"/>	Facial swelling/edema	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue (chronic)/fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue after eating	<input type="checkbox"/>	<input type="checkbox"/>
Fatigued in morning/difficulty getting out of bed	<input type="checkbox"/>	<input type="checkbox"/>	Feel groggy most days	<input type="checkbox"/>	<input type="checkbox"/>	Feel wired, but am tired	<input type="checkbox"/>	<input type="checkbox"/>
Feeling as if there is a lump in the throat	<input type="checkbox"/>	<input type="checkbox"/>	Feeling cold; difficulty getting warm	<input type="checkbox"/>	<input type="checkbox"/>	Feeling of excessive fullness 1 to 3 hours after eating	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Fever blisters (cold sores)	<input type="checkbox"/>	<input type="checkbox"/>	Fibroid tumors/breast	<input type="checkbox"/>	<input type="checkbox"/>
Fibroid tumors/uterus	<input type="checkbox"/>	<input type="checkbox"/>	Fingernails chip, peel, or break easily	<input type="checkbox"/>	<input type="checkbox"/>	Foot allergies	<input type="checkbox"/>	<input type="checkbox"/>
Forgetfulness	<input type="checkbox"/>	<input type="checkbox"/>	Foul-smelling stool	<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds or flu	<input type="checkbox"/>	<input type="checkbox"/>
Frequent ear infections	<input type="checkbox"/>	<input type="checkbox"/>	Frequent feeling of indifference	<input type="checkbox"/>	<input type="checkbox"/>	Frequent infections	<input type="checkbox"/>	<input type="checkbox"/>
Frequent mood swings	<input type="checkbox"/>	<input type="checkbox"/>	Frequent nighttime coughing	<input type="checkbox"/>	<input type="checkbox"/>	Frequent nighttime urination	<input type="checkbox"/>	<input type="checkbox"/>
Frequent respiratory infections	<input type="checkbox"/>	<input type="checkbox"/>	Frequent sighing	<input type="checkbox"/>	<input type="checkbox"/>	Frequent sinus infections/congested sinuses	<input type="checkbox"/>	<input type="checkbox"/>
Frequent sore throat	<input type="checkbox"/>	<input type="checkbox"/>	Frequent stuffy, runny nose	<input type="checkbox"/>	<input type="checkbox"/>	Frequent twitching	<input type="checkbox"/>	<input type="checkbox"/>
Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	Frequent use of antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	Frequent use of laxatives	<input type="checkbox"/>	<input type="checkbox"/>
Frequent yeast infections/problems	<input type="checkbox"/>	<input type="checkbox"/>	Frequent/chronic infections	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder removed	<input type="checkbox"/>	<input type="checkbox"/>
Generalized aches, sharp pains	<input type="checkbox"/>	<input type="checkbox"/>	Get occasional pain on right side of rib cage	<input type="checkbox"/>	<input type="checkbox"/>	Get short of breath easily	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Goiter (enlarged thyroid gland)	<input type="checkbox"/>	<input type="checkbox"/>	Greasy or shiny stools	<input type="checkbox"/>	<input type="checkbox"/>
Gulf War Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Have a pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Have amalgam fillings	<input type="checkbox"/>	<input type="checkbox"/>

