PAULA OWENS
est 1988

Client/Patient Questionnaire

Name: _____ Age: _____ DOB: _____

Phone: (Cell) _____ (Home) _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____

E-mail: _____

Current Weight: _____ Height: _____

The chart below will be filled in by Paula

Date	Service/Program

Notes

Paula Owens, MS, CCN

Holistic and Clinical Nutritionist, Functional Health Practioner

Website: PaulaOwens.com ☎: 480.706.1158

Identify the Root Cause ♥ Use Food as Medicine ♥ Learn-Heal-Thrive!

AGREEMENT

Congratulations on your decision to invest in your health—your most valuable investment.

It is with great pleasure that I look forward to working with and serving you!

The details of using food as medicine, personalized nutrition, identifying the root cause of any health challenges, exercise and fitness, recommendations for any specific health conditions, environmental and comprehensive lifestyle suggestions that will be provided to you are empowering sources of valuable information that can be used for a lifetime.

You can expect detailed and expert advice, guidance and recommendations that are bio-individualized specifically for you and your unique biochemistry to help you heal from any health challenge you may be experiencing, prevent future risk of disease, balance your body chemistry, and often completely reverse many common lifestyle disorders such as diabetes, anxiety, insomnia, obesity, autoimmune disorders, adrenal fatigue, hormone imbalances and many, many other health challenges.

You understand that taking personal responsibility, follow through, and compliance is a critical component of your healing and success. To be healthy, whole and disease-free, requires a fundamental paradigm shift. The way you think, beliefs about who you are, your behavior and values, your thoughts, choices, what's important and what motivates you all must be challenged. Without your active participation, compliance and follow through, my ability to help you is limited.

Information shared between you (the client/patient) and Paula Owens is strictly confidential.

Any blood lab work I look at is for nutritional purposes only. I am not treating or diagnosing disease.
Please initial _____

_____
Participant's Name (please print clearly)

_____
Participant's Signature Date

Nutritional Assessment Questionnaire 1.5

Name: _____ **Date:** _____/____/_____

Birth Date: _____ **Gender:** _____

Please list your five major health concerns in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Notes:

PART I

Read the following questions and circle the number that applies:

KEY: **0 = Do not consume or use** **2 = Consume or use weekly**
1 = Consume or use 2 to 3 times monthly **3 = Consume or use daily**

DIET

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1.	0 1 2 3	Alcohol	**7.**	0 1 2 3	Cigars/pipes	**14.**	0 1	Radiation exposure (0=no, 1=yes)
2.	0 1 2 3	Artificial sweeteners	**8.**	0 1 2 3	Caffeinated beverages	**15.**	0 1 2 3	Refined flour/baked goods
3.	0 1 2 3	Candy, desserts, refined sugar	**9.**	0 1 2 3	Fast foods	**16.**	0 1 2 3	Vitamins and minerals
			10.	0 1 2 3	Fried foods	**17.**	0 1 2 3	Water, distilled
4.	0 1 2 3	Carbonated beverages	**11.**	0 1 2 3	Luncheon meats	**18.**	0 1 2 3	Water, tap
5.	0 1 2 3	Chewing tobacco	**12.**	0 1 2 3	Margarine	**19.**	0 1 2 3	Water, well
6.	0 1 2 3	Cigarettes	**13.**	0 1 2 3	Milk products	**20.**	0 1 2 3	Diet often for weight control

LIFESTYLE

12

21. 0 1 2 3 Exercise per week (0 = 2 or more times a week, 1 = 1 time a week, 2 = 1 or 2 times a month, 3 = never, less than once a month)
22. 0 1 2 3 Changed jobs (0 = over 12 months ago, 1 = within last 12 months, 2 = within last 6 months, 3 = within last 2 months)
23. 0 1 2 3 Divorced (0 = never, over 2 years ago, 1 = within last 2 years, 2 = within last year, 3 = within last 6 months)
24. 0 1 2 3 Work over 60 hours/week (0 = never, 1 = occasionally, 2 = usually, 3 = always)

MEDICATIONS

Indicate any medications you're currently taking or have taken in the last month (0=no, 1=yes): 54

25.	0 1	Antacids	**39.**	0 1	Diuretics
26.	0 1	Antianxiety medications	**40.**	0 1	Estrogen or progesterone (pharmaceutical, prescription)
27.	0 1	Antibiotics			
28.	0 1	Anticonvulsants	**41.**	0 1	Estrogen or progesterone (natural)
29.	0 1	Antidepressants	**42.**	0 1	Heart medications
30.	0 1	Antifungals	**43.**	0 1	High blood pressure medications
31.	0 1	Aspirin/Ibuprofen	**44.**	0 1	Laxatives
32.	0 1	Asthma inhalers	**45.**	0 1	Recreational drugs
33.	0 1	Beta blockers	**46.**	0 1	Relaxants/Sleeping pills
34.	0 1	Birth control pills/implant contraceptives	**47.**	0 1	Testosterone (natural or prescription)
35.	0 1	Chemotherapy	**48.**	0 1	Thyroid medication
36.	0 1	Cholesterol lowering medications	**49.**	0 1	Acetaminophen (Tylenol)
37.	0 1	Cortisone/steroids	**50.**	0 1	Ulcer medications
38.	0 1	Diabetic medications/insulin	**51.**	0 1	Sildenafal citrate (Viagra)

PART II

(See key at bottom of page)

Section 1 – Upper Gastrointestinal System

55

52.	0 1 2 3	Belching or gas within one hour after eating	**61.**	0 1 2 3	Feel like skipping breakfast
53.	0 1 2 3	Heartburn or acid reflux	**62.**	0 1 2 3	Feel better if you don't eat
54.	0 1 2 3	Bloating within one hour after eating	**63.**	0 1 2 3	Sleepy after meals
55.	0 1	Vegan diet (no dairy, meat, fish or eggs) (0=no, 1=yes)	**64.**	0 1 2 3	Fingernails chip, peel or break easily
			65.	0 1 2 3	Anemia unresponsive to iron
56.	0 1 2 3	Bad breath (halitosis)	**66.**	0 1 2 3	Stomach pains or cramps
57.	0 1 2 3	Loss of taste for meat	**67.**	0 1 2 3	Diarrhea, chronic
58.	0 1 2 3	Sweat has a strong odor	**68.**	0 1 2 3	Diarrhea shortly after meals
59.	0 1 2 3	Stomach upset by taking vitamins	**69.**	0 1 2 3	Black or tarry colored stools
60.	0 1 2 3	Sense of excess fullness after meals	**70.**	0 1 2 3	Undigested food in stool

KEY: 0=No, symptom does not occur
1=Yes, minor or mild symptom, rarely occurs (monthly)
2=Moderate symptom, occurs occasionally (weekly)
3=Severe symptom, occurs frequently (daily)

