Body Ecology Consultation

Consultation Date: ________________________

Phone (310) 350-5053
Fax (310) 492-5217

Consultation Time: ________________________

Please call our office at (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?

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____

____

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:

Digestive Tract:

- ☐ Nausea
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloating
- ☐ Belching
- ☐ Excess Gas
- ☐ Heartburn

Ears:

- ☐ Itchy ears
- ☐ Earaches
- ☐ Ear Infections
- ☐ Ear Drainage
- ☐ Ringing in Ears
- ☐ Hearing Loss

Emotions:

- ☐ Mood Swings
- ☐ Anxiety
- ☐ Nervousness
- ☐ Anger/Irritability
- ☐ Depression

Energy:

- ☐ Fatigue
- ☐ Apathy
- ☐ Lethargy
- ☐ Hyperactivity
- ☐ Restlessness

Eyes:

- ☐ Watery Eyes
- ☐ Itchy or red eyes
- ☐ Blurred Vision
- ☐ Tunnel Vision

Heart:

- ☐ Irregular heartbeat
- ☐ Rapid heartbeat
- ☐ Chest pains

Joint/Muscle:

- ☐ Joint pain
- ☐ Arthritis
- ☐ Muscle pain
- ☐ Varicose veins

Head:

- ☐ Headaches
- ☐ Dizziness

Lungs:

- ☐ Chest congestion
- ☐ Asthma
- ☐ Shortness of breath

Mind:

- ☐ Poor memory
- ☐ Confusion
- ☐ Learning

Disabilities:

- ☐ Stuttering
- ☐ Poor concentration

- ☐ Mouth/Throat:
- ☐ Chronic sore throat
- ☐ Swollen gums
- ☐ Canker sores
- ☐ Sensitive teeth-nerves

Nose:

- ☐ Stuffy nose
- ☐ Sinus problems
- ☐ Hay Fever
- ☐ Sneezing
- ☐ Excess Mucus

Skin:

- ☐ Acne
- ☐ Hives or rashes
- ☐ Hair loss
- ☐ Excess sweating

Weight:

- ☐ Binge eating
- ☐ Cravings
- ☐ Excessive weight
- ☐ Compulsive eating
- ☐ Water retention
- ☐ Under-weight

Other:

☐ Frequent illness ☐ Frequent urination ☐ Genital itch ☐ Genital Discharge

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?______________ If so, when?_______________________ How many?_______

Are you 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

Feeling that bowels do not empty completely:	1	2	3	4
Lower abdominal pain relief by passing stool or gas:	1	2	3	4
Alternating constipation and diarrhea:	1	2	3	4
Diarrhea:	1	2	3	4
Constipation:	1	2	3	4
Hard dry or small stool:	1	2	3	4
Coated tongue of “fuzzy” debris on tongue:	1	2	3	4
Pass large amount of foul smelling gas:	1	2	3	4
More than 3 bowel movements daily:	1	2	3	4
Do you use laxatives frequently:	1	2	3	4

CATEGORY II – HYPOCHLORHYDRIA

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

CATEGORY III – HYPERACIDITY (ULCER)

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

CATEGORY IV – SMALL INTESTINE (PANCREAS)

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

CATEGORY V – BILIARY INSUFFICIENCY AND/OR STASIS

Greasy or high fat foods cause distress:	1	2	3	4
Lower bowel gas and or bloating several hours after eating:	1	2	3	4
Bitter metallic taste in mouth, especially in the morning:	1	2	3	4
Unexplained itchy skin:	1	2	3	4
Yellowish cast to eyes:	1	2	3	4
Stool color alternates for clay colored to normal brown:	1	2	3	4
Reddened skin, especially palms:	1	2	3	4
Dry or flaky skin and/or hair:	1	2	3	4
History of gallbladder attacks or stones:	1	2	3	4
Have you had your gallbladder removed?	1	2	3	4

CATEGORY VI - HYPOGLYCEMIA

Crave sweets during the day:	1	2	3	4
Irritable if meals are missed:	1	2	3	4
Depend on coffee to keep yourself going or started:	1	2	3	4
Get lightheaded if meals are missed:	1	2	3	4
Eating relieves fatigue:	1	2	3	4
Feel shaky, jittery, tremors:	1	2	3	4
Agitated, easily upset, nervous:	1	2	3	4
Poor memory, forgetful:	1	2	3	4
Blurred vision:	1	2	3	4

