MEDICATIONS

CURRENT MEDICATIONS

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

PREVIOUS MEDICATIONS: *Last 10 years*

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

Supplication and Brand	Dose	Frequency	Start Date (month/year)	Reason For Use

Have your medications or supplements ever caused you unusual side effects or problems? ○ Yes ○ No
Describe: _____

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ○ Yes ○ No

Have you had prolonged or regular use of Tylenol? ○ Yes ○ No

Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.) ○ Yes ○ No

Frequent antibiotics > 3 times/year ○ Yes ○ No

Long term antibiotics ○ Yes ○ No

Use of steroids (prednisone, nasal allergy inhalers) in the past ○ Yes ○ No

Use of oral contraceptives ○ Yes ○ No

Initial_____

SYMPTOM REVIEW

Please check all current symptoms occurring or present in the past 6 months.

GENERAL
☐ Cold Hands & Feet
☐ Cold Intolerance
☐ Low Body Temperature
☐ Low Blood Pressure
☐ Daytime Sleepiness
☐ Difficulty Falling Asleep
☐ Early Waking
☐ Fatigue
☐ Fever
☐ Flushing
☐ Heat Intolerance
☐ Night Waking
☐ Nightmares
☐ No Dream Recall

HEAD, EYES & EARS
☐ Conjunctivitis
☐ Distorted Sense of Smell
☐ Distorted Taste
☐ Ear Fullness
☐ Ear Pain
☐ Ear Ringing/Buzzing
☐ Lid Margin Redness
☐ Eye Crusting
☐ Eye Pain
☐ Hearing Loss
☐ Hearing Problems
☐ Headache
☐ Migraine
☐ Sensitivity to Loud Noises
☐ Vision problems (other than glasses)
☐ Macular Degeneration
☐ Vitreous Detachment
☐ Retinal Detachment

MUSCULOSKELETAL
☐ Back Muscle Spasm
☐ Calf Cramps
☐ Chest Tightness
☐ Foot Cramps
☐ Joint Deformity
☐ Joint Pain
☐ Joint Redness
☐ Joint Stiffness
☐ Muscle Pain
☐ Muscle Spasms
☐ Muscle Stiffness
Muscle Twitches:
- ☐ Around Eyes
- ☐ Arms or Legs
☐ Muscle Weakness
☐ Neck Muscle Spasm
☐ Tendonitis
☐ Tension Headache
☐ TMJ Problems

MOOD/NERVES
☐ Agoraphobia
☐ Anxiety
☐ Auditory Hallucinations
☐ Black-out
☐ Depression
Difficulty:
- ☐ Concentrating
- ☐ With Balance
- ☐ With Thinking
- ☐ With Judgment
- ☐ With Speech
- ☐ With Memory

☐ Dizziness (Spinning)
☐ Fainting
☐ Fearfulness
☐ Irritability
☐ Light-headedness
☐ Numbness
☐ Other Phobias
☐ Panic Attacks
☐ Paranoia
☐ Seizures
☐ Suicidal Thoughts
☐ Tingling
☐ Tremor/Trembling
☐ Visual Hallucinations

EATING
☐ Binge Eating
☐ Bulimia
☐ Can't Gain Weight
☐ Can't Lose Weight
☐ Can't Maintain Healthy Weight
☐ Frequent Dieting
☐ Poor Appetite
☐ Salt Cravings
☐ Carbohydrate Craving (breads, pastas)
☐ Sweet Cravings (candy, cookies, cakes)
☐ Chocolate Cravings
☐ Caffeine Dependency

DIGESTION
☐ Anal Spasms
☐ Bad Teeth
☐ Bleeding Gums
Bloating of:
- ☐ Lower Abdomen
- ☐ Whole Abdomen
- ☐ Bloating After Meals

☐ Blood in Stools
☐ Burping
☐ Canker Sores
☐ Cold Sores
☐ Constipation
☐ Cracking at Corner of Lips
☐ Cramps
☐ Dentures w/Poor Chewing
☐ Diarrhea
☐ Alternating Diarrhea and Constipation
☐ Difficulty Swallowing
☐ Dry Mouth
☐ Excess Flatulence/Gas
☐ Fissures
☐ Foods "Repeat" (Reflux)
☐ Gas
☐ Heartburn
☐ Hemorrhoids
☐ Indigestion
☐ Nausea
☐ Upper Abdominal Pain
☐ Vomiting
Intolerance to:
- ☐ Lactose
- ☐ All Dairy Products
- ☐ Wheat
- ☐ Gluten (Wheat, Rye, Barley)
- ☐ Corn
- ☐ Eggs
- ☐ Fatty Foods
- ☐ Yeast