Have or have had food poisoning	<input type="checkbox"/>	<input type="checkbox"/>	Have or have had cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack/stroke in past	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart enlargement	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Heaviness or tightness in the chest	<input type="checkbox"/>	<input type="checkbox"/>	Heavy feeling in legs	<input type="checkbox"/>	<input type="checkbox"/>	Heavy menstrual bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Hernias	<input type="checkbox"/>	<input type="checkbox"/>	Herpes virus	<input type="checkbox"/>	<input type="checkbox"/>
Hiatal hernia	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
History of miscarriage(s)	<input type="checkbox"/>	<input type="checkbox"/>	History of alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>	History of anemia	<input type="checkbox"/>	<input type="checkbox"/>
History of bowel disease	<input type="checkbox"/>	<input type="checkbox"/>	History of bronchitis and/or pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	History of gallbladder attacks/gallstones	<input type="checkbox"/>	<input type="checkbox"/>
History of gout	<input type="checkbox"/>	<input type="checkbox"/>	History of hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	History of mononucleosis/Epstein Barr virus	<input type="checkbox"/>	<input type="checkbox"/>
History of sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>	History of tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	HIV infection	<input type="checkbox"/>	<input type="checkbox"/>
Hives	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness, gravelly voice	<input type="checkbox"/>	<input type="checkbox"/>	Home pesticide treatments	<input type="checkbox"/>	<input type="checkbox"/>
Hormonal imbalance	<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	Incomplete bowel movements	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence (loss of bladder control)	<input type="checkbox"/>	<input type="checkbox"/>	Increased appetite, hungry after meals	<input type="checkbox"/>	<input type="checkbox"/>	Increased pulse rate while at rest	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Infertility	<input type="checkbox"/>	<input type="checkbox"/>	Infrequent urination	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Interstitial cystitis	<input type="checkbox"/>	<input type="checkbox"/>	Intolerance to carbohydrates (esp. beans and fiber)	<input type="checkbox"/>	<input type="checkbox"/>
Inward trembling	<input type="checkbox"/>	<input type="checkbox"/>	Irregular periods	<input type="checkbox"/>	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	<input type="checkbox"/>
Irritable before meal time	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	Kidney pain	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	Lack of energy	<input type="checkbox"/>	<input type="checkbox"/>	Lack of mental alertness	<input type="checkbox"/>	<input type="checkbox"/>
Leg cramps	<input type="checkbox"/>	<input type="checkbox"/>	Light-colored stool	<input type="checkbox"/>	<input type="checkbox"/>	Lightheaded standing up too fast	<input type="checkbox"/>	<input type="checkbox"/>
Light-headed, especially when standing up	<input type="checkbox"/>	<input type="checkbox"/>	Little to no physical activity	<input type="checkbox"/>	<input type="checkbox"/>	Live in a city, large urban area and/or industrialized area	<input type="checkbox"/>	<input type="checkbox"/>
Live in a damp and/or moldy environment	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Living space has poor ventilation (airtight)	<input type="checkbox"/>	<input type="checkbox"/>
Loss of color in hair and skin	<input type="checkbox"/>	<input type="checkbox"/>	Loss of patience	<input type="checkbox"/>	<input type="checkbox"/>	Loss of taste for meat	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Low blood sugar	<input type="checkbox"/>	<input type="checkbox"/>	Low body temperature	<input type="checkbox"/>	<input type="checkbox"/>
Low cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Low exercise tolerance	<input type="checkbox"/>	<input type="checkbox"/>	Low urine flow that is dark and strong smelling	<input type="checkbox"/>	<input type="checkbox"/>
Lower bowel gas	<input type="checkbox"/>	<input type="checkbox"/>	Lower bowel gas several hours after eating	<input type="checkbox"/>	<input type="checkbox"/>	Lumps in breast	<input type="checkbox"/>	<input type="checkbox"/>
Lumps in testicles	<input type="checkbox"/>	<input type="checkbox"/>	Lyme disease	<input type="checkbox"/>	<input type="checkbox"/>	Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>
Male infertility (low sperm count)	<input type="checkbox"/>	<input type="checkbox"/>	Mind always racing	<input type="checkbox"/>	<input type="checkbox"/>	Missing teeth	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Mucus and congestion (lungs)	<input type="checkbox"/>	<input type="checkbox"/>	Mucus in stool	<input type="checkbox"/>	<input type="checkbox"/>
Muscle cramping after exercise	<input type="checkbox"/>	<input type="checkbox"/>	Muscle cramping while at rest	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>
Muscle stiffness in morning	<input type="checkbox"/>	<input type="checkbox"/>	Muscle stiffness with damp weather	<input type="checkbox"/>	<input type="checkbox"/>	Muscles fatigue quickly	<input type="checkbox"/>	<input type="checkbox"/>
Nails are flattened and have concavities	<input type="checkbox"/>	<input type="checkbox"/>	Nails tend to be loose lift easily, and crack	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Need caffeine/coffee to help wake up	<input type="checkbox"/>	<input type="checkbox"/>	Need for antacids	<input type="checkbox"/>	<input type="checkbox"/>	Nervous stomach	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Never or rarely sweat	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>

