

Family history: Diabetes: _____ Heart disease: _____ Asthma: _____
Gallbladder disease: _____ Kidney disease: _____
Arthritis: _____ Stomach disorders: _____ Cancer: _____
Type of cancer: _____
Other: _____

Children: _____ # of Pregnancies: _____ Miscarriages: _____ Abortion: _____
Complications: _____
Mother: Age: _____ Died from: _____
Grandmother: Age: _____ Died from: _____
Grandfather: Age: _____ Died from: _____
Father: Age: _____ Died from: _____
Grandmother: Age: _____ Died from: _____
Grandfather: Age: _____ Died from: _____

Habits: Coffee _____ Tea _____ Sugar _____ Chocolate _____
Alcohol _____ Cigarettes _____ Drugs _____ Laxatives _____
Work _____ hrs/wk Sleep _____ hrs. Exercise _____ times/wk

Please describe what you are currently eating for:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

What are the three worst foods you eat each week? _____

What are the three healthiest foods you eat each week? _____

Childhood eating habits (types of foods) _____

List any nutritional supplements you are currently taking, including name brands and amounts:

List any prescription medication you are currently taking and dosages: _____

Operations/ Accidents or Injuries (what & when): _____

Health Check list

Digestive Tract:	<input type="checkbox"/>	Nausea
	<input type="checkbox"/>	Diarrhea
	<input type="checkbox"/>	Constipation
	<input type="checkbox"/>	Bloating
	<input type="checkbox"/>	Belching
	<input type="checkbox"/>	Excess Gas
	<input type="checkbox"/>	Heartburn
	Ears:	<input type="checkbox"/>
<input type="checkbox"/>		Earaches
<input type="checkbox"/>		Ear Infections
<input type="checkbox"/>		Ear Drainage
<input type="checkbox"/>		Ringing in Ears
<input type="checkbox"/>		Hearing Loss
Emotions:	<input type="checkbox"/>	Mood Swings
	<input type="checkbox"/>	Anxiety
	<input type="checkbox"/>	Nervousness
	<input type="checkbox"/>	Anger/Irritability
	<input type="checkbox"/>	Depression
Energy:	<input type="checkbox"/>	Fatigue
	<input type="checkbox"/>	Apathy
Lethargy:	<input type="checkbox"/>	Hyperactivity
	<input type="checkbox"/>	Restlessness
Eyes:	<input type="checkbox"/>	Watery Eyes
	<input type="checkbox"/>	Itchy or red eyes
	<input type="checkbox"/>	Blurred Vision
	<input type="checkbox"/>	Tunnel Vision
Heart:	<input type="checkbox"/>	Irregular heartbeat
	<input type="checkbox"/>	Rapid heartbeat
	<input type="checkbox"/>	Chest pains
Joint/Muscle:	<input type="checkbox"/>	Joint pain
	<input type="checkbox"/>	Arthritis
	<input type="checkbox"/>	Muscle pain
	<input type="checkbox"/>	Varicose veins
	<input type="checkbox"/>	Dizziness

Head:	<input type="checkbox"/>	Headaches
	<input type="checkbox"/>	Dizziness
Lungs:	<input type="checkbox"/>	Chest congestion
	<input type="checkbox"/>	Asthma
	<input type="checkbox"/>	Shortness of breath
Mind:	<input type="checkbox"/>	Poor memory
	<input type="checkbox"/>	Confusion
	<input type="checkbox"/>	Learning
Disabilities:	<input type="checkbox"/>	Stuttering
	<input type="checkbox"/>	Poor concentration
Mouth/Throat:	<input type="checkbox"/>	Chronic
	<input type="checkbox"/>	Sore throat
	<input type="checkbox"/>	Swollen gums
	<input type="checkbox"/>	Canker sores
	<input type="checkbox"/>	Sensitive teeth-nerves
Nose:	<input type="checkbox"/>	Stuffy nose
	<input type="checkbox"/>	Sinus problems
	<input type="checkbox"/>	Hay Fever
	<input type="checkbox"/>	Sneezing
	<input type="checkbox"/>	Excess Mucus
Skin:	<input type="checkbox"/>	Acne
	<input type="checkbox"/>	Hives or rashes
	<input type="checkbox"/>	Hair loss
	<input type="checkbox"/>	Excess sweating
Weight:	<input type="checkbox"/>	Binge eating
	<input type="checkbox"/>	Cravings
	<input type="checkbox"/>	Excessive weight
	<input type="checkbox"/>	Compulsive eating
	<input type="checkbox"/>	Water retention
	<input type="checkbox"/>	Under weight
Other:	<input type="checkbox"/>	Frequent illness
	<input type="checkbox"/>	Frequent urination
	<input type="checkbox"/>	Genital itch
	<input type="checkbox"/>	Discharge

From the following list what do you believe might be causing your fatigue:

Airborne: _____ Food: _____ Poor sleep habits: _____ Thyroid: _____ Stress: _____

Allergies: (Please list known) _____

Describe your hormone activity (your period as a teen/menopause difficulties):

Have you been tested within the last two years for any of the following hormones:

DHEA _____ Cortisol _____ Testosterone _____ Estrogen _____ Progesterone _____

What were the results of those tests?

