

# health equation<sup>s</sup>

## INTAKE FORM

Name \_\_\_\_\_ Date \_\_\_\_\_

Occupation \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ D.O.B. \_\_\_\_\_

Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Type \_\_\_\_\_

*Please circle words or check boxes for whatever applies to you; fill in blanks.*

◆ **Water, Salt, Energy, Stress:**

My current salt use is- *low, moderate, heavy, by taste*

Number of glasses of water each day \_\_\_\_\_

I have never used much or any salt- *True or False*

I crave salt and/or salty foods- *True or False*

I previously used salt more than now- *True or False*

I have unquenchable thirst- *True or False*

I have followed a low salt diet for \_\_\_\_\_ years.

I sweat ... *a-lot, moderately, very little, not-at-all*

Average energy level on a scale of 1 to 10 \_\_\_\_\_

Average stress level on a scale of 1 to 10 \_\_\_\_\_

◆ **Family History:**    cardiovascular disease    adult onset diabetes    thyroid disease    osteoporosis

◆ **Milk Intolerance:** (circle one) **Y**   **N**

◆ **Number of TOTAL pounds lost throughout your life dieting** \_\_\_\_\_.

◆ **Number of silver/amalgam fillings, currently** \_\_\_\_\_, **removed** \_\_\_\_\_.

◆ **Number of root canals, currently** \_\_\_\_\_, **removed** \_\_\_\_\_.

◆ **Exposure to heavy metals, chemicals, dust, infections, radiation, plastics:** \_\_\_\_\_

\_\_\_\_\_

◆ **Women Only**

Number of childbirths \_\_\_\_\_

Number of years nursing \_\_\_\_\_

Menstrual-related symptoms \_\_\_\_\_

\_\_\_\_\_

Perimenopausal years \_\_\_\_\_

Menopausal years \_\_\_\_\_

Menopausal symptoms \_\_\_\_\_

\_\_\_\_\_

◆ **Men Only**

Prostate enlargement?   **Y**   **N**

Elevated PSA?   **Y**   **N**

Urination difficulties?   **Y**   **N**

Nighttime urination?   **Y**   **N**

Sexual difficulties?   **Y**   **N**

**FOOD DIARY**

Please indicate the NUMBER OF SERVINGS PER WEEK you have of each of the following foods:

beef _____	fresh fruit _____
poultry _____	fresh vegetables _____
white _____	
dark _____	bread, cereals, grains and pastas:
	~refined/processed _____
lamb _____	~whole grain _____
fish _____	legumes _____ seeds _____
pork _____	nuts/nutbutters _____
soy "milk" _____	oils, <i>please specify</i> _____ <i>weekly</i>
tofu/soy _____	<i>kind(s)</i> _____ <i>servings</i>
products _____	_____
milk _____ %fat _____	_____
yogurt _____ %fat _____	_____
cottage _____	protein powder, <i>specify kind - weekly</i>
cheese _____ %fat _____	_____
eggs (# per week) _____	sweets (cookies, cakes, sodas,
	candy, ice cream, etc.) _____
butter _____	caffeine: tea _____ coffee _____
(sticks per week)	dark soda _____ light soda _____
cheese _____	wine _____ beer _____ liquor _____
(ounces per week)	

How much *calcium* do you supplement daily? \_\_\_\_\_ mg  
For how long? (*circle one*) weeks, months, years

How much *magnesium* do you supplement daily? \_\_\_\_\_ mg  
For how long? (*circle one*) weeks, months, years

**EXERCISE**

Please describe the type, frequency and duration of exercise.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**For Calculation of %BODY FAT**

Height \_\_\_\_\_ Weight \_\_\_\_\_

Abdomen Measurement at Navel \_\_\_\_\_ inches

(*Women only*) Hips Measurement at the Widest Point \_\_\_\_\_ inches

(*Men only*) Wrist Measurement \_\_\_\_\_ inches

**DIGESTION INDICATOR CHECKLIST**

- food allergies/intolerances: \_\_\_\_\_
- \_\_\_\_\_
- crave specific foods: \_\_\_\_\_
- \_\_\_\_\_
- avoid specific foods: \_\_\_\_\_
- \_\_\_\_\_
- low fat or no animal fat
- low or no carbohydrates
- burning sensation in stomach which eating relieves
- burping
- acid indigestion, sour stomach, heartburn
- tight/full upper abdomen after eating
- pale stools
- crave fats
- gall bladder attacks or stones
- abdominal bloating / distention
- flatulence (gas)
- coated tongue
- diarrhea
- constipation / incomplete evacuation
- alternating diarrhea and constipation
- loss of taste for meat
- always hungry
- low blood sugar  high blood sugar