Nipple discharge	<input type="checkbox"/>	<input type="checkbox"/>	No sense of smell	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>
Numbness, tingling, burning in extremities	<input type="checkbox"/>	<input type="checkbox"/>	Osteopenia/osteoporosis (bone loss)	<input type="checkbox"/>	<input type="checkbox"/>	Ovarian cysts	<input type="checkbox"/>	<input type="checkbox"/>
Overweight/obese	<input type="checkbox"/>	<input type="checkbox"/>	Pain between shoulders	<input type="checkbox"/>	<input type="checkbox"/>	Pain that awakens you from sleep	<input type="checkbox"/>	<input type="checkbox"/>
Pain with bowel movement	<input type="checkbox"/>	<input type="checkbox"/>	Painful intercourse	<input type="checkbox"/>	<input type="checkbox"/>	Pale, anemic, or yellowish skin	<input type="checkbox"/>	<input type="checkbox"/>
Pale, cool clammy skin	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations/irregular, skipped heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>
Partial hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>	Past stomach (peptic/duodenal) ulcer and/or gastritis	<input type="checkbox"/>	<input type="checkbox"/>	Periodontal (gum) disease	<input type="checkbox"/>	<input type="checkbox"/>
Periods of rapid heartbeats	<input type="checkbox"/>	<input type="checkbox"/>	Pesticide and garden chemical use	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
PMS	<input type="checkbox"/>	<input type="checkbox"/>	Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	Poor concentration	<input type="checkbox"/>	<input type="checkbox"/>
Poor memory/memory loss	<input type="checkbox"/>	<input type="checkbox"/>	Poor night vision	<input type="checkbox"/>	<input type="checkbox"/>	Poor stamina	<input type="checkbox"/>	<input type="checkbox"/>
Post nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	Premature graying of hair	<input type="checkbox"/>	<input type="checkbox"/>	Previous concussion	<input type="checkbox"/>	<input type="checkbox"/>
Previous or current use of aspirin or other anti-inflammatory medications	<input type="checkbox"/>	<input type="checkbox"/>	Prostate cancer	<input type="checkbox"/>	<input type="checkbox"/>	Pulse increases after eating meals	<input type="checkbox"/>	<input type="checkbox"/>
Quick to cry	<input type="checkbox"/>	<input type="checkbox"/>	Racing heart	<input type="checkbox"/>	<input type="checkbox"/>	Rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Rectal/anal itching	<input type="checkbox"/>	<input type="checkbox"/>	Reduced urine flow, hesitation, dribbling	<input type="checkbox"/>	<input type="checkbox"/>	Regular use of pain medication	<input type="checkbox"/>	<input type="checkbox"/>
Resist going to bed when tired	<input type="checkbox"/>	<input type="checkbox"/>	Salt craving	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis (curvature of the spine)	<input type="checkbox"/>	<input type="checkbox"/>
Scrotal pain or swelling	<input type="checkbox"/>	<input type="checkbox"/>	See halo around lights	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Sense of fullness after meals	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to caffeine	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to certain medications	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to chlorine and bromine	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to cold temperature	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to hot temperature	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to household cleaning products	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to light touch	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to MSG	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to room sprays and/or candles	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to soaps, detergents, and/or dryer sheets	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to sulfites (wine, dried fruit)	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to tobacco smoke	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to walking down the detergent aisle	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to light/noise	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to perfumes/gasoline fumes/chemicals	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to chocolate	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to smog/air pollution	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Sinus congestion (chronic)	<input type="checkbox"/>	<input type="checkbox"/>	Skin eruptions, boils	<input type="checkbox"/>	<input type="checkbox"/>
Skin rashes	<input type="checkbox"/>	<input type="checkbox"/>	Skin tags	<input type="checkbox"/>	<input type="checkbox"/>	Sleepy after meals	<input type="checkbox"/>	<input type="checkbox"/>
Slow to recover from surgery	<input type="checkbox"/>	<input type="checkbox"/>	Sluggish, foggy thinking	<input type="checkbox"/>	<input type="checkbox"/>	Sneezing spells	<input type="checkbox"/>	<input type="checkbox"/>
Sore on penis	<input type="checkbox"/>	<input type="checkbox"/>	Sour taste in mouth	<input type="checkbox"/>	<input type="checkbox"/>	Spider veins	<input type="checkbox"/>	<input type="checkbox"/>
Sprains, strains, and weak ligaments	<input type="checkbox"/>	<input type="checkbox"/>	Stiff, achy painful joints/swollen joints	<input type="checkbox"/>	<input type="checkbox"/>	Stomach pain just before or after meals	<input type="checkbox"/>	<input type="checkbox"/>
Stomach pain relieved by ingesting carbonated drinks	<input type="checkbox"/>	<input type="checkbox"/>	Stomach pain relieved by ingesting milk/cream	<input type="checkbox"/>	<input type="checkbox"/>	Stomach pains	<input type="checkbox"/>	<input type="checkbox"/>
Stomach upset after eating fatty/greasy foods	<input type="checkbox"/>	<input type="checkbox"/>	Stomach upset by taking vitamins/supplements	<input type="checkbox"/>	<input type="checkbox"/>	Stool (abdominal cramps, urgency or mucus in stool at least one time per week)	<input type="checkbox"/>	<input type="checkbox"/>
Stools poorly formed, greasy and/or foul smelling	<input type="checkbox"/>	<input type="checkbox"/>	Stressed-out most of the time	<input type="checkbox"/>	<input type="checkbox"/>	Strong-smelling urine	<input type="checkbox"/>	<input type="checkbox"/>
Sudden indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Sweet cravings	<input type="checkbox"/>	<input type="checkbox"/>	Swelling in calves, legs or feet	<input type="checkbox"/>	<input type="checkbox"/>
Swelling in knees	<input type="checkbox"/>	<input type="checkbox"/>	Swollen eyelids and face	<input type="checkbox"/>	<input type="checkbox"/>	Swollen lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>

