janey appleseed nutrition

at Fertile Ground Wellness Center
7355 E Orchard Road, Suite 350
Greenwood Village, CO 80111
www.janeyappleseednutrition.com

Welcome! I'm excited to begin our work together!

PLEASE BRING WITH YOU TO OUR FIRST APPOINTMENT*:

1. **Completed Health History form + MAF form**
2. **Electronic Payment Authorization form**
3. **Bottles of dietary supplements** you are currently taking (or considering taking) which may include any of the following examples: multivitamin, fish oil supplement, protein powders, dietary fiber supplements, green powders, antioxidant formulas, etc. The bottles are required so that we can identify the specific amounts and forms of the various nutrients.
4. **Pertinent Blood Work Results from current and past doctor visits.**

* *For remote consultations: please include a list of dietary supplements you are taking (including brand and dosage) and include this when you fax or scan/email all completed forms to me 24 hours BEFORE our appointment.*

As it is always helpful for us to have ample time to review this pertinent information, we request that you send us your Health History & MAF Questionnaire at least one day prior to your scheduled appointment. If accessible, you can send your paperwork to us by scanning and emailing it to janeyappleseednutrition@gmail.com or faxing to 720.836.4174. All remote consultations MUST fax or scan/email completed forms at least 24 hours before your scheduled appointment.

"One cannot think well, love well, sleep well, if one has not dined well."
-- Virginia Woolf

Janey Appleseed Office Policies

SCHEDULING APPOINTMENTS: To schedule or change an appointment, **please call: 303.248.3481 (office), 303.656.3847 (cell) or email janeyappleseednutrition@gmail.com.**

PAYMENT FOR SERVICES: Payment in full is required at time of service unless other arrangements have been made ahead of time. We accept cash, check and credit card. **Please make checks payable to: Sarah Jane Sandy, CNT.**

CANCELLATIONS: We understand unforeseen events arise that may prevent you from making your scheduled appointment. However, missing an appointment is a loss to everyone. Kindly provide **AT LEAST 24 HOURS NOTICE** if you need to cancel an appointment, or payment in full will be required for the time slot that was reserved for you. We will be happy to reschedule you.

INSURANCE COVERAGE: Unfortunately, most insurance companies do not cover nutrition appointments, even when they are doctor-prescribed. Hopefully, this will change in the future. It is the patient's responsibility to provide payment in full at time of service and then request reimbursement from the insurance company.

CONFIDENTIALITY: All information disclosed within sessions is confidential as outlined in the HIPAA notice of Privacy Practices. Additional copies can be made available during your office visit.

OFFICE HOURS: Office hours are available on Mondays. Remote Consultations are always available (either by telephone or Skype). Please call to reserve an appointment time.

Patient Informed Consent to Treatment

I, _____, hereby grant permission to Sarah Jane Sandy, CNT to conduct a complete evaluation and provide a dietary and nutrition supplement program, and lifestyle recommendations for the purpose of enhancing my health.

I understand that Sarah Jane Sandy, CNT has an educational background in nutrition, but is not a medical doctor, or licensed to give medical advice. I understand that any nutritional or other health information that is provided by Sarah Jane Sandy, CNT is not intended as a diagnosis, treatment, prescription or cure for any disease, mental or physical, and is not intended as a substitute for receiving regular medical care. Referrals are made for further treatment when appropriate.

I understand that a record will be kept confidential and will not be released to others unless they are involved in my care plan. I understand that I may look at my medical record at any time and can request a copy of it.

Liability Agreement

I have read and completed the above information to the best of my knowledge. I will not hold Sarah Jane Sandy, CNT responsible for any condition, of which she was not informed, which may worsen over time through treatment.

I have read the above statement and I understand it to my satisfaction. I certify that I have had an opportunity to have any and all questions answered about this information, and I freely seek the services offered. I also understand that payment is expected at the time of service. This agreement is being signed voluntarily and not under duress of any kind.

