

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	

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☎: 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

58

- | | | |
|---|----------------------------------|---|
| 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 |
| 4. 0 1 2 3 Carbonated beverages | 10. 0 1 2 3 Fried foods | 17. 0 1 2 3 Water, distilled |
| 5. 0 1 2 3 Chewing tobacco | 11. 0 1 2 3 Luncheon meats | 18. 0 1 2 3 Water, tap |
| 6. 0 1 2 3 Cigarettes | 12. 0 1 2 3 Margarine | 19. 0 1 2 3 Water, well |
| | 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

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

PART II (See key at bottom of page)

Section 1 – Upper Gastrointestinal System

55

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|---|--|
| 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 |
| 56. 0 1 2 3 Bad breath (halitosis) | 65. 0 1 2 3 Anemia unresponsive to iron |
| 57. 0 1 2 3 Loss of taste for meat | 66. 0 1 2 3 Stomach pains or cramps |
| 58. 0 1 2 3 Sweat has a strong odor | 67. 0 1 2 3 Diarrhea, chronic |
| 59. 0 1 2 3 Stomach upset by taking vitamins | 68. 0 1 2 3 Diarrhea shortly after meals |
| 60. 0 1 2 3 Sense of excess fullness after meals | 69. 0 1 2 3 Black or tarry colored stools |
| | 70. 0 1 2 3 Undigested food in stool |

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

Section 2 – Liver and Gallbladder

68

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|---|--|
| <p>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)</p> | <p>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</p> |
|---|--|

Section 3 – Small Intestine

47

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|--|--|
| <p>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</p> | <p>108. 0 1 2 3 Crohn's disease (0 =no, 1=yes in the past, 2=current 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</p> |
|--|--|

Section 4 – Large Intestine

58

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|--|---|
| <p>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</p> | <p>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</p> |
|--|---|

Section 5 – Mineral Needs

75

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| <p>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</p> | <p>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</p> |
|--|--|

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)
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Section 6 – Essential Fatty Acids

22

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

Section 7 – Sugar Handling

39

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

Section 8 – Vitamin Need

81

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

Section 9 – Adrenal

78

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

Section 10 – Pituitary

29

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|------|---------|---|------|---------|---|
| 239. | 0 1 | Height over 6' 6" (0=no, 1=yes) | 245. | 0 1 | Height under 4' 10" (0=no, 1=yes) |
| 240. | 0 1 | Early sexual development (before age 10) (0=no, 1=yes) | 246. | 0 1 2 3 | Decreased libido |
| 241. | 0 1 2 3 | Increased libido | 247. | 0 1 2 3 | Excessive thirst |
| 242. | 0 1 2 3 | Splitting type headache | 248. | 0 1 2 3 | Weight gain around hips or waist |
| 243. | 0 1 2 3 | Memory failing | 249. | 0 1 2 3 | Menstrual disorders |
| 244. | 0 1 | Tolerate sugar, feel fine when eating sugar (0=no, 1=yes) | 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	2=Moderate symptom, occurs occasionally (weekly)
1=Yes, minor or mild symptom, rarely occurs (monthly)	3=Severe symptom, occurs frequently (daily)

Section 11 – Thyroid

48

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

Section 12 – Men Only

27

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

Section 13 – Women Only

60

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

Section 14 – Cardiovascular

30

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

Section 15 – Kidney and Bladder

13

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

Section 16 – Immune system

30

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|------|---------|---|------|---------|--|
| 312. | 0 1 2 3 | Runny or drippy nose | 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) |
| 313. | 0 1 2 3 | Catch colds at the beginning of winter | 318. | 0 1 2 3 | Acne (adult) |
| 314. | 0 1 2 3 | Mucus producing cough | 319. | 0 1 2 3 | Itchy skin (Dermatitis) |
| 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) | 320. | 0 1 2 3 | Cysts, boils, rashes |
| 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) | 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	2=Moderate symptom, occurs occasionally (weekly)
1=Yes, minor or mild symptom, rarely occurs (monthly)	3=Severe symptom, occurs frequently (daily)