Swollen tongue/lips	<input type="checkbox"/>	<input type="checkbox"/>	Taken prednisone or other anti-inflammatory drugs for two weeks or longer	<input type="checkbox"/>	<input type="checkbox"/>	Tendency to retain water	<input type="checkbox"/>	<input type="checkbox"/>
Tendency to sleep too much	<input type="checkbox"/>	<input type="checkbox"/>	Tendency to startle easily	<input type="checkbox"/>	<input type="checkbox"/>	Tendency to sweat excessively	<input type="checkbox"/>	<input type="checkbox"/>
Tendonitis	<input type="checkbox"/>	<input type="checkbox"/>	Testicular pain	<input type="checkbox"/>	<input type="checkbox"/>	Thinning or loss of outside of eyebrows	<input type="checkbox"/>	<input type="checkbox"/>
Thinning skin	<input type="checkbox"/>	<input type="checkbox"/>	Three or more bowel movements a days	<input type="checkbox"/>	<input type="checkbox"/>	Throat closes up	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid condition	<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus (ringing in ears)	<input type="checkbox"/>	<input type="checkbox"/>	TMJ (jaw)	<input type="checkbox"/>	<input type="checkbox"/>
Tongue feels thick	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	Total hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>
Tremors (shaking)	<input type="checkbox"/>	<input type="checkbox"/>	Tremors (Confusion)	<input type="checkbox"/>	<input type="checkbox"/>	Trouble falling and staying asleep	<input type="checkbox"/>	<input type="checkbox"/>
Uncomfortable after eating fatty foods	<input type="checkbox"/>	<input type="checkbox"/>	Undigested food in stools	<input type="checkbox"/>	<input type="checkbox"/>	Unexplained hair loss	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained weight gain	<input type="checkbox"/>	<input type="checkbox"/>	Unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Urinary tract/kidney infections	<input type="checkbox"/>	<input type="checkbox"/>
Use of IUD	<input type="checkbox"/>	<input type="checkbox"/>	Use of oral contraceptive	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal itching	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting blood	<input type="checkbox"/>	<input type="checkbox"/>	Wake up at night with heartburn and/or regurgitation	<input type="checkbox"/>	<input type="checkbox"/>	Wake up unrefreshed	<input type="checkbox"/>	<input type="checkbox"/>
Waking up with sore heels	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Wear dentures	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	White spots on the nails	<input type="checkbox"/>	<input type="checkbox"/>
Wounds are slow in healing	<input type="checkbox"/>	<input type="checkbox"/>	Yearly flu vaccine	<input type="checkbox"/>	<input type="checkbox"/>	Yellow nails	<input type="checkbox"/>	<input type="checkbox"/>

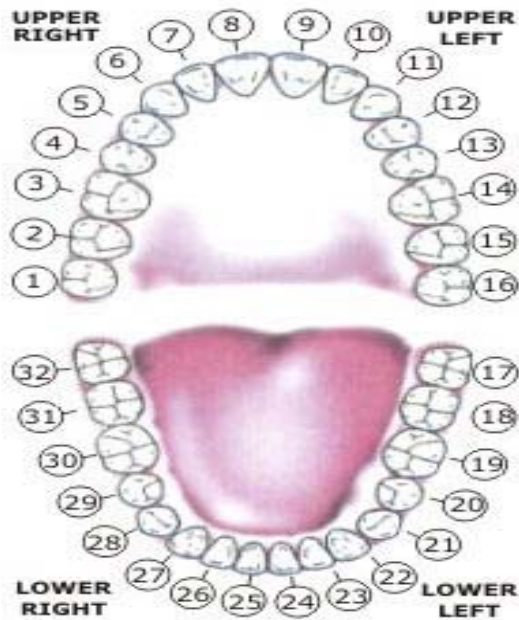
Check all symptoms or conditions you are presently experiencing or have had in the past