Section 2 – Liver and Gallbladder

68

71. 0 1 2 3 Pain between shoulder blades
72. 0 1 2 3 Stomach upset by greasy foods
73. 0 1 2 3 Greasy or shiny stools
74. 0 1 2 3 Nausea
75. 0 1 2 3 Sea, car, airplane or motion sickness
76. 0 1 History of morning sickness (0 = no, 1 = yes)
77. 0 1 2 3 Light or clay colored stools
78. 0 1 2 3 Dry skin, itchy feet or skin peels on feet
79. 0 1 2 3 Headache over eyes
80. 0 1 2 3 Gallbladder attacks (0=never, 1=years ago, 2=within last year, 3=within past 3 months)
81. 0 1 Gallbladder removed (0=no, 1=yes)
82. 0 1 2 3 Bitter taste in mouth, especially after meals
83. 0 1 Become sick if you were to drink wine (0=no, 1=yes)
84. 0 1 Easily intoxicated if you were to drink wine (0=no, 1=yes)
85. 0 1 Easily hung over if you were to drink wine (0=no, 1=yes)
86. 0 1 2 3 Alcohol per week (0=<3, 1=<7, 2 =<14, 3=>14)
87. 0 1 Recovering alcoholic (0=no, 1=yes)
88. 0 1 History of drug or alcohol abuse (0=no, 1=yes)
89. 0 1 History of hepatitis (0=no, 1=yes)
90. 0 1 Long term use of prescription/recreational drugs (0=no, 1=yes)
91. 0 1 2 3 Sensitive to chemicals (perfume, cleaning agents, etc.)
92. 0 1 2 3 Sensitive to tobacco smoke
93. 0 1 2 3 Exposure to diesel fumes
94. 0 1 2 3 Pain under right side of rib cage
95. 0 1 2 3 Hemorrhoids or varicose veins
96. 0 1 2 3 Nutrasweet (aspartame) consumption
97. 0 1 2 3 Sensitive to Nutrasweet (aspartame)
98. 0 1 2 3 Chronic fatigue or Fibromyalgia

Section 3 – Small Intestine

47

99. 0 1 2 3 Food allergies
100. 0 1 2 3 Abdominal bloating 1 to 2 hours after eating
101. 0 1 Specific foods make you tired or bloated (0=no, 1=yes)
102. 0 1 2 3 Pulse speeds after eating
103. 0 1 2 3 Airborne allergies
104. 0 1 2 3 Experience hives
105. 0 1 2 3 Sinus congestion, "stuffy head"
106. 0 1 2 3 Crave bread or noodles
107. 0 1 2 3 Alternating constipation and diarrhea
108. 0 1 2 3 Crohn's disease (0 =no, 1=yes in the past, 2=currently mild condition, 3=severe)
109. 0 1 2 3 Wheat or grain sensitivity
110. 0 1 2 3 Dairy sensitivity
111. 0 1 Are there foods you could not give up (0=no, 1=yes)
112. 0 1 2 3 Asthma, sinus infections, stuffy nose
113. 0 1 2 3 Bizarre vivid dreams, nightmares
114. 0 1 2 3 Use over-the-counter pain medications
115. 0 1 2 3 Feel spacey or unreal

Section 4 – Large Intestine

58

116. 0 1 2 3 Anus itches
117. 0 1 2 3 Coated tongue
118. 0 1 2 3 Feel worse in moldy or musty place
119. 0 1 2 3 Taken antibiotic for a total accumulated time of (0=never, 1= <1 month, 2= <3 months, 3= >3 months)
120. 0 1 2 3 Fungus or yeast infections
121. 0 1 2 3 Ring worm, "jock itch", "athletes foot", nail fungus
122. 0 1 2 3 Yeast symptoms increase with sugar, starch or alcohol
123. 0 1 2 3 Stools hard or difficult to pass
124. 0 1 History of parasites (0=no, 1=yes)
125. 0 1 2 3 Less than one bowel movement per day
126. 0 1 2 3 Stools have corners or edges, are flat or ribbon shaped
127. 0 1 2 3 Stools are not well formed (loose)
128. 0 1 2 3 Irritable bowel or mucus colitis
129. 0 1 2 3 Blood in stool
130. 0 1 2 3 Mucus in stool
131. 0 1 2 3 Excessive foul smelling lower bowel gas
132. 0 1 2 3 Bad breath or strong body odors
133. 0 1 2 3 Painful to press along outer sides of thighs (Iliotibial Band)
134. 0 1 2 3 Cramping in lower abdominal region
135. 0 1 2 3 Dark circles under eyes

Section 5 – Mineral Needs

75

136. 0 1 History of carpal tunnel syndrome (0=no, 1=yes)
137. 0 1 History of lower right abdominal pains or ileocecal valve problems (0=no, 1=yes)
138. 0 1 History of stress fracture (0=no, 1=yes)
139. 0 1 2 3 Bone loss (reduced density on bone scan)
140. 0 1 Are you shorter than you used to be? (0=no, 1=yes)
141. 0 1 2 3 Calf, foot or toe cramps at rest
142. 0 1 2 3 Cold sores, fever blisters or herpes lesions
143. 0 1 2 3 Frequent fevers
144. 0 1 2 3 Frequent skin rashes and/or hives
145. 0 1 Herniated disc (0=no, 1=yes)
146. 0 1 2 3 Excessively flexible joints, "double jointed"
147. 0 1 2 3 Joints pop or click
148. 0 1 2 3 Pain or swelling in joints
149. 0 1 2 3 Bursitis or tendonitis
150. 0 1 History of bone spurs (0=no, 1=yes)
151. 0 1 2 3 Morning stiffness
152. 0 1 2 3 Nausea with vomiting
153. 0 1 2 3 Crave chocolate
154. 0 1 2 3 Feet have a strong odor
155. 0 1 2 3 History of anemia
156. 0 1 2 3 Whites of eyes (sclera) blue tinted
157. 0 1 2 3 Hoarseness
158. 0 1 2 3 Difficulty swallowing
159. 0 1 2 3 Lump in throat
160. 0 1 2 3 Dry mouth, eyes and/or nose
161. 0 1 2 3 Gag easily
162. 0 1 2 3 White spots on fingernails
163. 0 1 2 3 Cuts heal slowly and/or scar easily
164. 0 1 2 3 Decreased sense of taste or smell

KEY: 0=No, symptom does not occur
1=Yes, minor or mild symptom, rarely occurs (monthly)
2=Moderate symptom, occurs occasionally (weekly)
3=Severe symptom, occurs frequently (daily)

Section 6 – Essential Fatty Acids

22

165. 0 1 Experience pain relief with aspirin (0=no, 1=yes)
166. 0 1 2 3 Crave fatty or greasy foods
167. 0 1 2 3 Low- or reduced-fat diet (0=never, 1=years ago, 2=within past year, 3=currently)
168. 0 1 2 3 Tension headaches at base of skull
169. 0 1 2 3 Headaches when out in the hot sun
170. 0 1 2 3 Sunburn easily or suffer sun poisoning
171. 0 1 2 3 Muscles easily fatigued
172. 0 1 2 3 Dry flaky skin or dandruff