Signature_____ Date_____

Pricing Information

Initial Consultation: $150 *(75 minutes)***
Follow-Up Sessions: $95 *(50 minutes)***
$60 *(30 minutes)***
*(**$27 for each additional 15 minutes)*

Packages

Initial Consultation + 4 Follow-Up Sessions: $477 *(regularly $530)*

5 Follow-Up Sessions: $427 *(regularly $475)*

8 Follow-Up Sessions: $646 *(regularly $760)*

Weekly Email Check-In's for 1 month: $80 *(includes 1 email per week for 1 month)*

Menu Planning: $55/hour

Programs

Begin Again!: $560 *(regularly $625)*
Do you need to lose weight? Are you tired and fatigued? Do you have food allergies but not sure how to manage them? Is your digestive system out of whack? Are your hormones imbalanced? Feel like you've fallen off track? In this program we will cover everything you need to know to begin to nourish your body and achieve your health goals.
Includes:

- **Initial Consultation, 90 min**
- **Grocery Store Walkabout, 60 min (includes shopping list & recipes)**
- **2 follow-up visits, 50 min each**
- **4 follow-up visits, 50 min each**

Menu Planning: $55/hour
1-week menu plans take approximately 2-3 hours to create & include shopping lists and recipes.

Weekly Email Check-In's for 1 month: $80
Includes 1 email exchange per week for one month.

Lab Testing

****Rhythm Plus, saliva**
The Rhythm Plus panel is a comprehensive salivary assessment of estradiol, progesterone, testosterone, cortisol, DHEA, and melatonin spanning **a full 28 day cycle**. In addition to mapping the foundational sex steroid hormones, this advanced profile reveals how the sex hormones are influenced by cortisol, DHEA, and melatonin. Imbalances revealed in this profile can help illuminate

root causes of disorders such as premenstrual syndrome (PMS), infertility, and menstrual irregularities.

Balance is the key. Research has long shown that fluctuating levels of estradiol, progesterone and testosterone play a major role in a woman's overall health, effecting:

- Menstrual Cycle
- Fertility
- Appetite Level
- Mood Swings
- Sex Drive
- Sleep Patterns

Chronic imbalances of these hormones are implicated in disorders such as:

- PMS
- Breast Cancer
- Anovulation
- Endometriosis
- Infertility
- Polycystic Ovary Disease
- Amenorrhea
- Osteoporosis

Saliva testing provides a thorough analysis of estradiol and progesterone over a full 28 day cycle. Testosterone is measured once from the 28th day specimen. By utilizing 11 saliva samples for analysis, the relationship and balance of these essential hormones are analyzed More precisely through time. The levels of estradiol and progesterone, as well as the ratio between the two, are clearly graphed for easy reference and patient education.

****AdvancedPlus Hormone Panel, saliva & blood test**

This test includes the addition of a comprehensive assessment of your thyroid and vitamin D levels, along reproductive and adrenal hormones. Hormonal symptoms often overlap with one another so a full evaluation of your overall hormonal profile is critical in diagnosing the core issues.

This is a complete adrenal function panel in addition to an assessment of reproductive hormone levels, complete thyroid panel, and an Vitamin D test in an all-in-one, easy-to-use home saliva & blood spot kit.

Includes:

Reproductive hormones: Estradiol (the most potent of the estrogens), Progesterone, DHEA-s, Testosterone; Tested in Saliva.

Adrenal hormones: the "master stress hormone" cortisol with four samples taken morning, noon, evening and bedtime to track adrenal function throughout the day; Tested in saliva.

Thyroid hormones: we measure the full complement of thyroid hormones, (TSH, free T4, free T3, TPO related antibodies); Tested in blood spot.

Vitamin D: both the active (D3) and supplemented (D2) forms in order to detect deficiency in the absence of symptoms and to monitor supplemented levels; Tested in blood spot.