- Anemia
- Autoimmune disorder(s) (including thyroid disease, type 1 diabetes, Sjorgren's syndrome)
- Bone loss (Osteopenia and/or osteoporosis)
- Chronic fatigue syndrome
- Chronic liver disease
- Cognitive disorders (difficulty with thinking, reasoning, and remembering)
- Eye irritation (including dryness, itching, reddened eyelids, watery)
- Fibromyalgia
- History of cancer on the reproductive organs (breast, uterus, prostate, testicular)
- History of cancer other than reproductive
- History of kidney disease
- Immediate family member with an autoimmune disease
- Irritable bowel syndrome
- Lactose intolerance
- Low platelet count
- Low sperm count
- Mood disorder (depression, bipolar)
- Non-Hodgkin's Lymphoma
- Obesity
- Parkinson's disease
- Peripheral neuropathy

## DENTAL HISTORY

Dental problems such as past root canals, infections, cavities, a broken tooth, impacted teeth, crowns, abscessed teeth, partials, and/or gum disease may be an underlying cause of some diseases.

Check the corresponding number beside the diagram to identify any teeth in which you have experienced a problem. Please note this applies to past and present problems.



1 2 3 4 5 6 7 8

9 10 11 12 13 14 15 16

17 18 19 20 21 22 23 24

25 26 27 28 29 30 31 32

## DIET HISTORY

Carefully review the following list of foods and check any foods you eat 3 or more days a week

<input type="checkbox"/> Agave	<input type="checkbox"/> Aged cheese	<input type="checkbox"/> Alcohol (wine, beer, hard liquor, cocktails)
<input type="checkbox"/> Alkanized water (ionized)	<input type="checkbox"/> Almonds	<input type="checkbox"/> Apples
<input type="checkbox"/> Apricot	<input type="checkbox"/> Artichokes	<input type="checkbox"/> Artificial sweeteners
<input type="checkbox"/> Asparagus	<input type="checkbox"/> Avocado	<input type="checkbox"/> Baked goods (pastries, deserts, etc.)
<input type="checkbox"/> Bananas	<input type="checkbox"/> Barley	<input type="checkbox"/> Basil
<input type="checkbox"/> Beets	<input type="checkbox"/> Black beans	<input type="checkbox"/> Black pepper
<input type="checkbox"/> Blackstrap molasses	<input type="checkbox"/> Blueberries	<input type="checkbox"/> Bok choy
<input type="checkbox"/> Bottled water	<input type="checkbox"/> Bread (wheat, rye, barley, oats)	<input type="checkbox"/> Breakfast cereals
<input type="checkbox"/> Broccoli	<input type="checkbox"/> Brown rice (unrefined)	<input type="checkbox"/> Brown rice syrup
<input type="checkbox"/> Brussel sprouts	<input type="checkbox"/> Buckwheat	<input type="checkbox"/> Butter (dairy)
<input type="checkbox"/> Cabbage	<input type="checkbox"/> Caffeinated coffee	<input type="checkbox"/> Candy
<input type="checkbox"/> Cane juice/sugar	<input type="checkbox"/> Canola oil	<input type="checkbox"/> Cantaloupe
<input type="checkbox"/> Carrots	<input type="checkbox"/> Cashews	<input type="checkbox"/> Cauliflower
<input type="checkbox"/> Cayenne pepper	<input type="checkbox"/> Celery	<input type="checkbox"/> Cheese
<input type="checkbox"/> Cheese (low-fat)	<input type="checkbox"/> Chicken	<input type="checkbox"/> Chili pepper (dried)
<input type="checkbox"/> Chocolate	<input type="checkbox"/> Cilantro	<input type="checkbox"/> Cinnamon
<input type="checkbox"/> Cloves	<input type="checkbox"/> Cod	<input type="checkbox"/> Collards
<input type="checkbox"/> Coriander Seeds	<input type="checkbox"/> Corn	<input type="checkbox"/> Cottonseed oil
<input type="checkbox"/> Cranberries	<input type="checkbox"/> Cream	<input type="checkbox"/> Cucumber
<input type="checkbox"/> Cumin seeds	<input type="checkbox"/> Decaffeinated coffee	<input type="checkbox"/> Diet soda
<input type="checkbox"/> Dill	<input type="checkbox"/> Distilled water	<input type="checkbox"/> Dry roasted nuts
<input type="checkbox"/> Eggplant	<input type="checkbox"/> Eggs	<input type="checkbox"/> Energy drinks
<input type="checkbox"/> Fast food	<input type="checkbox"/> Fennel	<input type="checkbox"/> Figs
<input type="checkbox"/> Filtered water	<input type="checkbox"/> Flaxseed	<input type="checkbox"/> Fried foods
<input type="checkbox"/> Frozen food	<input type="checkbox"/> Fructose	<input type="checkbox"/> Fruit juices (apple, orange, grapefruit)
<input type="checkbox"/> Garbanzo beans (chickpeas)	<input type="checkbox"/> Garlic	<input type="checkbox"/> Ginger
<input type="checkbox"/> Gluten-free products (bread, pasta, etc.)	<input type="checkbox"/> Grapefruit	<input type="checkbox"/> Grapes
<input type="checkbox"/> Green beans	<input type="checkbox"/> Green tea	<input type="checkbox"/> Halibut
<input type="checkbox"/> Herbal tea	<input type="checkbox"/> Honey	<input type="checkbox"/> Hot tea
<input type="checkbox"/> Iced tea	<input type="checkbox"/> Instant breakfast foods	<input type="checkbox"/> Kale
<input type="checkbox"/> Kidney beans	<input type="checkbox"/> Kiwifruit	<input type="checkbox"/> Lamb
<input type="checkbox"/> Leeks	<input type="checkbox"/> Lemons/limes	<input type="checkbox"/> Lentils
<input type="checkbox"/> Lettuce	<input type="checkbox"/> Lima beans	<input type="checkbox"/> Liver
<input type="checkbox"/> Maple syrup	<input type="checkbox"/> Margarine	<input type="checkbox"/> Mayonnaise
<input type="checkbox"/> Milk (cow)	<input type="checkbox"/> Milk (goat)	<input type="checkbox"/> Milk beverages (almond, soy, rice)
<input type="checkbox"/> Millet	<input type="checkbox"/> Miso	<input type="checkbox"/> Molasses
<input type="checkbox"/> MSG	<input type="checkbox"/> Mushrooms	<input type="checkbox"/> Mustard greens
<input type="checkbox"/> Mustard seeds	<input type="checkbox"/> Navy beans	<input type="checkbox"/> Nutritional shakes/drinks/bars
<input type="checkbox"/> Oatmeal	<input type="checkbox"/> Olive oil	<input type="checkbox"/> Olives
<input type="checkbox"/> Onions	<input type="checkbox"/> Oranges	<input type="checkbox"/> Oregano
<input type="checkbox"/> Papaya	<input type="checkbox"/> Parsley	<input type="checkbox"/> Pasta (gluten containing)
<input type="checkbox"/> Peach	<input type="checkbox"/> Peanuts	<input type="checkbox"/> Pears
<input type="checkbox"/> Peas (dried, split)	<input type="checkbox"/> Peppermint	<input type="checkbox"/> Pineapple