Section 7 – Sugar Handling

39

173. 0 1 2 3 Awaken a few hours after falling asleep, hard to get back to sleep
174. 0 1 2 3 Crave sweets
175. 0 1 2 3 Binge or uncontrolled eating
176. 0 1 2 3 Excessive appetite
177. 0 1 2 3 Crave coffee or sugar in the afternoon
178. 0 1 2 3 Sleepy in afternoon
179. 0 1 2 3 Fatigue that is relieved by eating
180. 0 1 2 3 Headache if meals are skipped or delayed
181. 0 1 2 3 Irritable before meals
182. 0 1 2 3 Shaky if meals delayed
183. 0 1 2 3 Family members with diabetes (0=none, 1=1 or 2, 2=3 or 4, 3=more than 4)
184. 0 1 2 3 Frequent thirst
185. 0 1 2 3 Frequent urination

Section 8 – Vitamin Need

81

186. 0 1 2 3 Muscles become easily fatigued
187. 0 1 2 3 Feel exhausted or sore after moderate exercise
188. 0 1 2 3 Vulnerable to insect bites
189. 0 1 2 3 Loss of muscle tone, heaviness in arms/legs
190. 0 1 2 3 Enlarged heart or congestive heart failure
191. 0 1 2 3 Pulse below 65 per minute (0=no, 1=yes)
192. 0 1 2 3 Ringing in the ears (Tinnitus)
193. 0 1 2 3 Numbness, tingling or itching in hands and feet
194. 0 1 2 3 Depressed
195. 0 1 2 3 Fear of impending doom
196. 0 1 2 3 Worrier, apprehensive, anxious
197. 0 1 2 3 Nervous or agitated
198. 0 1 2 3 Feelings of insecurity
199. 0 1 2 3 Heart races
200. 0 1 2 3 Can hear heart beat on pillow at night
201. 0 1 2 3 Whole body or limb jerk as falling asleep
202. 0 1 2 3 Night sweats
203. 0 1 2 3 Restless leg syndrome
204. 0 1 2 3 Cracks at corner of mouth (Cheilosis)
205. 0 1 2 3 Fragile skin, easily chaffed, as in shaving
206. 0 1 2 3 Polyps or warts
207. 0 1 2 3 MSG sensitivity
208. 0 1 2 3 Wake up without remembering dreams
209. 0 1 2 3 Small bumps on back of arms
210. 0 1 2 3 Strong light at night irritates eyes
211. 0 1 2 3 Nose bleeds and/or tend to bruise easily
212. 0 1 2 3 Bleeding gums especially when brushing teeth

Section 9 – Adrenal

78

213. 0 1 2 3 Tend to be a "night person"
214. 0 1 2 3 Difficulty falling asleep
215. 0 1 2 3 Slow starter in the morning
216. 0 1 2 3 Tend to be keyed up, trouble calming down
217. 0 1 2 3 Blood pressure above 120/80
218. 0 1 2 3 Headache after exercising
219. 0 1 2 3 Feeling wired or jittery after drinking coffee
220. 0 1 2 3 Clench or grind teeth
221. 0 1 2 3 Calm on the outside, troubled on the inside
222. 0 1 2 3 Chronic low back pain, worse with fatigue
223. 0 1 2 3 Become dizzy when standing up suddenly
224. 0 1 2 3 Difficulty maintaining manipulative correction
225. 0 1 2 3 Pain after manipulative correction
226. 0 1 2 3 Arthritic tendencies
227. 0 1 2 3 Crave salty foods
228. 0 1 2 3 Salt foods before tasting
229. 0 1 2 3 Perspire easily
230. 0 1 2 3 Chronic fatigue, or get drowsy often
231. 0 1 2 3 Afternoon yawning
232. 0 1 2 3 Afternoon headache
233. 0 1 2 3 Asthma, wheezing or difficulty breathing
234. 0 1 2 3 Pain on the medial or inner side of the knee
235. 0 1 2 3 Tendency to sprain ankles or "shin splints"
236. 0 1 2 3 Tendency to need sunglasses
237. 0 1 2 3 Allergies and/or hives
238. 0 1 2 3 Weakness, dizziness

Section 10 – Pituitary

29

239. 0 1 Height over 6' 6" (0=no, 1=yes)
240. 0 1 Early sexual development (before age 10) (0=no, 1=yes)
241. 0 1 2 3 Increased libido
242. 0 1 2 3 Splitting type headache
243. 0 1 2 3 Memory failing
244. 0 1 Tolerate sugar, feel fine when eating sugar (0=no, 1=yes)
245. 0 1 Height under 4' 10" (0=no, 1=yes)
246. 0 1 2 3 Decreased libido
247. 0 1 2 3 Excessive thirst
248. 0 1 2 3 Weight gain around hips or waist
249. 0 1 2 3 Menstrual disorders
250. 0 1 Delayed sexual development (after age 13) (0=no, 1=yes)
251. 0 1 2 3 Tendency to ulcers or colitis

KEY: 0=No, symptom does not occur
1=Yes, minor or mild symptom, rarely occurs (monthly)
2=Moderate symptom, occurs occasionally (weekly)
3=Severe symptom, occurs frequently (daily)

Section 11 – Thyroid

48

252. 0 1 2 3 Sensitive/allergic to iodine
253. 0 1 2 3 Difficulty gaining weight, even with large appetite
254. 0 1 2 3 Nervous, emotional, can't work under pressure
255. 0 1 2 3 Inward trembling
256. 0 1 2 3 Flush easily
257. 0 1 2 3 Fast pulse at rest
258. 0 1 2 3 Intolerance to high temperatures
259. 0 1 2 3 Difficulty losing weight
260. 0 1 2 3 Mentally sluggish, reduced initiative
261. 0 1 2 3 Easily fatigued, sleepy during the day
262. 0 1 2 3 Sensitive to cold, poor circulation (cold hands and feet)
263. 0 1 2 3 Constipation, chronic
264. 0 1 2 3 Excessive hair loss and/or coarse hair
265. 0 1 2 3 Morning headaches, wear off during the day
266. 0 1 2 3 Loss of lateral 1/3 of eyebrow
267. 0 1 2 3 Seasonal sadness

Section 12 – Men Only

27

268. 0 1 2 3 Prostate problems
269. 0 1 2 3 Difficulty with urination, dribbling
270. 0 1 2 3 Difficult to start and stop urine stream
271. 0 1 2 3 Pain or burning with urination
272. 0 1 2 3 Waking to urinate at night
273. 0 1 2 3 Interruption of stream during urination
274. 0 1 2 3 Pain on inside of legs or heels
275. 0 1 2 3 Feeling of incomplete bowel evacuation
276. 0 1 2 3 Decreased sexual function