Adrenal Function Panel, saliva

The Adrenal Function Panel examines 4 saliva samples over a 24-hour period for levels of cortisol and DHEA. Imbalances in these hormones are associated with ailments ranging from obesity and chronic fatigue to infertility, immune deficiency, digestive disorders and increased risk of cardiovascular disease. This test is a powerful and precise noninvasive salivary assay that evaluates bioactive levels of the body's important stress hormones, cortisol and DHEA. This profile serves as a critical tool for uncovering biochemical imbalances underlying anxiety, depression, menstrual disorders, infertility, chronic fatigue, obesity, digestive disorders, dysglycemia, and a host of other clinical conditions.

The adrenal hormones cortisol and DHEA function to influence:

- Metabolism
- Thyroid function
- Reproductive function
- Immune function
- Anti-inflammatory response
- Resistance to stress

Changing the amounts of cortisol and DHEA can profoundly affect:

- Energy levels
- Resistance to disease
- Hormone balance
- Emotional states
- General sense of well-being

The Adrenal Function Panel is ordered for people who suffer from:

- Chronic stress and related health problems
- Lack of vitality and energy
- Muscle and joint pain
- Infertility
- Hypoglycemia
- Migraine headaches
- Osteoporosis
- Difficulty losing weight
- Sleep disturbances
- Poor memory
- Alcohol intolerance
- Stress maladaptation
- Low sex drive
- Low body temperature
- Anxiety/Panic Attacks

Fasting insulin & glucose, blood

Tests the amount of glucose (blood sugar) and insulin in the bloodstream. If you regularly have too much glucose floating through your blood vessels, the excess sugar can slow down your circulation,

which, over time, can cause all of the problems you would expect to have if you had thick maple syrup clogging up your blood vessels. This is essentially what happens when a person becomes diabetic.

In order to keep the amount of sugar floating through your blood vessels at around a teaspoon, your body releases insulin whenever you eat foods that result in sugar entering your bloodstream. Eating sugary foods, most sweeteners, grains, cookies, pastries, cakes, pasta, and starchy vegetables like potatoes all lead to a release of sugar into your bloodstream. Insulin works by stimulating your cells to sponge up this excess sugar out of your bloodstream. Once inside your cells, sugar is used for energy, with any excess amount being converted to fat tissue.

If you have too much sugar floating around in your blood vessels, it is likely that you also have too much insulin traveling through your system as well. Even if your fasting blood sugar level is in a healthy range, it is possible that you have too much insulin floating through your vessels, particularly if you have high triglycerides and/or are overweight. Normal blood sugar and high blood insulin can be the result of your cells losing some sensitivity to insulin, which necessitates that your body releases extra insulin into your blood circulation in an attempt to stimulate your desensitized cells into sponging up excess sugar out of your blood circulation.

What's the problem with having too much insulin in your circulation?

Excess insulin is known to cause:

- Weight gain, since insulin promotes the storage of fat
- Lower cellular levels of magnesium, a mineral that is essential for keeping your blood vessels relaxed and your blood circulation efficient
- Polycystic Ovarian Syndrome, and the resulting hormonal imbalances
- An increase in sodium retention, which leads to holding excess water in your system, which causes high blood pressure
- Increased amounts of inflammatory compounds in your blood, which can cause direct physical damage to your blood vessel walls and encourage the development of blood clots which can lead to heart attacks and respiratory failure
- A reduction in HDL, an increase in undesirable small molecules of LDL, and an increase in triglycerides, all of which increase your risk for heart disease
- Possibly a higher risk for cancer due to insulin's ability to contribute to cell proliferation

****Iodine Loading, urine**

Iodine deficiency is a worldwide health concern. The identification and treatment of an iodine deficiency has obvious benefits. In order to determine the daily amount of essential iodine required for whole body sufficiency, an Iodine Loading Test must be performed. This test is based on the premise that the more iodine-deficient the body is, the more ingested iodine is retained, and the less is excreted in the urine.