**SLEEP CHECKLIST**

- Number of hours \_\_\_\_\_
- Sleep quality:
- poor  good
  - fair  excellent
  - awake during night at \_\_\_\_\_ a.m.
  - awake rested
  - difficulty falling asleep
  - awake too early
  - frequent snoring
  - another person has witnessed you stop breathing during sleep

**PLEASE INCLUDE A LIST OF ALL SUPPLEMENTS AND MEDICATIONS YOU ARE CURRENTLY TAKING. BE SURE TO LIST THE DOSE AND FREQUENCY FOR EACH ONE.**

# health equation<sup>S</sup>

HEALTH SURVEY FORM Name \_\_\_\_\_

Date \_\_\_\_\_

**INSTRUCTIONS: Number the boxes that apply to you with either a 1, 2, or 3 - -**

- (1) for **MILD** symptoms  
(2) for **MODERATE** symptoms  
(3) for **SEVERE** symptoms

**Leave the box blank if it does not apply to you!**

## GROUP 1

- 1  Acid foods upset
- 2  Get chilled, often
- 3  "Lump" in throat
- 4  Dry mouth-eyes-nose
- 5  Pulse speeds after meals
- 6  Keyed up-fail to calm
- 7  Cuts heal slowly
- 8  Gag easily
- 9  Unable to relax; startles easily
- 10  Extremities cold, clammy
- 11  Strong light irritates
- 12  Urine amount reduced
- 13  Heart pounds after retiring
- 14  "Nervous" stomach
- 15  Appetite reduced
- 16  Cold sweats often
- 17  Fever easily raised
- 18  Neuralgia-like pains
- 19  Staring, blinks little
- 20  Sour stomach frequent

## GROUP 4

- 56  Hands and feet go to sleep easily, numbness
- 57  Sigh frequently, "air hungry"
- 58  Aware of "breathing heavily"
- 59  High altitude discomfort
- 60  Open windows in closed room
- 61  Susceptible to colds & fevers
- 62  Afternoon "yawner"
- 63  Get drowsy often
- 64  Swollen ankles, worse at night
- 65  Muscle cramps, worse during exercise; get "charley horses"
- 66  Shortness of breath on exertion
- 67  Dull pain in chest or radiating into left arm, worse on exertion
- 68  Bruise easily, "black/blue" spots
- 69  Tendency to anemia
- 70  Nose bleeds frequent
- 71  Noises in head or "ringing in ears"
- 72  Tension under breastbone, or feeling of tightness, worse on exertion

## GROUP 2

- 21  Joint stiffness after arising
- 22  Muscle-leg-toe cramps at night
- 23  "Butterfly" stomach
- 24  Eyes or nose watery
- 25  Eyes blink often
- 26  Eyelids swollen, puffy
- 27  Indigestion soon after meals
- 28  Always seems hungry; feels "lightheaded" often
- 29  Digestion rapid
- 30  Vomiting frequent
- 31  Hoarseness frequent
- 32  Breathing irregular
- 33  Pulse slow; feels "irregular"
- 34  Gagging reflex slow
- 35  Difficulty swallowing
- 36  Constipation, diarrhea alternating
- 37  "Slow starter"
- 38  Get "chilled" frequently
- 39  Perspire easily
- 40  Circulation poor, sensitive to cold
- 41  Subject to colds, asthma, bronchitis

## GROUP 3

- 42  Eat when nervous
- 43  Excessive appetite
- 44  Hungry between meals
- 45  Irritable before meals
- 46  Get "shaky" if hungry
- 47  Fatigue, eating relieves
- 48  "Lightheaded" if meals delayed
- 49  Heart palpitates if meals missed or delayed
- 50  Afternoon headaches
- 51  Overeating sweets upsets
- 52  Awaken after few hours sleep-hard to get back to sleep
- 53  Crave candy or coffee in afternoons
- 54  Moods of depression-"blues" or melancholy
- 55  Abnormal craving for sweets or snacks