CATEGORY VII – ADRENAL HYPOFUNCTION

Cannot stay asleep:	1	2	3	4
Crave salt:	1	2	3	4
Slow starter in the morning:	1	2	3	4
Afternoon fatigue:	1	2	3	4
Dizziness when standing up quickly:	1	2	3	4
Afternoon Headaches:	1	2	3	4
Headaches with exertion or stress:	1	2	3	4
Weak nails:	1	2	3	4

CATEGORY VIII – ADRENAL HYPERFUNCTION

Cannot fall asleep:	1	2	3	4
Perspire easily:	1	2	3	4
Under high amounts of stress:	1	2	3	4
Weight gain when under stress:	1	2	3	4
Wake up tired even after 6 or more hours of sleep:	1	2	3	4
Excessive perspiration or perspiration with little or no activity:	1	2	3	4

CATEGORY IX - HYPOTHYROID

Tired, sluggish:	1	2	3	4
Feel cold – hands, feet, all over:	1	2	3	4
Require excessive amounts of sleep to function properly:	1	2	3	4
Increase in weight gain even with low-calorie diet:	1	2	3	4
Gain weight easily:	1	2	3	4
Difficult, infrequent bowel movements:	1	2	3	4
Depression, lack of motivation:	1	2	3	4
Morning headaches that wear off as the day progresses:	1	2	3	4
Outer third of eyebrow thins:	1	2	3	4
Thinning of hair on scalp, face or genitals or excessive falling hair:	1	2	3	4
Dryness of skin and/or scalp:	1	2	3	4
Mental sluggishness:	1	2	3	4

CATEGORY X – THYROID HYPERFUNCTION

Heart palpitations:	1	2	3	4
Inward trembling:	1	2	3	4
Increased pulse even at rest:	1	2	3	4
Nervousness and emotional:	1	2	3	4
Insomnia:	1	2	3	4
Night Sweats:	1	2	3	4
Difficulty gaining weight:	1	2	3	4

CATEGORY XI – PITUITARY HYPOFUNCTION

Diminished sex drive:	1	2	3	4
Menstrual disorders of lack of menstruation:	1	2	3	4
Increased ability to eat sugars without symptoms:	1	2	3	4

CATEGORY XII – PITUITARY HYPERFUNCTION

Increased sex drive:	1	2	3	4
Tolerance to sugars reduced:	1	2	3	4
“Splitting” type headaches:	1	2	3	4

CATEGORY XIII (MALES ONLY) - PROSTATE

Urination difficulty or dribbling:	1	2	3	4
Urination frequent:	1	2	3	4
Pain inside of legs or heels:	1	2	3	4
Feeling of incomplete bowel evacuation:	1	2	3	4
Leg nervousness at night:	1	2	3	4

CATEGORY XIV (MALES ONLY) - ANDROPAUSE

Decrease in libido:	1	2	3	4
Decrease in spontaneous morning erections:	1	2	3	4
Decrease in fullness of erections:	1	2	3	4
Difficulty in maintain morning erections:	1	2	3	4
Spells of mental fatigue:	1	2	3	4
Inability to concentrate:	1	2	3	4
Episodes of depression:	1	2	3	4
Muscle soreness:	1	2	3	4
Decrease in physical stamina:	1	2	3	4
Unexplained weight gain:	1	2	3	4
Increase in fat distribution around chest and hips:	1	2	3	4
Sweating attacks:	1	2	3	4
More emotional than in the past:	1	2	3	4

CATEGORY XV (MENSTRUATION FEMALES ONLY)

Are you menopausal?	1	2	3	4
Alternating menstrual cycle lengths?	1	2	3	4
Extended menstrual cycle, greater than 32 days?	1	2	3	4
Shortened menses, less than every 24 days?	1	2	3	4
Pain and cramping during periods:	1	2	3	4
Scanty blood flow:	1	2	3	4
Heavy blood flow:	1	2	3	4
Breast pain and swelling during menses:	1	2	3	4
Pelvic pain during menses:	1	2	3	4
Irritable and depressed during menses:	1	2	3	4
Acne break outs:	1	2	3	4

CATEGORY XVI (MENOPAUSAL FEMALES ONLY)

How many years have you been menopausal?_________________

Do you ever have uterine bleeding since menopause?	1	2	3	4
Hot Flashes:	1	2	3	4
Mental Fogginess:	1	2	3	4
Disinterest in Sex:	1	2	3	4
Mood Swings:	1	2	3	4
Depression:	1	2	3	4
Painful intercourse:	1	2	3	4
Shrinking breast:	1	2	3	4
Facial hair growth:	1	2	3	4
Acne:	1	2	3	4
Increased vaginal, pain, dryness or itching:	1	2	3	4

Do you smoke?____

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

How many alcoholic 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:____