



**PLEASE FILL OUT QUESTIONNAIRE IN INK
*DO NOT USE PENCIL***

This medical history questionnaire is uniquely designed to uncover the many and varied facets of your illness. In every case of chronic illness, which we prefer to think of as sustained illness, we seek to discover the multiple factors that come together to cause the illness rather than just prescribe medication to suppress the symptoms.

In many ways, this questionnaire will help us to function as Sherlock Holmes. Standard medicine is like Scotland Yard and for most cases this is adequate. Special cases, like yours, may require more in-depth and personalized detective work. The Sherlock Questionnaire is a tool to help you and our team uncover multiple factors, which may be influencing your sense of well being. You will notice that some questions are asked more than once; this is because each form has a helpful purpose.

Because we are interested in the detail others may have missed, please include even minor symptoms in your responses. We are interested in any message you are getting from your body, even though it may be considered irrelevant to “making a diagnosis.” All symptoms are useful clues in the kind of medical detective work we do. **WE ARE VERY INTERESTED IN SERVING IN WAYS SO YOU CAN REGAIN YOUR HEALTH. THE MORE INFORMATION YOU PROVIDE THE BETTER WE SHALL BE ABLE TO BE OF HELP.**

We look forward to seeing you soon.

3100 N. Hillside Avenue *Wichita, KS 67219 USA* (316) 682-3100* (316) 682-8357

PATIENT INFORMATION

Date _____

Name _____
(last) (first) (middle)

By what name do you like to be called? Mr. Mrs. Ms. _____

Date of Birth ____/____/____ Birthplace _____ Sex _____
(month) (day) (year)

Street Address _____
(number) (street name) (city) (state) (zip code)

Social Security Number ____ - ____ - ____

Person Responsible for Payment _____

Address _____ Phone _____

Signature _____ Date _____

WE DO NOT SUBMIT INSURANCE BUT WE WILL PROVIDE YOU WITH THE NECESSARY INFORMATION TO SUBMIT YOUR OWN FORMS.

Home Phone (____) _____ - _____ Business Phone (____) _____ - _____

FAX (____) _____ - _____ E-mail _____ @ _____

Employed by _____ Occupation _____

Employer's Address _____

In Emergency Notify _____ Phone (____) _____ - _____

Education: Years in High School _____ Years in College _____ Years Post Grad _____

Single: Yes ___ No ___ Married: Yes ___ No ___ How many times? _____

Widow (er): Yes ___ No ___ Divorced: Yes ___ No ___ How many times? _____

Weight: Current _____ One year ago _____ Maximum weight _____ When? _____

Date of last physical exam _____

Referred by: ___ Physician referral (name) _____ ___ Tours
___ Friend or family ___ Patient of the Clinic ___ TV, Radio, Newspaper Ad
___ Yellow pages ___ Other (please list) _____

Please check the color that best describes your eyes:

Blue Brown Green Grey Hazel

Please check the color that best describes your hair:

Brown Black Blonde Red White Grey Bald

Please check which best describes your handedness:

Right-handed Left-handed Ambidextrous

Please check the body type that best describes yours:

Ectomorph Endomorph Mesomorph
(slim, rangy body type) (rounder, plumper body type) (thicker, muscular body type)

I have access to a video tape/ dvd player Yes ___ No ___
I have access to an audio cassette/ cd player Yes ___ No ___

Name: _____ Appointment Date: _____

Please rank your most troubling symptoms by level of concern to you.

PROBLEM	ONSET	FREQUENCY	SEVERITY
1 _____	_____	_____	_____
2 _____	_____	_____	_____
3 _____	_____	_____	_____
4 _____	_____	_____	_____
5 _____	_____	_____	_____
6 _____	_____	_____	_____
7 _____	_____	_____	_____
8 _____	_____	_____	_____
9 _____	_____	_____	_____
10 _____	_____	_____	_____
11 _____	_____	_____	_____
12 _____	_____	_____	_____

What diagnoses or explanations have been given in the past?

Patient Name _____

Please circle the following: Taking everything into consideration, are you:

much worse / worse / the same / better / much better / Than six months ago?

How much have you spent personally on medical treatment in the past 5 years? _____

How much has your insurance company spent on your medical treatment in the past 5 years? _____

What has happened to you as a consequence of your illness?

What has happened to your family as a consequence of your illness?

What is the relationship between what is happening in your life now and what was happening about a year ago?

How will you know you are better as the result of learning new strategies at Riordan Clinic?

