Advanced Nutrition of California, Inc.

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Email: _____

NAME: _____ Tel)_____

Street: _____CELL: _____

City, State & Zip: _____ Do you Text? _____

Height _____ Cysts YES/NO

Weight _____ Fibroids YES/NO

Age _____

Do you know your blood type? No Yes: 0 A B AB

Would you like to have children? Yes/No Number of children presently_____

If you have had a **blood panel** run at your doctor's office within the last year please ask for a copy and send it to me at your convenience. It is not necessary to have a blood panel. Panels can consist of many different tests-chemistry, saliva, hormone, and thyroid. I will look at anything you can provide.

Present Health Status

Check each column where symptoms apply and elaborate in space provided below if necessary. Pleas indicate with a (x) any experiences below that you sometimes experience two checks (xx) for those which occur often; and use three checks (xxx) for those which are a major concern.

General

Cardiovascular
__High Blood Pressure
__Low Blood Pressure
__Pain in Heart
__Poor Circulation
__Swelling in Ankles
__Previous heart stroke/murmur

Skin
__Boils
__Bruises
__Dryness
__Itching
__Varicose Veins
__Skin Eruptions

Muscles/Joints
__Back
__Broken Bones
__Mobility Restriction
__Arthritis/Bursitis

Respiratory
__Chest Pain
__Difficulty breathing
__Tuberculosis
__Congestion

Eyes, Ears, Nose and Throat
__Asthma
__Eye Pains, Dry/Wet
__Failing Vision
__Hay Fever
__Sinus Infection
__Sinus Congestion
__Sore Throat
__Tonsils
__Hearing Loss

Gastro-Intestinal
__Belching
__Colitis
__Constipation
__Abdominal Pain
__Gall Stones
__Ulcers
__Indigestion

Urinary/Kidney
__Excessive Urination
__Water Retention
__Burning Urine
__Kidney Stones
__Lower Back Pain
__Dark circles under eyes
__Itchy Ears/eyes
__Emotional Insecurity
__Pain down legs
__Endometriosis diagnosed on Bladder***

Please comment on any of the symptoms checked above that you feel will give a complete overview of your present state of health:

_____

_____

Past Health Problems

List all major problems you've had in the past five years (surgeries, etc):

Problem Year

_____

_____

_____

Besides food allergies, are you allergic to anything? List: _____

Are you allergic to any medications? If so, what kind? _____

Are you allergic to any foods? What kinds?

_____

Do you take any regular medications either prescribed or over the counter, including Vitamins and herbal supplements? Please List:

_____

_____

_____

Common Physical Activities

__Desk Sitting (how Long?)
__Sitting in a car (how Long?)
__Jogging/Running
__Balance Ball
__Aerobics
__Swimming
__Weight Lifting
__Walking
__Pilate
__Other_____

__Standing (how Long?)
__Yoga
__Tai Chi
__Hiking
__Bike Riding
__Horseback Riding
__Tennis
__Bending/Lifting

Are any of these activities on a regular basis? _____

_____

Dietary Habits

Please check each item listed below if it is included in your daily – or usual diet:

__Red meat
__Fish
__Poultry
__Fruits
__Vegetables
__Raw Foods
__Grains
__Nuts
__Seeds
__Fermented Food

__Butter
__Milk
__Cheese
__Yogurt
__Sugar
__Honey
__Baked Goods
__Desserts

__Coffee
__Black Tea
__Herbal Tea
__Alcohol
__Vitamins
__Protein Supplements
__Food Supplements
__Smoke cigarettes

What do you like about your dietary habits, and what you would like to change?

_____

Contraceptive History

List the kind(s) of contraceptives you have used, if any, and for how long.

BC Pills
IUD (Plain)
IUD (with Progesterone)
Chemical Spermicides
Diaphragm
Depo Provera
Rhythm
Mucous Method
Condoms
Patch
Other_____

Pregnancy History

List each pregnancy you have had, including miscarriages and abortions

Pregnancy/Date Miscarriage/Date Abortion/Date

Family History

Circle any significant family health history: Diabetes, cancer, heart problems, mental illness, asthma, heart disease, tuberculosis, gout, epilepsy, thyroid problems, obesity, etc.

Other_____

Reproductive History

Check any of the following problems that are currently happening in your life.

__Vaginal Fibroid
__Uterine Cysts
__Anemia
__Thyroid
__Endometriosis
__Cervical Dysplasia When? How Long?
__Pelvic pain
__Pain down legs**
__Painful intercourse
__Swelling of hands, feet, ankles
__Yeast Infections - frequency? _____
__Vaginal Infection
__Breast Pain
__Breast Lump(s), have they been removed? _____
__Vaginal Itching, discharge
__Difficulty in conceiving
__General fatigue, exhaustion
__Headaches
__Migraines
__Pelvic inflammatory disease (PID)

__Genital herpes
__Shortness of breath
__Dramatic mood swings
__Dry vaginal lining
__Breakthrough bleeding
__Hormone Replacement Therapy
__Hot Flashes

Current State of Emotions and Feelings

Are you able to express your feelings and emotions? _____

Is there an excess of stress in your life? _____

What is causing the stress? _____

Are you satisfied with your job? _____

If in a relationship, are you satisfied with it?_____

Are you lonely?
_____

If there is one thing in your life you would like to change right now, what is it? Can you change it?
_____

Are you a "nervous type" person? Y / N
Have you a "super woman" complex? Y / N

Do you sleep well? _____

Do you dream? Y / N Are your dreams violent?_____

Are you satisfied with your general energy level?_____

Do you often feel exhausted and fatigued? _____

Which of these feelings dominate in your life: Joy Happiness Anger
Sadness Fear Sympathy Worry Depression

If you were to choose one or two emotions, which seem predominant in your life:

_____ and _____

Please indicate approximate date and describe the nature of any traumatic experiences you have had in the past 7 years (divorce, loss of lover, loss of job, change of residence, injury, death, etc.)

Year **Event**

REPRODUCTIVE & BOWEL QUESTIONNAIRE

DIGESTION

How would you describe your digestion (please circle): Slow Normal Fast

Are there certain foods that you have problems digesting?_____

_____

Do fatty foods cause indigestion, diarrhea, or pain?_____

SKIN TEXTURE

Do you have soft skin on the back of your upper arms, or is it bumpy?_____

_____How about the back of thighs?_____

Do you have/had lumps removed from your body? Yes_____No_____ If yes, please describe where on the body and how long ago._____

_____

Do you still have your tonsils? Yes____ No_____ if yes, do you ever get tonsillitis?

_____ How often? _____

Have you had a hysterectomy? Yes_____ No _____

Do your have a period every month? Yes _____ No_____ If no, please describe.

_____

Would you describe your flow as (please circle): Heavy Medium Light

Are your periods clotty? _____ If yes, the size of a _____

How long are your periods? _____

Does your period disappear and return anytime during your menstrual flow?

On your own scale of 1 to 10 (ten being the most painful) is your period painful?

Do you have pain at a particular time of your cycle or is it sporadic?_____

Where is the pain? _____

Bowels

How many bowel movements a day do you have? _____

Would you consider them normal (normal is fully formed, smooth and 5" or longer).

Constipated Normal Diarrhea

If there is anything you would like to comment on, please do:

3 DAY MEAL REGIST
consecutive dates.

Morning

Morning

Morning