Section 13 – Women Only

60

277. 0 1 2 3 Depression during periods
278. 0 1 2 3 Mood swings associated with periods (PMS)
279. 0 1 2 3 Crave chocolate around periods
280. 0 1 2 3 Breast tenderness associated with cycle
281. 0 1 2 3 Excessive menstrual flow
282. 0 1 2 3 Scanty blood flow during periods
283. 0 1 2 3 Occasional skipped periods
284. 0 1 2 3 Variations in menstrual cycles
285. 0 1 2 3 Endometriosis
286. 0 1 2 3 Uterine fibroids
287. 0 1 2 3 Breast fibroids, benign masses
288. 0 1 2 3 Painful intercourse (dysparenia)
289. 0 1 2 3 Vaginal discharge
290. 0 1 2 3 Vaginal dryness
291. 0 1 2 3 Vaginal itchiness
292. 0 1 2 3 Gain weight around hips, thighs and buttocks
293. 0 1 2 3 Excess facial or body hair
294. 0 1 2 3 Hot flashes
295. 0 1 2 3 Night sweats (in menopausal females)
296. 0 1 2 3 Thinning skin

Section 14 – Cardiovascular

30

297. 0 1 2 3 Aware of heavy and/or irregular breathing
298. 0 1 2 3 Discomfort at high altitudes
299. 0 1 2 3 "Air hunger" or sigh frequently
300. 0 1 2 3 Compelled to open windows in a closed room
301. 0 1 2 3 Shortness of breath with moderate exertion
302. 0 1 2 3 Ankles swell, especially at end of day
303. 0 1 2 3 Cough at night
304. 0 1 2 3 Blush or face turns red for no reason
305. 0 1 2 3 Dull pain or tightness in chest and/or radiate into right arm, worse with exertion
306. 0 1 2 3 Muscle cramps with exertion

Section 15 – Kidney and Bladder

13

307. 0 1 2 3 Pain in mid-back region
308. 0 1 2 3 Puffy around the eyes, dark circles under eyes
309. 0 1 History of kidney stones (0=no, 1=yes)
310. 0 1 2 3 Cloudy, bloody or darkened urine
311. 0 1 2 3 Urine has a strong odor

Section 16 – Immune system

30

312. 0 1 2 3 Runny or drippy nose
313. 0 1 2 3 Catch colds at the beginning of winter
314. 0 1 2 3 Mucus producing cough
315. 0 1 2 3 Frequent colds or flu (0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year)
316. 0 1 2 3 Other infections (sinus, ear, lung, skin, bladder, kidney, etc.) (0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year)
317. 0 1 2 3 Never get sick (0 = sick only 1 or 2 times in last 2 years, 1 = not sick in last 2 years, 2 = not sick in last 4 years, 3 = not sick in last 7 years)
318. 0 1 2 3 Acne (adult)
319. 0 1 2 3 Itchy skin (Dermatitis)
320. 0 1 2 3 Cysts, boils, rashes
321. 0 1 2 3 History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue Syndrome, Hepatitis or other chronic viral condition (0 = no, 1 = yes in the past, 2 = currently mild condition, 3 = severe)

KEY: 0=No, symptom does not occur
1=Yes, minor or mild symptom, rarely occurs (monthly)
2=Moderate symptom, occurs occasionally (weekly)
3=Severe symptom, occurs frequently (daily)

CANDIDA/YEAST/FUNGAL INFECTION QUESTIONNAIRE

Section One-History	Point Score
1. Have you taken tetracycline or other antibiotics for acne for one month or longer?	25
2. Have you at any time in your life taken other "broad-spectrum" antibiotics for respiratory, urinary, or other infections for two months or longer, or in short courses four or more times in a one-year period?	20
3. Have you ever taken a broad-Spectrum antibiotic (even a single course)?	6
4. Have you at anytime in your life been bothered by persistent prostatitis, vaginititis, or other problems affecting your reproductive organs?	25
5. Have you been pregnant....	
One time?	3
Two or more times?	5
6. Have you taken birth control pills...	
For six month to two years?	8
For more than two years?	15
7. Have you taken prednisone or other Cortisone type drugs.....	
For two weeks or less?	6
For more than two weeks?	15
8. Does exposure to perfumes, insecticides, Fabric shop odors, and other chemicals Provoke...	
Mild symptoms?	5
Moderate to severe symptoms?	20
9. Are your symptoms worse on damp, Muggy days or moldy places?	20
10. Have you ever had athlete's foot, Ringworm, "jock itch", or other chronic Infections of the skin or nails?	
Mild to moderate?	10
Severe or persistent?	20
11. Do you crave sugar?	10
12. Do you crave breads?	10
13. Do you crave alcoholic beverages?	10
14. Does tobacco smoke bother you?	10

TOTAL SCORE FOR THIS SECTION_____

Section Two-Major Symptoms	Point Score
For each of your symptoms, enter the Appropriate figure in the Point Score column.	
Symptom is occasional or mild	Score 3 points
Symptom is frequent and/or moderately severe	Score 6 points
Symptom is severe and/or disabling	Score 9 points
1. Fatigue or lethargy	_____
2. Feeling of being doomed	_____
3. Poor memory	_____
4. Feeling "spacey" or "unreal"	_____
5. Depression	_____
6. Numbness, burning, or tingling	_____
7. Muscle aches	_____
8. Muscle weakness or paralysis	_____
9. Pain and/or swelling in joints	_____
10. Abdominal pain	_____
11. Constipation	_____
12. Diarrhea	_____
13. Bloating	_____
14. Persistent vaginal itch	_____
15. Persistent vaginal burning	_____
16. Prostatitis	_____
17. Impotence	_____
18. Loss of sexual desire	_____
19. Endometriosis	_____
20. Premenstrual tension	_____
21. Cramping and other menstrual irregularities	_____
22. Spots in front of eyes	_____
23. Erratic vision	_____

TOTAL SCORE FOR THIS SECTION_____

CANDIDA/YEAST/FUNGAL INFECTION QUESTIONNAIRE

Section Three-Other Symptoms Point Score

For each of your symptoms, enter the appropriate figure in the Point Score column.

Symptom is occasional or mild — Score 1 point
Symptom is frequent and/or moderately severe — Score 2 points
Symptom is severe and/or disabling — Score 3 points

1. Drowsiness _____
2. Irritability _____
3. Lack of coordination _____
4. Inability to concentrate _____
5. Frequent mood swings _____
6. Headache _____
7. Dizziness/loss of balance _____
8. Pressure above ears, feeling of head swelling and tingling _____
9. Itching _____
10. Other rashes _____
11. Heartburn _____
12. Indigestion _____
13. Belching and intestinal gas _____
14. Mucus in stools _____
15. Hemorrhoids _____
16. Dry mouth _____
17. Rash or blisters in mouth _____
18. Bad breath _____
19. Joint swelling or arthritis _____
20. Nasal congestion or discharge _____
21. Postnasal drip _____
22. Nasal itching _____
23. Sore or dry throat _____
24. Cough _____
25. Pain or tightness in chest _____
26. Wheezing or shortness of breath _____
27. Urinary urgency or frequency _____
28. Burning on urination _____
29. failing vision _____
30. Burning or tearing of eyes _____
31. Recurrent infections or fluid in ears _____
32. Ear pain or deafness _____

TOTAL SECTION SCORE _____

Section Four- Final Score

Total score from Section 1 _____
Total score from Section 2 _____
Total score from Section 3 _____

TOTAL ALL SECTIONS =_____

READING YOUR SCORE

	Women	Men
Yeast-connected health problems are almost certainly present	**>180**	**>140**
Yeast-connected health problems are probably present	**120-180**	**90-140**
Yeast-connected health problems are probably present	**60-119**	**40-89**
Yeast-connected health problems are less likely to be present	**<60**	**<40**

HEALTH HISTORY

Name: _____ **Date:** _____

Physician's Name & Phone: _____

Emergency Contact & Phone: _____

List your top major health concerns that you wish to accomplish by working with Paula:

1. _____

2. _____

3. _____

Do you currently experience or have you in the past experienced any of the following?