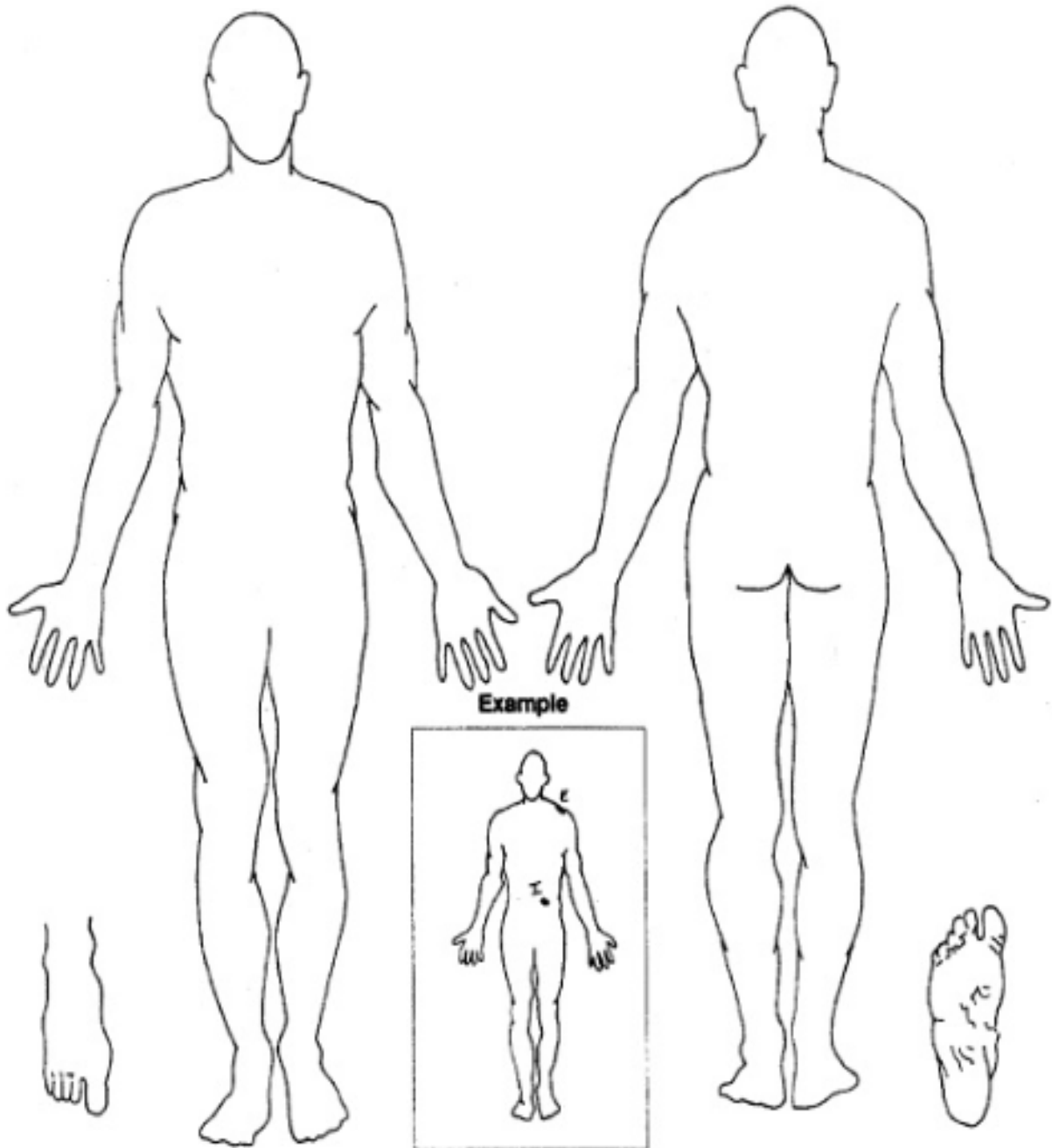
Patient Name _____

<p>OPERATIONS:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; text-align: center;"><u>When</u></td> <td style="width: 50%; text-align: center;"><u>When</u></td> </tr> <tr> <td>Tonsillectomy _____</td> <td>Appendectomy _____</td> </tr> <tr> <td>Hysterectomy _____</td> <td>Hernia _____</td> </tr> <tr> <td>Gall Bladder _____</td> <td>P.E. Tubes in ears _____</td> </tr> <tr> <td>1st Dental Filling _____</td> <td>1st Root Canal _____</td> </tr> <tr> <td>Other Surgeries _____</td> <td>_____</td> </tr> </table>	<u>When</u>	<u>When</u>	Tonsillectomy _____	Appendectomy _____	Hysterectomy _____	Hernia _____	Gall Bladder _____	P.E. Tubes in ears _____	1 st Dental Filling _____	1 st Root Canal _____	Other Surgeries _____	_____	<p>DIAGNOSTIC STUDIES:</p> <p>Date when have you had a(n) :</p> <p>Chest X-ray _____</p> <p>Mammogram _____</p> <p>EKG _____</p> <p>Sigmoidoscopy _____</p> <p>Colonoscopy _____</p> <p>Upper GI Series _____</p> <p>Barium Enema _____</p> <p>Neck X-ray _____</p> <p>MRI Scan of:</p> <p>Brain _____</p> <p>Abdomen _____</p> <p>Spine _____</p> <p>Liver Scan _____</p> <p>Bone Scan _____</p>
<u>When</u>	<u>When</u>												
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<u>When</u>	<u>When</u>												
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Flu _____	_____												

Patient Name _____

PAIN PROFILE

Please mark, in the drawing below, the areas where you have felt pain in the last month.
Put **E** for **external** (or *superficial*) pain or **I** for **internal** (or *deep*) pain near the area that you mark.
Put **EI** if **both** (*superficial and deep*) pain have been experienced. (See **Example**).