Every cell in the body contains and utilizes iodine. Essential for life, iodine has many effects on the body: hormone production, nerve and muscle function, metabolism, tissue growth and repair, and cell respiration.

It has been estimated that approximately one third of the world's population is iodine deficient, and studies in the United States have suggested that the number may be even higher, with some estimates as high as 95%. Iodine deficiencies can occur not only because of inadequate intake, but

also due to the damaging toxins we are exposed to every day. Given the various functions of iodine in the body, it is easy to see how even a slight deficiency can cause widespread problems. An especially interesting area of study in iodine deficiency is the field of hormone balancing. Iodine is a crucial ingredient in the delicate balance of the endocrine system, and deficiencies have been implicated in conditions such as diabetes, polycystic ovarian disease (PCOS), fibrocystic breast disease, increased breast cancer risk and most commonly goiter.

****NutraEval, urine or blood**

For those of you who really love to measure everything, and want to know where your nutritional deficiencies are...consider your prayers answered. NutrEval test provides a framework of core nutrients in 5 areas: Antioxidants, B Vitamins, Digestive Support, Essential Fatty Acids, and Minerals. This specialized lab test looks at your levels of antioxidants, B vitamins, minerals, digestive function, gut flora, neurotransmitters, toxins and detoxification capacity, malabsorption, gut bacteria, yeast and fungi, oxidative stress, and toxic elements (like lead and mercury).

ELECTRONIC PAYMENT AUTHORIZATION

Please indicate the form of payment you wish to use for any services rendered through this practice. The following forms of payment are accepted: Visa, MasterCard and Discover. Service fees will be deducted from the designated account at the time services are rendered.

Client Information:
Client Name: _____ Date of Birth: _____
Address: _____ City_____ State: _____ Zip: _____
Home Number: _____ Mobile Number: _____

Cardholder Information:
Please indicate the name and address associated with the credit or debit card you wish to use.
Name: _____
Address: _____ City_____ State: _____ Zip: _____
Email: _____

I authorize any service fees to be deducted from the credit or debit card ending in _____ (provide the last four digits of the card).

_____ _____
Cardholder Signature Date

Credit/Debit Card Information:
Please provide your payment information below. The debit or credit card information you provide on this form will be destroyed once your first payment has been made.

Card Type (circle one): Visa MasterCard Discover

Card Number: _____ Expiration Date: _____

Verification Code:_____ *(located on the back of the credit card, the last three digits to the right of the card number.)*

Health History

Date_____

Name_____Age_____Date of Birth_____

Address_____

Home Phone_____Cell/Work Phone_____Email_____

Relationship Status_____Children?_____Occupation_____Hours per week you work_____

Emergency Contact_____Phone_____Cell_____

Are you currently under a doctor's care or any other health professional? Y N Please provide name and reason:

_____

How did you hear about us? (doctor, nurse, flyer, website, friend, other)_____

What is your primary reason(s) for seeking nutrition advice? Please describe current condition.

What do you feel are your biggest nutritional challenges and difficulties?

Do you have any chronic health problems or other diagnoses, (such as anemia, high cholesterol, high blood pressure, hypoglycemia, gastrointestinal problem, etc.)? Please include date diagnosed and all current and past treatment.

Please list all vitamins, herbs or medications that **you** are currently taking or have taken in the <u>past 2 months</u>:

_____ _____
_____ _____
_____ _____
_____ _____

Do you experience chronic pain anywhere in your body? Y N Where?_____

On a scale of 1-10, how would you rate your pain?_____

How would you describe your overall general health now? Poor Fair Good Excellent

How has it been most of your life? Poor Fair Good Excellent

Do you have good energy levels? Y N Inconsistent

Current Height:_____ Current Weight:_____ Weight six months ago:_____ One year ago:_____

Do you consider yourself: Underweight Overweight Just Right

Please circle:

I have / have not previously used diet or exercise to lose or gain weight.
I have / have not previously used medications or supplements to lose or gain weight.