## ENVIRONMENTAL TOXIN EXPOSURE EVALUATION

Thousands of toxic chemicals in the environment (and workplace) can produce adverse effects on health status. Please review the list of toxins and check the substance that applies to you.

<input type="checkbox"/> Acrylic nail applications	<input type="checkbox"/> Aerosols	<input type="checkbox"/> Air fresheners
<input type="checkbox"/> Aniline dyes	<input type="checkbox"/> Around or use herbicides	<input type="checkbox"/> Celluloid
<input type="checkbox"/> Chemical industry employee	<input type="checkbox"/> Coolant for transformers	<input type="checkbox"/> Deodorizers
<input type="checkbox"/> Dewaxing	<input type="checkbox"/> Do old home renovations	<input type="checkbox"/> Drying/packing
<input type="checkbox"/> Dyes	<input type="checkbox"/> Eat foods with food additives	<input type="checkbox"/> Eat fried foods
<input type="checkbox"/> Eat non-organic citrus fruits	<input type="checkbox"/> Emergency worker (firefighter, police)	<input type="checkbox"/> Enamelers
<input type="checkbox"/> Exposure to fungicides	<input type="checkbox"/> Exposure to non-organic dry cleaning fluids	<input type="checkbox"/> Exposure to pesticides
<input type="checkbox"/> Flames retardants	<input type="checkbox"/> Floor polishers	<input type="checkbox"/> Food preservatives
<input type="checkbox"/> Gardener	<input type="checkbox"/> Heat transfer fluid	<input type="checkbox"/> High to moderate use of waxes (i.e. floor, auto etc.)
<input type="checkbox"/> Household cleaners that contain toxic chemicals	<input type="checkbox"/> Hydraulic fluids	<input type="checkbox"/> Inks
<input type="checkbox"/> Install swimming pools	<input type="checkbox"/> Lacquers	<input type="checkbox"/> Leather tooling/dying
<input type="checkbox"/> Linoleum	<input type="checkbox"/> Lithography	<input type="checkbox"/> Live close to landfill - hazardous waste sites
<input type="checkbox"/> Live near a dye plant	<input type="checkbox"/> Live near a highway and/or railroad	<input type="checkbox"/> Live near a plastic plant
<input type="checkbox"/> Live near nickel refinery	<input type="checkbox"/> Live or work around old playgrounds	<input type="checkbox"/> Livestock worker
<input type="checkbox"/> Longshoreman	<input type="checkbox"/> Make enamels	<input type="checkbox"/> Make or use cosmetics with aluminum
<input type="checkbox"/> Make or use perfumes	<input type="checkbox"/> Make soaps	<input type="checkbox"/> Manufacture of reinforced plastic boats
<input type="checkbox"/> Manufacture or wear bronzers (tanners)	<input type="checkbox"/> Manufacture or wear rayon	<input type="checkbox"/> Manufacture or work with degreasing
<input type="checkbox"/> Manufacture plastic products or high use of household plastics	<input type="checkbox"/> Moderate to heavy use of spot removers	<input type="checkbox"/> Neoprene cement
<input type="checkbox"/> Ore processing	<input type="checkbox"/> Paint	<input type="checkbox"/> Paint removers
<input type="checkbox"/> Paint strippers	<input type="checkbox"/> Paint thinners	<input type="checkbox"/> Permanent-press fabrics/chemicals
<input type="checkbox"/> Photogravure	<input type="checkbox"/> Polymers	<input type="checkbox"/> Polyurethane exposure
<input type="checkbox"/> Printing press	<input type="checkbox"/> Refinery workers	<input type="checkbox"/> Resins
<input type="checkbox"/> Road construction worker	<input type="checkbox"/> Rotogravures	<input type="checkbox"/> Service station attendant
