

Body Ecology Consultation

Phone (888) 489-3438
Fax (310) 492-5217

Consultation Date: _____

Consultation Time: _____

Please call our office at (888) 489-3438 or (310) 350-5053 to schedule your consultation. The following form is to be completed 24 hours prior to your consultation and emailed to consultations@bodyecology.com or printed out and faxed to the above number.

Health History Questionnaire

If you have any test results, etc. please feel free to attach copies along with any pertinent information not covered here. All client information is kept strictly confidential.

Personal Information:

Name: _____ Phone: _____

Address: _____

City: _____ State: ____ Zip Code: ____

Occupation: _____ Email: _____

Age: ____ Height: _____ Weight: ____ lbs. Blood Type: ____

How long have you been on The Body Ecology Diet? _____

Describe your current symptoms:

What have you already tried that worked well for you?

What have you already tried without success? For what reason do you believe it was not successful?

What challenges have been getting in the way of accomplishing your recovery and health goals?

Family History:

Diabetes

Heart Disease

Asthma

Gallbladder Disease

Kidney Disease

Arthritis

Stomach Disorders

Cancer

If so, type of Cancer: _____

Other: _____

of Children: _____ # of Pregnancies: _____ # of Miscarriages: _____ # of Abortions: _____

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/day

Exercise: _____ times/wk

Please describe what you are currently eating for:

Breakfast:

Lunch:

Dinner:

Snacks:

What are the three worst foods you eat during the week?

1. _____
2. _____
3. _____

What are the three healthiest foods you eat during the week?

1. _____
2. _____
3. _____

What were your 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:

<p>Digestive Tract:</p> <ul style="list-style-type: none">NauseaDiarrheaConstipationBloatingBelchingExcess GasHeartburn <p>Ears:</p> <ul style="list-style-type: none">Itchy earsEarachesEar InfectionsEar Drainage ringing in EarsHearing Loss <p>Emotions:</p> <ul style="list-style-type: none">Mood SwingsAnxietyNervousnessAnger/IrritabilityDepression <p>Energy:</p> <ul style="list-style-type: none">FatigueApathy	<p>Lethargy:</p> <ul style="list-style-type: none">HyperactivityRestlessness <p>Eyes:</p> <ul style="list-style-type: none">Watery EyesItchy or red eyesBlurred VisionTunnel Vision <p>Heart:</p> <ul style="list-style-type: none">Irregular heartbeatRapid heartbeatChest pains <p>Joint/Muscle:</p> <ul style="list-style-type: none">Joint painArthritisMuscle painVaricose veins <p>Head:</p> <ul style="list-style-type: none">HeadachesDizziness <p>Lungs:</p> <ul style="list-style-type: none">Chest congestionAsthmaShortness of breath	<p>Mind:</p> <ul style="list-style-type: none">Poor memoryConfusionLearning <p>Disabilities:</p> <ul style="list-style-type: none">StutteringPoor concentration <p>Mouth/Throat:</p> <ul style="list-style-type: none">ChronicSore throatSwollen gumsCanker soresSensitive teeth-nerves <p>Nose:</p> <ul style="list-style-type: none">Stuffy noseSinus problemsHay FeverSneezingExcess Mucus <p>Skin:</p> <ul style="list-style-type: none">AcneHives or rashesHair lossExcess sweating
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<p>Weight:</p> <ul style="list-style-type: none">Binge eatingCravingsExcessive weightCompulsive eatingWater retentionUnder-weight

<p>Other:</p> <ul style="list-style-type: none">Frequent illnessFrequent urinationGenital itchDischarge

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

- Airborne?
- Food?
- Poor Sleep Habits?
- Thyroid?
- Stress?

Please list your known allergies:

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

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

- Yes
- No

If so, 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?

Metabolic Assessment Form

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

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

Please choose on a scale of 1 - 4 the appropriate answer to each question below.

1 = Least/Never 4 = Most/Always

Category I - Colon

1 2 3 4

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

Category II - Hypocholrhidria

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

Category III - Hyperacidity (Ulcer)

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

Category IV - Small Intestine (Pancreas)

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

Category V - Biliary Insufficiency and/or stasis

Greasy or high fat foods cause distress
Lower bowel gas and or bloating several
hours after eating
Bitter metallic taste in mouth,
especially in the morning
Unexplained itchy skin
Yellowish cast to eyes
Stool color alternates for clay colored to
normal brown
Reddened skin, especially palms
Dry or flaky skin and/or hair
History of gallbladder attacks or stones
Have you had your gallbladder removed?

Category VI - Hypoglycemia

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

Category VIII - Adrenal Hypofunction

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

Category IX - Adrenal Hyperfunction

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

Category X - Hypothyroid

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

Category XI - Thyroid Hyperfunction

Heart palpitations
Inward trembling
Increased pulse even at rest
Nervousness and emotional
Insomnia
Night Sweats
Difficulty gaining weight

Category XII - Pituitary Hypofunction

1 2 3 4

Diminished sex drive

Menstrual disorders or lack of menstruation

Increased ability to eat sugars without symptoms

Category XIII - Pituitary Hyperfunction

Increased sex drive

Tolerance to sugars reduced

“Splitting” type headaches

Category XIV (Males Only) - Prostate

Urination difficulty or dribbling

Urination frequent

Pain inside of legs or heels

Feeling of incomplete bowel evacuation

Leg nervousness at night

Category XV (Males Only) - Andropause

Decrease in libido

Decrease in spontaneous morning erections

Decrease in fullness of erections

Difficulty in maintain morning erections

Spells of mental fatigue

Inability to concentrate

Episodes of depression

Muscle soreness

Decrease in physical stamina

Unexplained weight gain

Increase in fat distribution around chest and hips

Sweating attacks

More emotional than in the past

Category XVI (Menstruation Females Only)

Are you a menopausal?

Alternating menstrual cycle lengths?

Extended menstrual cycle, greater than 32 days?

Shortened menses, less than every 24 days?

Pain and cramping during periods

Scanty blood flow

Heavy blood flow

Breast pain and swelling during menses

Pelvic pain during menses

Irritable and depressed during menses

Acne break outs

Category XVII (Menopausal Females Only)

How many years have you been menopausal? _____

Do you ever have uterine bleeding since menopause

Hot Flashes Mental

Fogginess

Disinterest in Sex

Mood Swings

Depression

Painful intercourse

Shrinking breast

Facial hair growth

Acne

Increased vaginal, pain, dryness or itching

Do you smoke? _____

How many times a week do you eat raw nuts and seeds? _____

How many alcohol beverages do you consume per week? _____

How many times do you eat out per week? _____

How many times a week do you schedule for workouts? _____

How many caffeinated beverages do you consume per day? _____

How many times a week do you eat fish? _____

Rate your stress levels on a scale of 1-10 during the average week. _____

Medications

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

Antacids

Antibiotics

Antidepressants

Antifungals

Antihistamines

Anti-Inflammatory

Anxiety Medication

Aspirin/Tylenol

Diuretics

High Blood Pressure

High Cholesterol

Hormones Replacements

Hydrocortisone Cream

Oral Contraceptives

Thyroid Hormones

Others: _____