Do you diet frequently?_____ Are you currently on a diet?_____ If yes, please describe:_____

How often do you feel bloated or gassy after a meal?

Hardly Ever _____ 25% of the time _____ Half the time _____ Always _____

How often do you have a bowel movement?

3+ time/day _____ 1-2x/day _____ 3-5x/week _____ 1-3x/week _____

General Medical History

Please indicate if you currently have or have had ***in the past year*** any of the following symptoms or diagnoses with a letter **"S"** for self. Also, please mark any illnesses that you believe one or more of your parents/grandparents/siblings have had with an **"F"** for family:

____Acne breakouts
____Alcoholism
____Allergies
____Anemia
____Antibiotic use (extended)
____Anxiety
____Autoimmune disease
____Bloating/gas
____Cancer
____Candida Albicans
____Celiac Disease
____Chron's Disease
____Colds/flu
____Constipation
____Depression
____Diarrhea
____Diabetes
____Diverticulosis
____Drug Addictions
____Dry skin
____Dry hair
____Eating Disorder
____Eczema
____Endometriosis
____Excessive fatigue
____Facial hair growth
____Fainting/dizzy spells
____Feel hot often
____Feel cold often
____Fibroids
____Gastritis
____Hair loss/thinning
____Headaches
____Heartburn/reflux
____Heart Disease
____Hemorrhoids
____Herpes
____High Blood Pressure
____High Cholesterol
____Hot Flashes
____Hypoglycemic
____Hypothyroid
____Hyperthyroid
____Insomnia
____Irregular menses
____Irritable Bowel Syndrome
____Irritable/depressed during menses
____Leg/muscle cramps
____Less than 1 bowel movement per day
____Liver Disease
____Low Blood Pressure
____Low Cholesterol
____Low libido
____Lupus
____Menstrual clotting
____Menstrual cramps
____Mercury Amalgam Fillings
____Migraines
____Multiple Sclerosis
____Nausea
____Nervous breakdown
____Nervousness
____Numbness
____PMS
____Polycystic Ovarian Syndrome
____Rheumatoid arthritis
____Sciatica
____Skin ulcers
____STD
____Thyroid disease
____Ulcerative Colitis
____Unexplained Weight Gain
____Yeast Infections (chronic)

REPRODUCTIVE HISTORY

Women:

Regular menses cycle? Yes ___ No ___ # of days between periods?_____ Length of period?_____ Clots?_____

Flow is Heavy ___ Medium ___ Light ____; Pain or Cramping? Yes ___ No ___; Abnormal Discharge? Yes___ No ___

Date of last period_____ PMS symptoms:_____

If you use a contraceptive, what type?_____For how long?_____Symptoms:_____

Number of pregnancies:_____ Miscarriages:_____ C-sections:_____

Are you trying to conceive?_____ If yes, how long have you been trying to conceive?_____

Menopause?_____ Describe any related symptoms: _____

_____

Please rate your current sexual libido on a scale of 1-10 (10 being the highest):_____

NUTRITION INFORMATION

On a scale of 1-10 (10 being extremely healthful), how do you rate your diet?_____ / 10

Please describe any current dietary restrictions that you have:_____

_____

Do you have food allergies?_____If so, please describe:_____

Please describe what you think are your “worst” food habits:_____

What foods do you crave?_____

What foods do you avoid? Why?_____

Do you snack during the day?_____Describe: _____

Please describe what a “typical” day of food consists of for you (i.e., breakfast = cereal with milk and coffee, lunch = salad with low-fat dressing and half turkey sandwich, dinner = spaghetti with meatballs, garlic bread and wine, snack = almonds and an apple):_____

_____

_____

_____

How many ounces of water do you drink per day?_____

What is your drinking water source? Tap Bottled Filtered Reverse Osmosis Distilled Well

Food Frequency: How often do you eat the following foods? Place a check mark in the appropriate box.