## GROUP 5

- 73  Dizziness
- 74  Dry skin
- 75  Burning feet
- 76  Blurred vision
- 77  Itching skin and feet
- 78  Excessive falling hair
- 79  Frequent skin rashes
- 80  Bitter, metallic taste in mouth in mornings
- 81  Bowel movements painful or difficult
- 82  Worrier, feels insecure
- 83  Feeling queasy; headache over eyes
- 84  Greasy foods upset
- 85  Stools light-colored
- 86  Skin peels on foot soles
- 87  Pain between shoulder blades
- 88  Use laxatives
- 89  Stools alternate from soft to watery
- 90  History of gallbladder attacks or gallstones
- 91  Sneezing attacks
- 92  Dreaming, nightmare type bad dreams
- 93  Bad breath (halitosis)
- 94  Milk products cause distress
- 95  Sensitive to hot weather
- 96  Burning or itching anus
- 97  Crave sweets

**GROUP 6**

- 98  Loss of taste for meat
- 99  Lower bowel gas several hours after eating
- 100  Burning stomach sensations, eating relieves
- 101  Coated tongue
- 102  Pass large amounts of foul smelling gas
- 103  Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
- 104  Mucus colitis or "irritable bowel"
- 105  Gas shortly after eating
- 106  Stomach "bloating" after eating

**GROUP 7 (A)**

- 107  Insomnia
- 108  Nervousness
- 109  Can't gain weight
- 110  Intolerance to heat
- 111  Highly emotional
- 112  Flush easily
- 113  Night sweats
- 114  Thin, moist skin
- 115  Inward trembling
- 116  Heart palpitates
- 117  Increased appetite without weight gain
- 118  Pulse fast at rest
- 119  Eyelids and face twitch
- 120  Irritable and restless
- 121  Can't work under pressure

**(B)**

- 122  Increase in weight
- 123  Decrease in appetite
- 124  Fatigue easily
- 125  Ringing in ears
- 126  Sleepy during day
- 127  Sensitive to cold
- 128  Dry or scaly skin
- 129  Constipation
- 130  Mental sluggishness
- 131  Hair coarse, falls out
- 132  Headache upon arising, wears off during day
- 133  Slow pulse, below 65
- 134  Frequency of urination
- 135  Impaired hearing
- 136  Reduced initiative

**GROUP 7 (continued)**

**(C)**

- 137  Failing memory
- 138  Low blood pressure
- 139  Increased sex drive
- 140  Headaches, "splitting or rending" type
- 141  Decreased sugar tolerance

**(D)**

- 142  Abnormal thirst
- 143  Bloating of abdomen
- 144  Weight gain around hips or waist
- 145  Sex drive reduced or lacking
- 146  Tendency to ulcers, colitis
- 147  Increased sugar tolerance
- 148  Women: menstrual disorders
- 149  Young girls: lack of menstrual function

**(E)**

- 150  Dizziness
- 151  Headaches
- 152  Hot flashes
- 153  Increased blood pressure
- 154  Hair growth on face or body (female)
- 155  Sugar in urine (not diabetes)
- 156  Masculine tendencies (female)

**(F)**

- 157  Weakness, dizziness
- 158  Chronic fatigue
- 159  Low blood pressure
- 160  Nails weak, ridged
- 161  Tendency to hives
- 162  Arthritic tendencies
- 163  Perspiration increases
- 164  Bowel disorders
- 165  Poor circulation
- 166  Swollen ankles
- 167  Crave salt
- 168  Brown spots or bronzing of skin
- 169  Allergies – tendency to asthma
- 170  Weakness after colds, influenza
- 171  Exhaustion – muscular and nervous
- 172  Respiratory disorders

**FEMALE ONLY**

- 173  Very easily fatigued
- 174  Premenstrual tension
- 175  Painful menses
- 176  Depressed feelings before menstruation
- 177  Menstruation excessive and prolonged
- 178  Painful breasts
- 179  Menstruate too frequently
- 180  Vaginal discharge
- 181  Hysterectomy/ovaries removed
- 182  Menopausal hot flashes
- 183  Menses scanty or missed
- 184  Acne, worse at menses
- 185  Depression of long standing

**MALE ONLY**

- 186  Prostate trouble
- 187  Urination difficult or dribbling
- 188  Night urination frequent
- 189  Depression
- 190  Pain on inside of legs or heels
- 191  Feeling of incomplete bowel evacuation
- 192  Lack of energy
- 193  Migrating aches and pains
- 194  Tire too easily
- 195  Avoids activity
- 196  Leg nervousness at night
- 197  Diminished sex drive

**IMPORTANT**

Please list below the five main health complaints you have in order of their importance, most important first:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_