Circle ANY that apply; include start date or date diagnosed

Smoking Habit? Yes No *If yes*, how many years? _____

Currently smoking? Yes No

Cigarettes Vaping Cigars Marijuana Chew tobacco

Currently live with or work with a smoker Yes No

Hernia, hiatal hernia or any condition aggravated by heavy lifting? Yes No

Diabetic, pre-diabetic or hypoglycemic? Yes No

Thyroid disorder or thyroid autoimmune?

Hypothyroid? Hyperthyroid? Hashimoto's? Grave's?

Fibromyalgia Yes No

Chronic Fatigue Syndrome Yes No

Circle ANY that apply to you. Include start date or date diagnosed.

Water damage in your home, workplace, or school? Yes No

Mold exposure? Yes No Unknown

Lyme disease? Yes No Unknown

Do you live next to or near a golf course, public park or public green belt area where pesticides, herbicides and fertilizers are used?

Yes No

Live or work in close vicinity of overhead electrical wires, cellphone towers or 5G towers?

Yes No

Diagnosed with an autoimmune disorder? Yes No

If yes, which autoimmune disease(s)? _____

If yes, date diagnosed? _____

Asthma **Seasonal allergies** **Chronic bronchitis**

Chronic sinus infections **Pneumonia** **COPD** **Chronic coughing**

Chronic throat clearing

Prior or current VIRAL INFECTIONS? Please circle and include dates

Epstein-Barr Mono Hepatitis HIV HPV

Herpes CMV Shingles COVID-19

Other _____

Vaccinations (injections) **Circle those that apply to you and include date(s) of injection(s)**

Flu vaccine Polio Hep B COVID-19

Shingles Pneumonia HPV Covid booster shots

Other _____

Covid shots or covid boosters

Yes No

If yes, include date of shots, which brand of shots or boosters, and any side effects that you're aware of

_____

_____

_____

History of kidney stones? Yes No

Liver or Gallbladder problems? Yes No

History of gallstones Yes No

Has your gallbladder been removed? Yes No

If yes, why and date removed _____

Tattoos? Yes No

If yes, how many? _____

Date of tattoos _____

Skin conditions. *Please circle any that apply to you*

Eczema	Psoriasis	Hives or Rash	Dandruff
Rosacea	Acne	Dry skin	Fungus
Cracked heels	Jock itch	Athlete's foot	Spider veins
Varicose veins	Whites of eyes are yellow		

Other _____

Body piercings (other than ears)

Yes No

If yes, location _____

Do you have any pets? Yes No

If yes, type of pet(s) _____

Location of the electrical meter at your residence (i.e., garage, outside bedroom wall, etc.)

_____

Circle any of the following that you use

Fragrance candles	Air fresheners (home, workplace or vehicle)	
Electric vehicle	Dryer sheets	Fabric softeners
Sunscreen	Ear buds	Air pods
Apple or smart watch	Fitness trackers	Microwave oven
Nonstick cookware	Plastic water bottles	Bluetooth headset
Contact lenses	Nail Polish	

Circle ANY that apply to you.

Are you currently being treated for a musculoskeletal problem that would restrict you from engaging in physical activity?

Do you experience low back pain? Yes No

If yes, does pain radiate down to the glute or leg?

Any problems with muscle, bone, joint (spine, shoulder, elbow, wrist, hip, knee, ankle), bursitis, arthritis, or back injuries?

Do you currently or have you ever had an eating or exercise disorder? Yes No

If yes, please circle those that apply.

Exercise bulimia	Orthorexia	Anorexia
Binge/purge bulimia	Dysmorphia	Food phobia

Number of daily bowel movements _____

Does your stool have a strong odor? Yes No Sometimes

Do you experience constipation? Yes No Sometimes

Do you experience loose stool or diarrhea? Yes No Sometimes

Have you been diagnosed with a gastrointestinal disorder?

Ulcerative colitis	Diverticulitis	Irritable Bowel Disease
Crohn's disease	Gastritis	Irritable Bowel Syndrome
Colon Polyps	Other _____	

Date of your last blood test _____

Have you ever been diagnosed with a sexually transmitted disease (STD)?

Yes No

If yes, which one(s) _____

Do you experience headaches or migraines? Yes No

If yes, how often? _____

Have you experienced any head, neck or traumatic brain injuries (including auto accidents)? Yes No

If yes, when? _____

Sleep apnea? Yes No If yes, do you use a CPAC device? Yes No

If yes, date of diagnosis _____

Have you traveled or lived outside of the United States? Yes No

If yes, where? (location)	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Oral • Dental Health

How often do you get your teeth cleaned? _____

How often do you brush your teeth? _____ Floss? _____

Mercury amalgam fillings? Yes No If yes, how many? _____

Do you have any root canaled teeth? _____Yes _____No

If yes, how many? _____ Date of root canals _____

Periodontal disease? Yes No

Gingivitis? Yes No

Do your gums bleed when brushing? Yes No

Do you currently have braces or Invisalign? Yes No

Do you wear a nightguard during sleep? Yes No

Do you grind your teeth during sleep? Yes No

Do you use an electric toothbrush? Yes No

What brand of toothpaste do you use? _____

List any other teeth, oral health, mouth, or gum problems

_____

_____

Skin Care and Household Products

Skincare products that you use (lotions, soap, body wash, deodorant, antiperspirant, cosmetics, makeup, shampoo, colognes, perfume, toothpaste, oral healthcare products)

Cleaning products that you use (disinfectants, bug spray, pest control, laundry detergent, bathroom cleaning products, …)

Circle any of the following that you currently take or have taken in the past 3 years.
Include the start date, dosage and frequency.

Antacids or PPIs	Laxatives or Stool Softeners	Cortisone steroids
Antibiotics	Cipro (antibiotic)	Oral Contraceptives
Prednisone	Fluoroquinolone antibiotics	Adderall
Antifungals	Ulcer Medication	Tylenol or Motrin
Anti-Inflammatories	Aspirin	Diflucan
Over-the-Counter Drugs	Antidepressants, SSRIs	Hormone HRT
Statin (cholesterol) drugs	NSAIDs, Tylenol, Advil	Diabetes medication
Hypertension meds	Antihistamines	Diuretics
Opioids	Narcotics	Methamphetamines
Marijuana	Ecstasy	Antipsychotics
Botox	CBD	Sleep Aids
Pain medication	THC or CBD gummies	

Other (please list) _____

FEMALES ONLY. Circle any that apply to you.