FOODS	NEVER	<1x/MONTH	<1x/WEEK	2-4x/WEEK	DAILY
Fresh vegetables					
Fresh fruit					
Fish/Seafood					
Red meat					
Chicken/Turkey					
Pork/ham/bacon					
Eggs					
Lunch Meat					
Milk					
Cheese					
Yogurt					
Ice cream					
Nuts & seeds					
Nut butters (i.e. peanut butter, almond butter)					
Beans/legumes (i.e. hummus)					

FOODS	NEVER	<1x/MONTH	<1x/WEEK	2-4x/WEEK	DAILY
Whole grains (i.e. rice, quinoa, oatmeal, etc)					
Bread					
Pasta					
Crackers/Chips					
Boxed cereal					
Corn (chips, tortillas, on the cob, etc)					
Soy/soy foods (tofu, soy milk/yogurt, fake meats, edamame)					
Butter					
Coconut Oil					
Olive oil					
Margarine					
Canola Oil (or other vegetable oil)					
Fried foods					
Sweets (dessert, candy, cookies, chocolate)					
Artificial Sweetener (i.e. Splenda, Equal, chewing gum)					
Gatorade/ other energy drinks					
Juice					
Alcohol					
Caffeine					
Soda/diet soda					

Any foods that are not listed that are consumed regularly_____

Any beverages that are not listed that are consumed regularly_____

What percentage of the food you consume is organic?_____% What food items do you choose to buy organic?_____

_____

What percentage of your food is freshly prepared?_____%

What percentage of the food that you prepare comes frozen, canned, in a box or pre-made?_____%

Meal Planning:

Who plans your meals?_____ Who cooks?_____ Who shops?_____ Do you like to cook?_____

If no, would you be willing to learn some basic cooking techniques?_____

Where do you do most of your grocery shopping?_____

Dining Habits:

How often do you eat breakfast?

Daily_____ 4-6 days/wk_____ 2-4 days/wk_____ 0-2 days/wk_____

How many times do you eat out per week:

0-2_____ 3-5_____ 6-10_____ 10+_____

How often do you eat:

At fast food restaurants?_____
At casual dining restaurants?_____
At business meetings?_____
At "fine dining" restaurants?_____
"On the run" (rushed, in the car, standing in the kitchen, etc.) _____
In front of the t.v.?_____

Are you conscious of <u>what</u> and <u>how much</u> you put in your mouth? Y N

Do you consider yourself a *fast-eater* or a *slow-eater* (circle one)? Do you chew your food thoroughly?_____

Are you often ravenous before meals? Y N

Are you often overly full at the end of each meal? Y N

Sugar Consumption:

How often do you consume white/refined sugar or white/refined sugar products (candy, chocolate, cookies, pastries, dessert, honey, agave, maple syrup, etc)?

Often___ Eat daily___ Binge___ Moderate___ Eat several times weekly___ Rarely___ None___

How does eating sugar make you feel, both physically and emotionally/mentally?_____

Do you use other sweeteners besides sugar? If so, which ones?_____

LIFESTYLE

Do you use tobacco? Y N # per day_____ # of years_____ If quit, when?_____

Do you drink alcohol? Y N # per day/week_____ What type of alcohol do you drink?_____

Do you use recreational substances? Y N Please list:_____

How often?_____

Which do you use on regularly?

Ammonia____	Cosmetics____	Dryer Fabric Scent____	Hair Spray____
Antiperspirant____	Cologne____	Eye drops____	Perfume____
Canned Goods____	Deodorant____	Fluoridated products____	Plastic____
Cleaning Supplies____			
Clorox____			

EXERCISE

How often do you exercise?

Daily _____ 4-6x/wk _____ 2-4x/wk _____ Once a week _____ Never _____

What type of exercise do you do?_____

How often do you go walking or hiking outdoors?

Daily _____ 4-6x/wk _____ 2-4x/wk _____ Once a week _____ Never _____

What percentage of your workouts include strength training?

