

# GENERAL INFORMATION SHEET

Name \_\_\_\_\_ Age \_\_\_\_\_ Sex: M F Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State/Prov. \_\_\_\_\_ Postal Code \_\_\_\_\_ Country \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

E-Mail Address \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Occupation \_\_\_\_\_ How were you referred? \_\_\_\_\_

What are your main health concerns or conditions? \_\_\_\_\_

Please list any medications or food supplements you are currently taking:

Please list any recent medical tests results you have, such as blood tests:

Please list illnesses in your family such as heart disease, cancer, TB, diabetes or arthritis.

**DIET:** What are examples of typical breakfasts for you?

Beverages

\_\_\_\_\_  
\_\_\_\_\_

Mid-morning Snacks

What are typical lunches for you?

Beverages

\_\_\_\_\_  
\_\_\_\_\_

Mid-afternoon Snacks

What are typical dinners for you?

Beverages

\_\_\_\_\_  
\_\_\_\_\_

Evening Snacks

How often and what kind of exercise do you do?

About how many hours of sleep do you get per day?

I understand that nutritional balancing is a means to reduce stress and balance body chemistry. It is not intended as diagnosis, treatment or prescription for any condition or disease.

Signed \_\_\_\_\_

Date \_\_\_\_\_

Name \_\_\_\_\_

## ***SYMPTOMS SHEET***

**CIRCLE any conditions or symptoms that presently describe you.  
PLACE A STAR next to the symptoms most important to you.**

Joint Pain  
Joint Stiffness  
Arthritis, Osteo  
Arthritis, Rheumatoid  
Muscle Pain  
Muscle Weakness  
Muscle Cramps  
Bursitis  
Fractures  
Osteoporosis  
Gout

Sweet Cravings  
Sugar Reactions  
Irritable before meals  
Can't Skip Meals  
Hypoglycemia  
Crave Starches  
Fat Cravings  
Other Food Cravings  
Food Allergies  
Excessive hunger  
No hunger  
Diabetes

Rapid Heart Rate  
Skipped Heart Beats  
Heart Palpitations  
Heart Attack  
Poor Circulation  
Dizziness  
Low or High Blood Pressure  
Angina  
Arteriosclerosis  
High Cholesterol \_\_\_\_\_  
High Triglycerides \_\_\_\_\_

Cough  
Bronchitis  
Asthma  
Post-nasal Drip  
Sinus Congestion  
Allergies  
Emphysema

Fatigue  
Hypothyroidism  
Low Body Temperature  
Cold in Winter/Dry Skin  
Tend to Gain Weight  
Hyperthyroidism  
Acne

Eczema  
Fungal Infections/Candida  
Psoriasis  
Hives  
Hair Loss  
Slow Wound Healing  
Cataracts  
Glaucoma  
Meniere's Disease  
Tooth Decay  
Excessive Plaque on Teeth  
Gum Disease

Infections/Viruses  
Tumors/Cancer  
Multiple Sclerosis  
Parkinson's Disease  
Scleroderma  
Fear  
Anger  
Anxiety  
Bipolar Disorder  
Brain Fog  
Confusion  
Depression  
Irritability  
Mind Races  
Mood Swings  
Obsessive/Compulsive  
Panic Attacks  
Poor Memory  
Schizophrenia  
Trouble Sleeping  
Suicidal thoughts  
Autism  
Attention Deficit  
Hyperkinesia  
Dyslexia  
Seizures  
Learning Disability  
Mental Retardation  
Delayed Development

Bladder Infections  
Kidney Infections  
Trouble Urinating  
Frequent Urination  
Painful Urination  
Kidney Stones  
Water Retention  
Kidney Stones  
Water Retention

Sinus Headaches  
Tension Headaches  
Migraine Headaches  
Neuritis  
Eye diseases  
Constipation  
Diarrhea  
Intestinal Gas  
Bloating  
Heartburn  
Ulcer  
Stomach Pain  
Colitis  
Gall Stones  
Fissures  
Hemorrhoids  
Cirrhosis  
Diverticulitis  
Tend to Gain Weight  
Tend to Lose Weight

Anemia  
Easy Bruising

Dental Amalgams  
Drug Addiction  
Alcoholism  
Smoking

### **WOMEN:**

Premenstrual Syndrome  
Water Retention  
Cramps  
No Menstruation  
Heavy periods  
Light/Irregular Periods  
Ovarian Cysts  
Fibroid Tumors  
Abnormal Pap Smear  
Menopause  
Fibrocystic Breasts  
Breast Tumors  
Yeast Infections  
Hot Flashes  
Currently pregnant  
Abuse  
Rape

### **MEN:**

Prostate Problems  
Impotence  
Infertility

**Other Symptoms or Comments:** \_\_\_\_\_