CANDIDA/YEAST/FUNGAL INFECTION QUESTIONNAIRE

Section One-History	Point Score	Section Two-Major Symptoms	Point Score
1. Have you taken tetracycline or other antibiotics for acne for one month or longer?	25	For each of your symptoms, enter the Appropriate figure in the Point Score column.	
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	Symptom is occasional or mild	Score 3 points
3. Have you ever taken a broad-Spectrum antibiotic (even a single course)?	6	Symptom is frequent and/or moderately severe	Score 6 points
4. Have you at anytime in your life been bothered by persistent prostatitis, vaginitis, or other problems affecting your reproductive organs?	25	Symptom is severe and/or disabling	Score 9 points
5. Have you been pregnant....		1. Fatigue or lethargy	_____
One time?	3	2. Feeling of being doomed	_____
Two or more times?	5	3. Poor memory	_____
6. Have you taken birth control pills...		4. Feeling "spacey" or "unreal"	_____
For six month to two years?	8	5. Depression	_____
For more than two years?	15	6. Numbness, burning, or tingling	_____
7. Have you taken prednisone or other Cortisone type drugs.....		7. Muscle aches	_____
For two weeks or less?	6	8. Muscle weakness or paralysis	_____
For more than two weeks?	15	9. Pain and/or swelling in joints	_____
8. Does exposure to perfumes, insecticides, Fabric shop odors, and other chemicals Provoke...		10. Abdominal pain	_____
Mild symptoms?	5	11. Constipation	_____
Moderate to severe symptoms?	20	12. Diarrhea	_____
9. Are your symptoms worse on damp, Muggy days or moldy places?	20	13. Bloating	_____
10. Have you ever had athlete's foot, Ringworm, "jock itch", or other chronic Infections of the skin or nails?		14. Persistent vaginal itch	_____
Mild to moderate?	10	15. Persistent vaginal burning	_____
Severe or persistent?	20	16. Prostatitis	_____
11. Do you crave sugar?	10	17. Impotence	_____
12. Do you crave breads?	10	18. Loss of sexual desire	_____
13. Do you crave alcoholic beverages?	10	19. Endometriosis	_____
14. Does tobacco smoke bother you?	10	20. Premenstrual tension	_____
		21. Cramping and other menstrual irregularities	_____
		22. Spots in front of eyes	_____
		23. Erratic vision	_____
TOTAL SCORE FOR THIS SECTION _____		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. _____

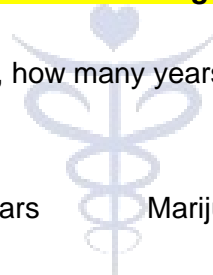
Do you currently experience or have you in the past experienced any of the following?

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

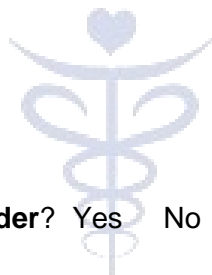
Lyme disease? Yes No Unknown

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

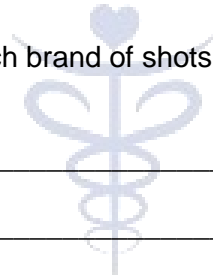
Shingles Pneumonia HPV Covid booster shots

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 _____ | | | |

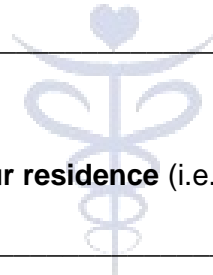
Body piercings (other than ears)

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

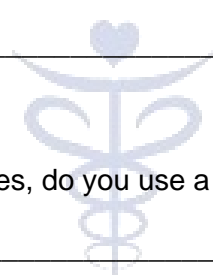
If yes, how often? _____

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 |

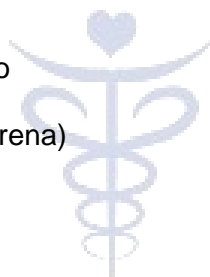
Oral Contraceptives (birth control pills) currently or in the past? Yes No

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

Gynecomastia (man boobs)

Frequent urination at night

Low libido or loss of sexual interest

Sleep apnea

Prostate cancer

Enlarged prostate

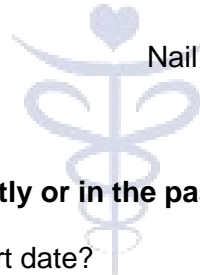
STDs

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
<i>Example: Metformin</i>	<i>Type 2 Diabetes</i>	<i>500 mg</i>	<i>2 per day</i>	<i>Jan 2012</i>
<i>Example: Synthroid</i>	<i>Thyroid</i>	<i>120 gm</i>	<i>1 in the AM</i>	<i>May 2015</i>

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
<i>Example: Magnesium Glycinate</i>	<i>Designs for Health</i>	<i>600 mg</i>	<i>1x at Bedtime</i>	<i>Since 2009</i>



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.)



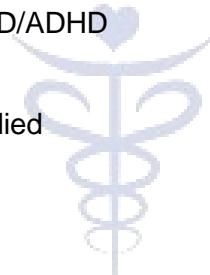
List any immunizations/vaccines given to you at birth through age 7

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? _____

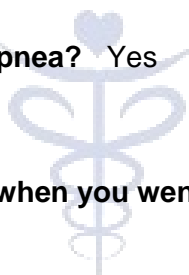
What time do you arise? _____

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

Exposed to chemicals at home or work

Do not exercise regularly

Experience unexplained aches and pain

Tired all the time

Worry over job, income, money

Stressful relationships

Use stimulants (meds, red bull drinks, other)

Libido is lower than you'd like

Feelings of isolation or loneliness

Chronic, excessive stress

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

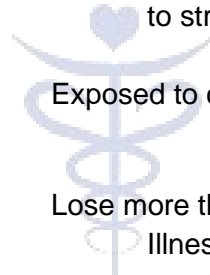
Exercise to exhaustion

Exposed to cigarette, cigar or marijuana smoke

Frequent upper respiratory infections

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

Experience memory problems



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

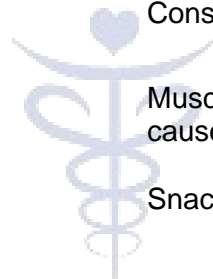
“Love” specific foods

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


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



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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