Have you had previous colon cleansing sessions with a professional colon hydro therapist?

Yes _____ No _____

When? _____ How many? _____

Are they currently doing colonics or enemas now? _____

What was your Candida Questionnaire score from The Body Ecology Diet Book? _____

What have some other professionals told you about your health? _____

Private Consultation (90 minutes)	\$350.00
A Consultation for Two (90 minutes)	\$500.00 (\$250.00 each)
Group Consultation (for 4 people)	\$600.00 (\$150.00 each)
Follow up 1/2 Hour Private Consultation (30 minutes)	\$125.00

For credit card payment, please give your credit card information when scheduling your appointment. Your card will be charged only after the consultation is completed.

Metabolic Assessment Form

Name: _____ Age: _____ Sex: _____

PART 1

Please list the 5 major health concerns in your order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

PART II Please circle the appropriate number “0-3” on all questions below.
0 as the least/never to 3 as the most/always.

Category I - Colon

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relief by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard dry or small stool	0	1	2	3
Coated tongue of “fuzzy” debris on tongue	0	1	2	3
Pass large amount of foul smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Do you use laxatives frequently	0	1	2	3

Category II – Hypochlorhydria

Excessive belching or aching 1-4 hours after eating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested foods found in stools	0	1	2	3

Category III – Hyperacidity (Ulcer)

Stomach pain, burning or aching 1-4 hours after eating	0	1	2	3
Do you frequently use antacids	0	1	2	3
Feeling hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief from antacids, food, milk, carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine	0	1	2	3

Category IV – Small Intestine (Pancreas)

Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage bloated	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and /or vomiting	0	1	2	3
Excessive passage of gas	0	1	2	3
Stool undigested, foul smelling mucous-like, greasy or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Category V – Biliary Insufficiency and/or stasis

Greasy or high fat foods cause distress	0	1	2	3
Lower bowel gas and or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates for clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed	Yes		No	

Category VI - Hypoglycemia

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep yourself going or started	0	1	2	3
Get lightheaded and if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, tremors	0	1	2	3
Agitates, easily upset, nervous	0	1	2	3
Poor memory, forgetful	0	1	2	3
Blurred vision	0	1	2	3

Category VII – Insulin Resistance

Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3

Category VIII – Adrenal Hypofunction

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon Headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category IX – Adrenal Hyperfunction

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category X - Hypothyroid

Tired, sluggish	0	1	2	3
Feel cold – hands, feel, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight gain even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression, lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face or genitals or excessive falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XI – Thyroid Hyperfunction

Heart palpations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervousness and emotional	0	1	2	3
Insomnia	0	1	2	3
Night Sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XII – Pituitary Hypofunction

Diminished sex drive	0	1	2	3
Menstrual disorders of lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XIII – Pituitary Hyperfunction

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
“Splitting” type headaches	0	1	2	3

Category XIV (Males Only) - Prostate

Urination difficulty or dribbling	0	1	2	3
Urination frequent	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

Category XV (Males Only) - Andropause

Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintain morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decrease in physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional then in the past	0	1	2	3

Category XVI (Menstruation Females Only)

Are you a menopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle, greater than 32 days	Yes	No		
Shortened menses, less than every 24 days	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne break outs	0	1	2	3

Category XVII (Menopausal Females Only)

How many years have you been menopausal?	_____			
Do you ever have uterine bleeding since menopause?	Yes	No		
Hot Flashes	0	1	2	3
Mental Fogginess	0	1	2	3
Disinterest in Sex	0	1	2	3
Mood Swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breast	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal, pain, dryness or itching	0	1	2	3

PART III

Do you smoke? _____
 How many alcohol beverages do you consume per week? _____
 How many times do you eat out per week? _____
 How many caffeinated beverages do you consume per day? _____
 List the three worst foods you eat during the average week. _____, _____, _____
 List the three healthiest foods you eat during the average week. _____, _____, _____
 Rate your stress levels on a scale of 1-10 during the average week. _____

How many times a week do you eat fish? _____
 How many times a week do you eat raw nuts and seeds? _____
 How many times a week do you schedule for workouts? _____

Medications

Circle any of the following medications that you are currently taking.

Antacids	Anti-Inflammatory
Antibiotics	Anxiety Medication
Antidepressants	Aspirin/Tylenol
Antifungals	Diuretics
Antihistamines	High Blood Pressure

High Cholesterol	Others:
Hormones Replacements	
Hydrocortisone Cream	
Oral Contraceptives	
Thyroid Hormones	