100% _____ 75% _____ 50% _____ 25% _____ None% _____

Do you eat within an hour of working out?

Always _____ Usually _____ Not usually _____ Never _____

Do you get up and stretch or walk around during the day if you've been sitting?

I get up every 20-30 min _____ Maybe once an hour or two _____ Once or twice a day _____

I'm glued to my desk _____

How do you feel about your amount of exercise? Less than I need More than I need Just Right

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SLEEP

What's the average amount of sleep you get each night?

More than 8 hours _____ 5-7 hours _____ 2-4 hours _____ Less than 2 hours _____

Do you sleep well?_____ Do you wake up at night?_____ If so, how many times? _____

Do you have alarm clocks or other electronic gadgets with LED lights in your bedroom? _____

How often do you wake up refreshed and ready to start your day?

Most mornings _____ 3-4 x/wk _____ Once a week _____ Hardly ever _____

Do you use medication for sleep?_____ If so, what kind and how often? _____

Do you watch TV in bed?

No way _____ Once in a while _____ Often _____ Every night _____

How many nights a week do you drink alcohol?

I usually don't drink _____ 1-2 _____ 3-4 _____ 5-7 _____

How often do you drink caffeine after 2pm?

Never _____ 1-2 days/wk _____ 2-5 days/wk _____ 6-7 days/wk _____

EMOTIONAL STATE

Which of these apply to you?

Happy Sad Depressed Lonely Isolated Anxious Fearful Angry Content Joyful Judgmental Irritated

Do you wake up with enthusiasm in the morning?

Almost Always _____ Often _____ Occasionally _____ Seldom _____ Never really _____

On a scale of 0 (no stress) to 10 (FREAKING OUT), how do you rate your overall daily stress level?_____

How would you rate your level of happiness in life (scale of 1 – 10, 10 being the highest): _____

How would you rate your level of happiness in your job (scale of 1 – 10, 10 being the highest):_____

How often do you feel depressed?

Hardly Ever _____ On occasion with good cause _____ Here there each month _____
At least once a week _____ A few times a week or more _____

Please list the major stressors in your life:_____
_____

What activities do you engage in to counterbalance stress in your life?_____
_____

If you could change one thing in your life right now, what would it be?_____
_____

Do you ever eat when you are sad, worried, or upset? (If yes, please describe.)_____
_____

What do you do to help you relax, fall asleep or "wind down" at the end of a stressful day?_____
_____

Please provide any other insights and/or information that you feel might be helpful in your health maintenance:_____
_____
_____
_____

Symptom Questionnaire

(Adapted from Julia Ross's book, "The Diet Cure")

This questionnaire is a quick way to assess many potential root causes of clinical conditions. We use this questionnaire as a springboard to develop a personalized nutrition program and, upon follow-up, to assess improvement.

Blood Sugar and Stress _____**Total Score**

4 Crave a lift from sweets or alcohol, but experience a drop in mood afterwards
4 Family history of diabetes, hypoglycemia or alcoholism
4 Fatigue after meals
3 Nervous, jittery, irritable, headachy or worse, on and off during the day. Calmer after meals.
3 Frequent infections, allergies or asthma, especially when the weather changes
3 Mental confusion, decreased memory, hard to focus or get organized
4 Frequent thirst
3 Night sweats (not due to menopause)
5 Light-headed, especially upon standing up
4 Crave salty foods or licorice
4 Often feel stressed, overwhelmed and exhausted
4 Dark circles under eyes or eyes sensitive to bright light
4 More awake at night

If your score is over 12, it's important that you work on balancing blood sugar and controlling your stress levels.