☐ Liver Disease/Jaundice (Yellow Eyes or Skin)
☐ Abnormal Liver Function Tests
☐ Lower Abdominal Pain
☐ Mucus in Stools
☐ Periodontal Disease
☐ Sore Tongue
☐ Strong Stool Odor
☐ Undigested Food in Stools

Initial_____

SKIN PROBLEMS
- ☐ Acne on Back
- ☐ Acne on Chest
- ☐ Acne on Face
- ☐ Acne on Shoulders
- ☐ Athlete's Foot
- ☐ Bumps on Back of Upper Arms
- ☐ Cellulite
- ☐ Dark Circles Under Eyes
- ☐ Ears Get Red
- ☐ Easy Bruising
- ☐ Lack Of Sweating
- ☐ Eczema
- ☐ Hives
- ☐ Jock Itch
- ☐ Lackluster Skin
- ☐ Moles w/Color/Size Change
- ☐ Oily Skin
- ☐ Pale Skin
- ☐ Patchy Dullness
- ☐ Rash
- ☐ Red Face
- ☐ Sensitivity to Bites
- ☐ Sensitivity to Poison Ivy/Oak
- ☐ Shingles
- ☐ Skin Darkening
- ☐ Strong Body Odor
- ☐ Hair Loss
- ☐ Vitiligo

ITCHING SKIN
- ☐ Skin in General
- ☐ Anus
- ☐ Arms
- ☐ Ear Canals
- ☐ Eyes
- ☐ Feet
- ☐ Hands
- ☐ Legs
- ☐ Nipples
- ☐ Nose
- ☐ Penis
- ☐ Roof of Mouth
- ☐ Scalp
- ☐ Throat

SKIN, DRYNESS OF
- ☐ Eyes
- ☐ Feet
  - ☐ Any Cracking?
  - ☐ Any Peeling?
- ☐ Hair
  - ☐ And Unmanageable?
- ☐ Hands
  - ☐ Any Cracking?
  - ☐ Any Peeling?
- ☐ Mouth/Throat
- ☐ Scalp
  - ☐ Any Dandruff?
- ☐ Skin In General

LYMPH NODES
- ☐ Enlarged/neck
- ☐ Tender/neck
- ☐ Other Enlarged/Tender
- ☐ Lymph Nodes

NAILS
- ☐ Bitten
- ☐ Brittle
- ☐ Curve Up
- ☐ Frayed
- ☐ Fungus-Fingers
- ☐ Fungus-Toes
- ☐ Pitting
- ☐ Ragged Cuticles
- ☐ Ridges
- ☐ Soft

Thickening of:
- ☐ Fingernails
- ☐ Toenails

- ☐ White Spots/Lines

RESPIRATORY
- ☐ Bad Breath
- ☐ Bad Odor in Nose
- ☐ Cough-Dry
- ☐ Cough-Productive
- ☐ Hoarseness
- ☐ Sore Throat

Hay Fever:
- ☐ Spring
- ☐ Summer
- ☐ Fall
- ☐ Change Of Season

- ☐ Nasal Stuffiness
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Fullness
- ☐ Sinus Infection
- ☐ Snoring
- ☐ Wheezing
- ☐ Winter Stuffiness

CARDIOVASCULAR
- ☐ Angina/chest pain
- ☐ Breathlessness
- ☐ Heart Murmur
- ☐ Irregular Pulse
- ☐ Palpitations
- ☐ Phlebitis
- ☐ Swollen Ankles/Feet
- ☐ Varicose Veins

URINARY
- ☐ Bed Wetting
- ☐ Hesitancy (trouble getting started)
- ☐ Infection
- ☐ Kidney Disease
- ☐ Leaking/Incontinence
- ☐ Pain/Burning
- ☐ Prostate Infection
- ☐ Urgency

MALE REPRODUCTIVE
- ☐ Discharge From Penis
- ☐ Ejaculation Problem
- ☐ Genital Pain
- ☐ Impotence
- ☐ Prostate or Urinary Infection
- ☐ Lumps In Testicles
- ☐ Poor Libido (Sex Drive)

FEMALE REPRODUCTIVE
- ☐ Breast Cysts
- ☐ Breast Lumps
- ☐ Breast Tenderness
- ☐ Ovarian Cyst
- ☐ Poor Libido (Sex Drive)
- ☐ Vaginal Discharge
- ☐ Vaginal Odor
- ☐ Vaginal Itch
- ☐ Vaginal Pain with Sex

Premenstrual:
- ☐ Bloating Breast Tenderness
- ☐ Carbohydrate Cravings
- ☐ Chocolate Cravings
- ☐ Constipation
- ☐ Decreased Sleep
- ☐ Diarrhea
- ☐ Fatigue
- ☐ Increased Sleep
- ☐ Irritability