<input type="checkbox"/> Shoemaker/shoe dye exposure	<input type="checkbox"/> Silk manufacturing	<input type="checkbox"/> Smoking or breathing secondhand smoke
<input type="checkbox"/> Spray paints	<input type="checkbox"/> Stains	<input type="checkbox"/> Trucker
<input type="checkbox"/> Use antacids	<input type="checkbox"/> Use antiperspirants	<input type="checkbox"/> Use art supplies
<input type="checkbox"/> Use buffered aspirin	<input type="checkbox"/> Use disinfectants	<input type="checkbox"/> Use household cleaners with ammonia
<input type="checkbox"/> Use insect repellent	<input type="checkbox"/> Use kerosene as heat source	<input type="checkbox"/> Use of chemical skin peels
<input type="checkbox"/> Use of lice treatment	<input type="checkbox"/> Use of mothballs	<input type="checkbox"/> Use of plastic shower stalls
<input type="checkbox"/> Use or live near use of fumigants	<input type="checkbox"/> Use or make plastic shower curtains	<input type="checkbox"/> Use pots and pans with aluminum
<input type="checkbox"/> Use talc powder	<input type="checkbox"/> Use varnishes	<input type="checkbox"/> Vehicle exhaust

<input type="checkbox"/>	Warehouse worker	<input type="checkbox"/>	Wear contact lenses	<input type="checkbox"/>	Work around automobile exhaust
<input type="checkbox"/>	Work around or with dyes/live near dye industry	<input type="checkbox"/>	Work around sawdust	<input type="checkbox"/>	Work as pilot/flight attendant
<input type="checkbox"/>	Work as x-ray medical personnel	<input type="checkbox"/>	Work at a gas station	<input type="checkbox"/>	Work in a tire company/business
<input type="checkbox"/>	Work in construction (including sewers, wells)	<input type="checkbox"/>	Work in or around a cotton plant	<input type="checkbox"/>	Work in or around metal fabricating
<input type="checkbox"/>	Work in textiles	<input type="checkbox"/>	Work near or at nuclear reactors/plant	<input type="checkbox"/>	Work on or near a farm
<input type="checkbox"/>	Work or worked as a field worker	<input type="checkbox"/>	Work or worked as a roofer	<input type="checkbox"/>	Work or worked in a paper company
<input type="checkbox"/>	Work or worked in the rubber industry	<input type="checkbox"/>	Work with acrylics	<input type="checkbox"/>	Work with adhesives/glues
<input type="checkbox"/>	Work with asphalt floor tiles	<input type="checkbox"/>	Work with auto clutch, brake, transmission	<input type="checkbox"/>	Work with bearings, casting, and pewter
<input type="checkbox"/>	Work with ceramics	<input type="checkbox"/>	Work with fertilizer	<input type="checkbox"/>	Work with insulation for electrical wire
<input type="checkbox"/>	Work with lead storage batteries	<input type="checkbox"/>	Work with or around explosives	<input type="checkbox"/>	Work with or around fireworks
<input type="checkbox"/>	Work with or moderate/high use of wood preservatives	<input type="checkbox"/>	Work with or use metal cleaners	<input type="checkbox"/>	Work with photographic film
<input type="checkbox"/>	Work with pressure-treated lumber	<input type="checkbox"/>	Work with sheet and pipe metal	<input type="checkbox"/>	Work with stained glass
<input type="checkbox"/>	Worked as fumigator	<input type="checkbox"/>	Worked or work as an aerial pesticide applicator	<input type="checkbox"/>	Worked or work as an engraver
<input type="checkbox"/>	Worked or work with color printing				