Are you pregnant? (currently or within the last 12 months) Yes No

Are you nursing? Yes No

Do you have breast implants? Yes No If yes, date of implantation _____

Breast explant surgery? Yes No If yes, date of explant surgery? _____

Have you been diagnosed with endometriosis? Yes No

Fibroids? Yes No If yes, breast, uterine or both? _____

Urinary Tract Infections? Yes No

If yes, date(s) of UTI _____

If antibiotics were used, please list which antibiotic

_____

Ovarian cysts? Yes No

Polycystic Ovarian Syndrome (PCOS)? Yes No

Hysterectomy? Yes No

If yes, date _____ Full _____ Partial _____

Are you post-menopausal? (one year or more since your last menstrual period) Yes No

If yes, what age did you go through menopause? _____

Do you have a menstrual cycle/period every month? Yes No

Do you use fragrances (perfume, cologne, scented lotions)? Yes No

Do you wear nylon or synthetic pantyhose or underwear? Yes No

FEMALES ONLY. Circle any that apply to you.

Do you experience PMS? Yes No

Circle any symptoms that you experience

Tender breasts	Mood swings	Carb or sweet cravings
Cramps	Increased appetite	Irritability
Weight gain	Bloating	Acne
Depression	Anxiety	Water retention

Oral Contraceptives (birth control pills) currently or in the past? Yes No

Implanted birth control device, currently or in the past. Yes No

IUD, currently or in the past. Yes No

If yes, brand name of IUD (i.e. Mirena)

Date of IUD

Hormone Replacement Therapy currently or in the past? Yes No

If yes, please list ALL hormones, method of application, and date started

Hormone	Dates (started/ended)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

MALES ONLY. Circle any that apply to you. Include date diagnosed or symptoms started

Prostate problems	Prostatitis
Erectile dysfunction	Gout
Low testosterone	Gynectomastia (man boobs)
Frequent urination at night	Low libido or loss of sexual interest
Sleep apnea	Prostate cancer
Enlarged prostate	STDs
Testicular cancer	Jock Itch
Athlete's foot	Nail Fungus

Hormone replacement therapy currently or in the past? Yes No

If yes, list specific hormones and start date?

Hormone (method of delivery: topical, pill, troche, injection) Date

_____ _____

_____ _____

_____ _____

MEDICATIONS, PRESCRIPTION DRUGS and OTC DRUGS

List any medications, hormones, OTC or prescription drugs you currently take in the chart below. *Please print clearly.*

Include birth control pills, antibiotics, Accutane, antidepressants, blood thinners, asthma, hormone therapy, thyroid hormones, statin drugs, Adderall, Xanax, etc.

Note: List vitamins and supplements on the next page

Medication	Reason for use	Dose	Frequency	Start date
Example: Metformin	*Type 2 Diabetes*	*500 mg*	*2 per day*	*Jan 2012*
Example: Synthroid	*Thyroid*	*120 gm*	*1 in the AM*	*May 2015*

Other than those listed above, list any medications or drugs you have taken in the last five (5) years?

Medication	Reason for use	Dose	Frequency	Start date

VITAMINS and NUTRITIONAL SUPPLEMENTS

Use the chart below to list all vitamins or other supplemental products you currently use
Include meal replacement drinks, bars, protein powder, herbs, etc.

Supplement or Vitamin Name	Brand	Dose	Frequency	Length of time
Example: Magnesium Glycinate	*Designs for Health*	*600 mg*	*1x at Bedtime*	*Since 2009*

HEALTH TIMELINE

List any specifics, events, traumas, surgeries, accidents, health conditions or major challenges in your life

Family history (mother and father's health)

Father: _____

Mother: _____

Your Mother's general health during pregnancy with you

Was mother exposed to toxins, stress?

Did mom get immunizations during pregnancy?

Was the pregnancy expected, accepted by mom and family?

Did your mother use Tylenol while pregnant? Yes No Do not know

Did your mother use alcohol or drugs while pregnant? Yes No Do not know

Were you given any Tylenol as a child or infant? Yes No

Your birth (circle any that apply to you)

C-section	Forceps	Fetal Monitoring
Intense labor	ICU	Born prematurely

Your infancy: what kind of baby were you?

(fussy, happy, sick, ear infections, breast fed, bottle fed, restless, bowel problems, etc.)

List any immunizations/vaccines given to you at birth through age 7

Early childhood

Social	Shy	Friends	Wet the bed
Active	Allergies	Sickness/Illness	Ear infections
Medications/drugs	Antibiotics	Abuse	

Grade school

Sick days	ADD/ADHD	OCD	Difficulty focusing
Accidents	Bullied		

Menstrual periods (females only)

Cramps	Mood Changes	PMS
Missed periods	Heavy flow	

High school: Any change in habits (isolation, moodiness, alcohol or drug use, marijuana, Rx medications, birth control, illness/sickness, dental problems, change in friends…)

Post-graduate - college

What was your major? _____

Were you a 'party' person during high school, after graduating or while attending college?

Yes No

Relationships (married, divorced, etc.)

If married (or in a relationship), describe your spouse's (partner's) health:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Do you have supportive relationships?

Yes No

_____

_____

List any abuse, neglect or traumas (emotional, mental, physical, sexual) that you may have experienced and the approximate date the trauma or abuse occurred.

Trauma or Abuse	Date

Circle if you currently experience, have been diagnosed with or are being treated for any of the following (currently or in the past)

Anorexia	Over-exercising	Food phobias
Bulimia	Orthorexia	Depression
Cutting	Bipolar	Schizophrenia
Poor body image	Self-harming	Suicidal thoughts

Addictions: Circle if you are currently struggling with or have in the past suffered from:

Food	Alcohol	Drugs (pharmaceutical, OTC or recreational drugs)	
Exercise	Social media	Sex, pornography	Smoke marijuana
Shopping	Gambling	Negative self-talk	MSM news
Smartphone	Working	Complaining	Chronic dieting
Internet	Plastic surgery	Smoking (cigarettes)	Vaping

Other: _____

If so, are you currently or did you participate in treatment (outpatient, inpatient, support groups, therapy, etc.)?

Yes No

List any surgeries, accidents, injuries, or infections. Include the date.

Surgeries, Accidents, Concussions, Brain Injuries, or Infections	Date

Courses of treatments

Courses of treatment, therapies or lifestyle changes that **have worked** for you

Courses of treatment, therapies or otherwise that **have *not* worked** for you

PHYSICAL ACTIVITY AND LIFESTYLE

Are you presently involved in a consistent exercise program? Yes No

If yes, please list activity, duration, frequency and intensity.

How would you characterize your life? Please circle.

Highly stressful moderately stressful Low in stress

On a scale of 1 to 10 (1=no stress, 10=a lot of stress, rate the amount of stress for:

_____Career or work _____Personal Life

List the 5 main stress factors or issues that create stress in your life

1.

2.

3.

4.

5.

Forms of recovery, relaxation, stress relief, support and/or bodywork you currently use?