Menstrual:
- ☐ Cramps
- ☐ Heavy Periods
- ☐ Irregular Periods
- ☐ No Periods
- ☐ Scanty Periods
- ☐ Spotting Between

Initial_____

3-DAY LIFESTYLE JOURNAL Name: _____ Date: __/___/___

DAY 1

FOOD PLAN TYPE: _____ CALORIC PRESCRIPTION: _____ BODY WEIGHT: _____

TIME	DAY EVENT	FOOD & DRINK INTAKE (include type, amount, brand)	PFC-PHYTOS
	WAKE-UP		___ P ___ F ___ C □ R □ O □ Y □ G□ B □ T □ W
	BREAKFAST		___ P ___ F ___ C □ R □ O □ Y □ G□ B □ T □ W
	MID-AM SNACK		___ P ___ F ___ C □ R □ O □ Y □ G□ B □ T □ W
	LUNCH		___ P ___ F ___ C □ R □ O □ Y □ G□ B □ T □ W
	MID-PM SNACK		___ P ___ F ___ C □ R □ O □ Y □ G□ B □ T □ W
	DINNER		___ P ___ F ___ C □ R □ O □ Y □ G□ B □ T □ W
	PM SNACK		___ P ___ F ___ C □ R □ O □ Y □ G□ B □ T □ W

P = Proteins; F = Fats; C = Carbohydrates; R= Red; O = Orange; Y = Yellow; G= Green; B = Blue; T = Tan; W = White

Sleep & Relaxation	Exercise & Movement	Stress & Resilience	Relationships & Networks
SLEEP Quantity: _____(hours) Quality: Fair/Good **RELAXATION:** Yes/No Type/Amount:	Type(s) & Duration:	Stressors: Stress Reduction Practice:	Supporting: Non-supporting:

MENTAL	EMOTIONAL	SPIRITUAL

3-DAY LIFESTYLE JOURNAL Name: _____ Date: __/___/___

DAY 2

FOOD PLAN TYPE: _____ CALORIC PRESCRIPTION: _____ BODY WEIGHT: _____

TIME	DAY EVENT	FOOD & DRINK INTAKE (include type, amount, brand)	PFC-PHYTOS
	WAKE-UP		___ P ___ F ___ C □ R □ O □ Y □ G□ B □ T □ W
	BREAKFAST		___ P ___ F ___ C □ R □ O □ Y □ G□ B □ T □ W
	MID-AM SNACK		___ P ___ F ___ C □ R □ O □ Y □ G□ B □ T □ W
	LUNCH		___ P ___ F ___ C □ R □ O □ Y □ G□ B □ T □ W
	MID-PM SNACK		___ P ___ F ___ C □ R □ O □ Y □ G□ B □ T □ W
	DINNER		___ P ___ F ___ C □ R □ O □ Y □ G□ B □ T □ W
	PM SNACK		___ P ___ F ___ C □ R □ O □ Y □ G□ B □ T □ W

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Sleep & Relaxation	Exercise & Movement	Stress & Resilience	Relationships & Networks
SLEEP Quantity: _____(hours) Quality: Fair/Good **RELAXATION:** Yes/No Type/Amount:	Type(s) & Duration:	Stressors: Stress Reduction Practice:	Supporting: Non-supporting:

MENTAL	EMOTIONAL	SPIRITUAL

3-DAY LIFESTYLE JOURNAL Name: _____ Date: __/___/___

DAY 3

FOOD PLAN TYPE: _____ CALORIC PRESCRIPTION: _____ BODY WEIGHT: _____

TIME	DAY EVENT	FOOD & DRINK INTAKE (include type, amount, brand)	PFC-PHYTOS
	WAKE-UP		___ P ___ F ___ C □ R □ O □ Y □ G□ B □ T □ W
	BREAKFAST		___ P ___ F ___ C □ R □ O □ Y □ G□ B □ T □ W
	MID-AM SNACK		___ P ___ F ___ C □ R □ O □ Y □ G□ B □ T □ W
	LUNCH		___ P ___ F ___ C □ R □ O □ Y □ G□ B □ T □ W
	MID-PM SNACK		___ P ___ F ___ C □ R □ O □ Y □ G□ B □ T □ W
	DINNER		___ P ___ F ___ C □ R □ O □ Y □ G□ B □ T □ W
	PM SNACK		___ P ___ F ___ C □ R □ O □ Y □ G□ B □ T □ W

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Sleep & Relaxation	Exercise & Movement	Stress & Resilience	Relationships & Networks
SLEEP Quantity: _____(hours) Quality: Fair/Good **RELAXATION:** Yes/No Type/Amount:	Type(s) & Duration:	Stressors: Stress Reduction Practice:	Supporting: Non-supporting:

MENTAL	EMOTIONAL	SPIRITUAL