Do any members of your household work with environmental toxins Yes No

Do you have a whole house filtration system? Yes No

Home water supply: Well water Public water

EMOTIONAL & PSYCHOLOGICAL HISTORY			
Emotions are commonly underestimated when related to their impact on health.			
They are an important component of your overall health status.			
Answering the following questions will assist your clinician in providing you with optimal health care.			
Please be reminded that any information you provide in this questionnaire is treated confidentially and is protected under HIPAA laws.			
Carefully review the following list of emotions and check any emotion you experience on a regular basis.			
<input type="checkbox"/>	Anger	<input type="checkbox"/>	Antisocial tendencies
<input type="checkbox"/>	Bitterness	<input type="checkbox"/>	Cloudy thinking
<input type="checkbox"/>	Considered lazy	<input type="checkbox"/>	Controlling, bossy personality
<input type="checkbox"/>	Cry easily	<input type="checkbox"/>	Defensiveness
<input type="checkbox"/>	Detached, apathy	<input type="checkbox"/>	Disappointment
<input type="checkbox"/>	Excessive laughter	<input type="checkbox"/>	Excessively talkative
<input type="checkbox"/>	Fear of letting go	<input type="checkbox"/>	Fear that people are out to get you
<input type="checkbox"/>	Feeling lost	<input type="checkbox"/>	Feeling out of control
<input type="checkbox"/>	Feeling stuck or frozen	<input type="checkbox"/>	Fits of rage
<input type="checkbox"/>	Frustration	<input type="checkbox"/>	Get agitated easily
<input type="checkbox"/>	Guilt	<input type="checkbox"/>	Heartbreak
<input type="checkbox"/>	Hopelessness	<input type="checkbox"/>	Humiliation
<input type="checkbox"/>	Impatience/antsy	<input type="checkbox"/>	Inability to assimilate new information
<input type="checkbox"/>	Indecisiveness	<input type="checkbox"/>	Insecurity
<input type="checkbox"/>	Jealousy	<input type="checkbox"/>	Judgmental
<input type="checkbox"/>	Lack of courage	<input type="checkbox"/>	Lack of joy
<input type="checkbox"/>	Living through others	<input type="checkbox"/>	Low self-esteem
<input type="checkbox"/>	Neatness freak	<input type="checkbox"/>	Negative outlook
<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	No desire for anything
<input type="checkbox"/>	Not feeling safe	<input type="checkbox"/>	Not feeling worth of living life fully
<input type="checkbox"/>	Over-compassionate	<input type="checkbox"/>	Overwhelmed
<input type="checkbox"/>	Regrets	<input type="checkbox"/>	Rejection
<input type="checkbox"/>	Resistant to change	<input type="checkbox"/>	Restlessness
<input type="checkbox"/>	Self-defeating	<input type="checkbox"/>	Sentimental
<input type="checkbox"/>	Shortness of temper	<input type="checkbox"/>	Stifled feeling
<input type="checkbox"/>	Suicidal tendencies	<input type="checkbox"/>	Suspicion
<input type="checkbox"/>	Tend to be argumentative	<input type="checkbox"/>	Tend to be clingy
<input type="checkbox"/>	Tend to overthink things	<input type="checkbox"/>	Tend to procrastinate
<input type="checkbox"/>	Victimized	<input type="checkbox"/>	Worry

**FOOD AND SUBSTANCE ALLERGY**

Please select the food(s) and/or substance(s) to which you are aware that you are allergic.

- |   |  |                                    |
|---|--|------------------------------------|
| <input type="checkbox"/> Almonds        | <input type="checkbox"/> Birch pollen            | <input type="checkbox"/> Cashews   |
| <input type="checkbox"/> Eggs           | <input type="checkbox"/> Fish                    | <input type="checkbox"/> Grass     |
| <input type="checkbox"/> Latex (rubber) | <input type="checkbox"/> Milk and dairy products | <input type="checkbox"/> MSG       |
| <input type="checkbox"/> Peanuts        | <input type="checkbox"/> Ragweed                 | <input type="checkbox"/> Shellfish |
| <input type="checkbox"/> Soy            | <input type="checkbox"/> Sulfite                 | <input type="checkbox"/> Wheat     |