Circle those that apply

Physical therapy	Chiropractic	Counseling	EMDR
HBOT	Red light therapy	Biofeedback	Journaling
Active release (ART)	Rolfing	Prayer	Meditation
Massage	Hypnotherapy	Cold water	Cold showers
Focused breathing	Hydrotherapy	Yoga	Aromatherapy
Coaching	Hypnotherapy	Stretching	Infrared sauna
Acupuncture	Grounding		

Other _____

Do you have a spiritual practice? Yes No

What is your belief system? _____

_____

_____

Do you experience fatigue or lack of energy? Yes No Sometimes

How many hours of television do you watch weekly? _____hours/week

How many hours per week do you sit at a computer? _____hours/week

What time do you turn off your smartphone at night? _____

What time do you turn off your computer at night? _____

Do you have difficulty falling asleep? Yes No Sometimes

Do you have difficulty staying asleep? Yes No Sometimes

Do you have difficulty waking up in the morning? Yes No Sometimes

How many hours of sleep do you get each night? _____

Is it sound sleeping (uninterrupted sleep)? Yes No Sometimes

What time do you go to bed? _____

What time do you arise? _____

Do you use medications (OTC and/or Rx) for sleep? Yes No Sometimes

If yes, what? _____

Are you a mouth breather? Yes No

Have you been diagnosed with sleep apnea? Yes No

Do you wake up more exhausted than when you went to bed? Yes No Sometimes

Do you consistently wake up between 11pm – 1am? Yes No

Do you consistently wake up between 1am – 3am? Yes No

Do you consistently wake up between 3am – 5am? Yes No

Is there a television in your bedroom? Yes No

Where do you keep your smartphone at night when you go to bed?

_____

CIRCLE THOSE THAT APPLY TO YOU

Diet often

Do not exercise regularly

Tired all the time

Stressful relationships

Libido is lower than you'd like

Chronic, excessive stress

Exercise to exhaustion

Frequent upper respiratory infections

Experience memory problems

Exposed to chemicals at home or work

Experience unexplained aches and pain

Worry over job, income, money

Use stimulants (meds, red bull drinks, other)

Feelings of isolation or loneliness

Take medications prescribed by a physician related to stress/psychological disorder

Exposed to cigarette, cigar or marijuana smoke

Lose more than 2 days of work annually due to Illness or sickness

Days per week that you currently devote to structured exercise

_____days

Types of activities you enjoy

____Walking	____Mountain biking	____Racquetball
____Jogging	____Cardio machines	____Tennis
____Long-distance biking	____Sprinting	____Yoga
____Strength training	____Golf	____In-line skating
____Hiking	____Swimming	____Stretching
____Cycle classes	____Sports Specific	____Jump Rope
____Qi Gong	____Pilates	____ Crossfit-style workouts
____ Pickleball	____ Climbing	

____Other (please list): _____

FOOD and DIET HABITS

What time of day do you eat your first meal?

What time of day is your last meal?

How many meals do you eat daily?

What do you eat and drink at your first meal of the day?

Are you vegan or vegetarian? Yes No

If yes, please circle the foods you avoid:

Meat Eggs Cheese Fish Dairy

Other _____

Circle if you consume any of the following:

Butter	Sugar	Salt	Milk	Nonfat Products	Red Meat
Candy	Alcohol	Coffee	Margarine	Luncheon Meats	Cereal
Grains	Bagels	Soda	Kombucha	Soy Products	Soy Milk
Fast food	Cheese	Nutrasweet	TruVia	Equal	Sweet ‘n Low
Bread	Wheat	Chips	Splenda	Low fat products	Juice

Green foods, plants, veggies and leafy greens? Yes No

Approximate servings daily? _____

Do you shop for and consume certified organic foods as much as possible? Yes No

How many times per week do you eat at a restaurant? _____

What type of cookware do you use? _____

Do you have a water filtration system in your kitchen? Yes No

If yes, what type? _____

Do you have a water filter in the shower? Yes No

Do you have a water softener? Yes No

If yes, do you use sodium chloride pellets or potassium chloride pellets?

_____

Which oils and fats do you use?

Coconut	Olive	Canola	Avocado	Oil Sprays, such as Pam	
Soybean	Lard	Butter	Margarine	Ghee	Tallow
Sunflower	Safflower	Corn oil	Grapeseed		

Other _____

What foods (*if any*) do you EXCLUDE from your diet?

Foods or beverages you will NOT or CHOOSE not to eat:

Foods or beverages that you do NOT like:

Answer the following either TRUE or FALSE
If your answer is "sometimes," then you should choose TRUE

1.	T	F	I eat bread (any kind).
2.	T	F	I drink fruit juice (any kind).
3.	T	F	I drink milk.
4.	T	F	I have more than one serving of fruit daily.
5.	T	F	I choose agave over sugar.
6.	T	F	I get out of breath on my daily walk.
7.	T	F	My total cholesterol is below 150.
8.	T	F	I have diabetes.
9.	T	F	I am overweight.
10.	T	F	I don't exercise regularly.
11.	T	F	I eat a low-fat diet.
12.	T	F	Neurological conditions run in my family.
13.	T	F	I don't take a vitamin D supplement.
14.	T	F	I take a statin drug.
15.	T	F	I avoid high-cholesterol foods.
16.	T	F	I drink soda (diet or regular).
17.	T	F	I don't drink red wine.
18.	T	F	I drink beer.
19.	T	F	I eat cereal (any kind).
20.	T	F	I've experienced a concussion or traumatic brain injury?

Circle if your answer is YES

Take antacids regularly

Taken antibiotics in the past More than 1-2x in the past 3 years

Burp or belch after meals

Experience abdominal bloating or intestinal gas

Less than one well-formed bowel movement daily

Rectal itching Chronic constipation Diarrhea or loose stool

Do you crave: Peanut butter? Sugar & Sweets? Breads? Chocolate? Alcohol?

Do you crave corn chips? Potatoes? Carbohydrates?

Do you experience digestive disturbances not relieved by digestive enzymes?

Do you have late night food cravings?

Do you notice undigested food particles in your stools?

Do you feel nauseated after taking vitamins or supplements?

Is there a greenish tinge to the back of your tongue in the morning?

White coating on your tongue

Experience unexplained depression?

Do you have any vague abdominal or digestive complaints?

Do you experience unexplained headaches? Joint and muscle pain?

Have you had or do you have hives, psoriasis, eczema or chronic skin rashes?

Do you feel bad all over for no apparent reason?

Are you bothered by erratic vision or spots before the eyes?

History of using NSAIDs, Tylenol or other anti-inflammatories?

Circle if your answer is **YES**

Has your memory been noticeably poor? Do you have a space-y feeling or find it hard to focus? Yes No

Have you taken prednisone, Decadron or other steroid or cortisone-type drugs for more than two weeks? Yes No

Do you experience chronic, ongoing stress? Yes No

Do you drink too much alcohol? Yes No

Do you get too little sleep and rest? Yes No

Do you **currently** have (or within the last 6-12 months) any of the following?

Circle those that apply to you and include the date symptoms started.