Thyroid Function _____**Total Score**

4 Low energy
4 Easily chilled (especially hands and feet)
4 Other family members have thyroid problems
4 Gain weight easily, without overeating; hard to lose excess weight

3 Have to force yourself to do even moderate exercise
4 Find it hard to get going in the morning
3 High cholesterol
3 Low blood pressure
4 Weight gain began near the start of menses, pregnancy, menopause or after traumatic event
3 Chronic headaches
3 Loss of outer third portion of eyebrows
3 Depression, loss of vitality
3 Use food, caffeine, tobacco and/or other stimulants to get going

If your score is over 15, you may need to get your thyroid checked. There are many ways nutritionally to support your thyroid, for more energy, naturally.

Food Allergies _____**Total Score**

3 Crave milk, ice cream, yogurt, or cheese or doughy foods and eat them frequently
3 Experience bloating after meals
4 Gas, frequent belching
3 Digestive discomfort of any kind
3 Chronic constipation and/or diarrhea
4 Respiratory problems, such as asthma, postnasal drip, congestion
3 Low energy or drowsiness, especially after meals
4 Allergic to milk products or other common foods
3 Under-eat or often prefer beverages to solid foods
3 Avoid food or throw up food because bloating after eating makes you feel fat or tired
4 Can't gain weight
3 Hyperactivity or depression
3 Severe headaches or migraine
4 Food allergies in the family

If your score is over 12, you may be craving foods you are allergic to. Elimination diets can pinpoint the offending foods, and elimination of them usually results in weight loss and increased energy.

Antinutrient Load _____**Total Score**

1 Drink tap water majority of the time
1 More than half the food you eat is not organic
1 Spend an hour or more a day in traffic
1 Live in a city
1 Smoke, or live or work with smokers
1 Eat fried foods often
1 Eat nonorganic meat or fish or large fish like tuna or swordfish
1 Take more than twenty painkillers in a year
1 Take, on average, one course of antibiotics each year
1 Most of the food you eat or drink is in contact with soft plastic or cling wrap
1 Consume an alcoholic drink on most days

The ideal score is 0. A score of 5 or more means you are likely to be taking in a significant quantity of antinutrients. Any yes answer highlights areas in your diet and lifestyle that warrant attention.

Yeast _____**Total Score**

4 Often bloated; abdominal extension
3 Foggy-headed
2 Depressed
4 Recurrent yeast infections
4 Used antibiotics extensively (any point in life)
4 Used cortisone or birth control pills for more than one year
4 Have chronic fungus on nails or skin; athlete's foot
3 Recurring sinus or ear infections as an adult or child
3 Achy muscles and joints
4 Rashes
3 Stool unusual in color, shape or consistency

If your score is over 12, you most likely have yeast overgrowth which can be addressed through dietary changes and nutritional therapies.

Low Calorie Dieting _____**Total Score**

4 Increased cravings for and focus on food, overeating
4 Regain weight after dieting, more than was lost
3 Increased moodiness, irritability, anxiety or depression
3 Less energy and endurance
3 Usually eat less than 2,100 calories/day
3 Skip meals, especially breakfast
3 Eat mostly low-fat carbs like bagels and pasta
2 Constantly think about weight
2 Use aspartame daily
2 Take Prozac or similar serotonin-boosting drugs
2 Have become vegetarian
3 Decreased self-esteem
4 Have become bulimic or anorexic

If your score is over 12, your body may not be burning calories as fast as it could and should, due to low calorie intake. You may also be deficient in critical nutrients. Through counseling, you will learn why it's important NOT to deprive yourself of food.

Hormones (women only) _____**Total Score**

4 Premenstrual mood swings
4 Premenstrual or menopausal food cravings
4 Irregular periods or migraines
3 Experienced miscarriage, abortion, or infertility
4 Use(d) birth control pills or hormone medication
3 Uncomfortable periods - cramps, lengthy or heavy bleeding, sore breasts
4 Peri- or postmenopausal discomfort (hot flashes, weight gain, sweats, insomnia, mental dullness)
3 Skin eruptions with period

If your score is over 6, your hormones may be out of balance and you may benefit from salivary hormone testing to determine baseline hormone levels. Well-balanced hormones regulate everything from reproduction to emotions, general health, and well-being.