Athlete's foot	Ringworm	Nail fungus
Jock itch	Parasites	Chronic fungus or yeast infections
Candida	Sinus infections	Lyme disease
Dandruff	Bladder infection	Urinary tract infections (UTIs)
Bloody stool	Mucus in stool	Food in stool

Circle any that apply to you

Acne	Bloating, belching, gas
Constipation	Loss of sexual desire or feeling
Diarrhea, loose stool	Depression
Grind teeth	Fatigue, low energy, tired all the time
Endometriosis	Impotence, erectile dysfunction
PMS symptoms	Cold hands or feet
Rectal itching	Abdominal pain
Nasal congestion, post-nasal drip	Dizziness, loss of balance
Brain fog, spacey feeling	Nasal itching
Rash, sores or blisters in the mouth	Crying attacks, cry easily
Numbness, tingling, burning	Peripheral neuropathy
Cold sores	Arrythmia, heart palpitations

Circle any that apply to you

Migraine headaches

Cry easily

Cravings for sweets, bread, carbs, starch

Unexplained skin problems, hives, rashes

Difficulty gaining weight

Food allergies, food sensitivities

Difficulty digesting dairy products

Tendency to over consume alcohol

Weight gain

Unexplained fatigue

Unable to relax, difficulty relaxing

Unexplained digestive problems

Female hormone imbalances, (PMS, severe menopausal symptoms)

Overly sensitive to emotional pain

Tend to overeat sweets, bread, and carbs

Abdominal pain or cramping

Bloated belly or distended belly

Intestinal gas

"Love" specific foods

Eat when upset, to relax, not hungry or to numb emotions

Constipation or diarrhea of no known cause

Muscle or joint pain or stiffness of unknown cause

Snack between meals

FOOD LOG

Using the three following pages, write down everything you eat and drink for three days.
Include the following:

1. Everything you eat and drink in the order in which it was consumed. Use brand names.

2. All meals, beverages and snacks, including soda, candy and gum.

3. Approximate amount consumed. Use standard measuring cups and spoons.
   Record protein in approximate ounces, cooked. (3 ounces = size of deck of cards)

4. Items added to your food (sugar on cereal, butter on bread, salad dressing (type of dressing, ingredients, spices), etc.

5. Time food was consumed

6. How your meals were prepared. (Baked, fried, raw, boiled, broiled, etc.)

7. Use a separate sheet for each day (see below for 3 days / 3 sheets)

9. How you felt one hour after consuming your meal or snack.
   (tired, lethargic, energized, neutral, alert, mentally exhausted, satiated, bloated)

Example

Time	Amount	Food and preparation
6 AM	12 ounces	Filtered water, juice from a lime, Redmond's salt
7:30am	2 cups	organic coffee
11am	2 eggs	organic, pasture-raised eggs sautéed in grass-fed butter
	1/2 cup	blueberries
	3-4 oz.	Ground bison burger
	1/2	avocado
5pm	8-10 ounces	Wild salmon, gilled, lemon, ginger and butter
	4 cups	arugula, red onion, cilantro, pecans, pear
	1/2 cup	olive oil and lemon

Include daily water intake: Total ounces of water consumed for the day

DAILY FOOD & BEVERAGE INTAKE **Date: _____**

Time of day	**Food & Beverages (approx. amount, cooking method, ingredients, spices used)** Include how you felt 1-2 hours afterwards (GI distress, satiated, craving sweets, still hungry, bloated, belching, headache, sleepy, bowel movements, heartburn, etc.)
Water (ounces)	

DAILY FOOD & BEVERAGE INTAKE **Date: _____**

Time of day	**Food & Beverages (approx. amount, cooking method, ingredients, spices used)** Include how you felt 1-2 hours afterwards (GI distress, satiated, craving sweets, still hungry, bloated, belching, headache, sleepy, bowel movements, heartburn, etc.)
Water (ounces)	

DAILY FOOD & BEVERAGE INTAKE **Date: _____**

Time of day	**Food & Beverages (approx. amount, cooking method, ingredients, spices used)** Include how you felt 1-2 hours afterwards (GI distress, satiated, craving sweets, still hungry, bloated, belching, headache, sleepy, bowel movements, heartburn, etc.)
Water (ounces)	

HEALTH INVESTMENT POLICY AGREEMENT

SERVICE OPTIONS

- **Ultimate Lifestyle Plan, $1858**
- **Formal Consultation: $349**
- **Functional Blood Chemistry Analysis: $399**
- **Health Coaching options:**

  3 hours (180 minutes), $564

  6 hours (360 minutes), $988

  12 hours (720 minutes), $1,789

- The cost of any lab work is the full responsibility of the client/patient.
- All services are conducted via telephone: this includes your formal consultation, review of blood chemistry analysis, stool test review, review of any other lab tests, and health coaching calls

PLEASE INITIAL: _____

HEALTH INVESTMENT POLICY AGREEMENT

- **Ultimate Lifestyle Plan: $1,858**

The Ultimate Lifestyle Plan is an all-inclusive plan that includes:

- Formal Consultation conducted via telephone
- Functional Blood Chemistry Analysis that includes:
  1. Detailed reports indicating your personal nutritional excesses or deficiencies
  2. Identification of any potential hidden health problems, imbalances or subclinical issues
  3. A bio-individualized nutrient supplement protocol personalized to balance your body chemistry
  4. An interpretation and review of your blood chemistry analysis conducted via telephone
- Ultimate Lifestyle Booklet: Bio-individualized nutrition, dietary, environmental, personal care, and lifestyle action steps that can be used for a lifetime
- Three (3) additional consulting hours (180 minutes) VIP Health Coaching

► **The 3-hour health coaching that is included with the Ultimate Lifestyle Plan expires 3 months after the date of your first coaching call.**
Additional Health Coaching is available to purchase after your 3-hours have been used or expired.
Visit my website for information on continued health coaching options (3 hours, 6 hours or 12 hours).

The Ultimate Lifestyle Plan requires a copy of your recent blood work and completion of the Client Questionnaire.

The Ultimate Lifestyle Plan is a bio-individualized plan that is personalized specifically for you and your unique biochemistry, metabolism, health conditions, and lifestyle.

The Ultimate Lifestyle Plan is available to clients from anywhere in the United States.

PLEASE INITIAL: _____

HEALTH INVESTMENT POLICY AGREEMENT

Acceptable payment options

- Submit via **Zelle** to my email address
- Submit a check payable to Paula Owens
- Cash

- Payment must be made in full to proceed. No payment plans

- Vitamins and supplements will be suggested based on your unique needs, health conditions, nutrient deficiencies, imbalances, and biochemistry. It is recommended that supplements are purchased from my online dispensary, a licensed practitioner or directly from the manufacturer.

  If you purchase your supplements from an unlicensed practitioner or elsewhere, I cannot accept responsibility for the quality of the product, if it is black market, counterfeit, expired, any interactions or problems you may experience, your results (or lack of results), or for making any future adjustments in your protocol. *Thank you for understanding*.

- If you need to reschedule your appointment, a 24-hour cancellation notice is greatly appreciated.

PLEASE INITIAL: _____

Signature Date