Patient Name _____

MEDICATIONS:

How many times and at what ages have you taken:

	Infancy	Childhood	Teen	Adulthood
Antibiotics	_____	_____	_____	_____
Steroids	_____	_____	_____	_____

What medications are you taking now? Include non-prescription drugs.

	Date started	Date Stopped*	Dosage	# per day
Aspirin	_____	_____	_____	_____
Antihistamine	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

VITAMINS, MINERALS AND OTHER NUTRITIONAL SUPPLEMENTS:

List all vitamins, minerals, and other nutritional supplements. Indicate the mg or IU's and the form (e.g. calcium carbonate vs calcium lactate) when possible.

	Date started	Date Stopped*	Dosage	# per day
Multivit./Mineral	_____	_____	_____	_____
High potency	_____	_____	_____	_____
Multivit./Mineral	_____	_____	_____	_____
Vitamin C	_____	_____	_____	_____
Vitamin E	_____	_____	_____	_____
Anti-oxidant	_____	_____	_____	_____
Calcium	_____	_____	_____	_____
Magnesium	_____	_____	_____	_____
Garlic	_____	_____	_____	_____
Lecithin	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

* If you are still taking the supplement, leave this space blank.

Patient Name _____

FAMILY HISTORY

Please complete the following information as it relates to your family's health history.									
	If Living		If Deceased			If Living		If Deceased	
	Age	Health	Age at Death	Cause		Age	Health	Age at Death	Cause
Father					Husband or Wife				
Mother					Son				
Brother					Daughter				
Sister	1.				1.				
	2.				2.				
	3.				3.				
					4.				

Place an "X" in the appropriate column for any illnesses that your blood relatives have experienced. Take your time filling out this questionnaire and feel free to discuss these items with your family members.

ILLNESSES	Father	Mother	Brothers or Sisters	Grand-parents	Children	ILLNESSES	Father	Mother	Brothers Or Sisters	Grand-parents	Children
Alcoholism						Undiagnosed Chronic Illness					
Allergies						Jaundice					
Anemia						Kidney or bladder problems					
Appendicitis						Meningitis					
Arthritis/Rheumatism						Menstrual Problems					
Asthma						Mental Illness					
Bleeding						Miscarriage or Spontaneous Abortion					
Blood pressure- High						Neuritis or Neuralgia					
Blood pressure- Low						Obesity					
Bronchitis- Chronic						Pleurisy					
Bursitis, Sciatica, Lumbago						Pneumonia					
Cancer						Polio					
Cholesterol- High						Prostate Problems					
Cirrhosis						Rheumatic Fever					
Colon problem						Skin Problems					
Physical Abnormalities /Birth Defects						Stroke					
Convulsions						Stomach or Small Intestinal Disease					
Depression						Suicide- Attempt or Successful					
Diabetes						Surgeries					
Emphysema						Teeth/Gum problems					
Gall Bladder Disease						Transfusions					
Headache						Triglycerides - Too High					
Heart Problem						Tuberculosis					
Hepatitis						Ulcers					
Hernia						Vaginal Problems					
Hemorrhoids						Varicose Veins					
Hypoglycemia						Veneral Disease					

Patient Name _____

CURRENT SYMPTOM PROFILE

Please circle the dot that best approximates how you've been feeling for the past month on each symptom listed below.
Use margins for comments.

	Health	←-----→	Dis-ease				
1. Energetic	•	•	•	•	•	•	Fatigued
2. Headache-free	•	•	•	•	•	•	Headaches
3. Migraine-free	•	•	•	•	•	•	Migraines
4. Anger-free	•	•	•	•	•	•	Angry often
5. No fluid retention	•	•	•	•	•	•	Fluid retention
6. Calm	•	•	•	•	•	•	Anxious
7. Confident	•	•	•	•	•	•	Panicky
8. Healthy hair	•	•	•	•	•	•	Hair loss
9. Depression-free	•	•	•	•	•	•	Depressed
10. Good memory	•	•	•	•	•	•	Poor memory
11. Good concentration	•	•	•	•	•	•	Can't concentrate
12. Sexual functions OK	•	•	•	•	•	•	Sexual dysfunction
13. Healthy nails	•	•	•	•	•	•	Nail abnormalities
14. Strong motivation	•	•	•	•	•	•	Low motivation
15. BM 1to 3 times/day	•	•	•	•	•	•	Constipation
16. Healthy bowels	•	•	•	•	•	•	Bowel spasms/diarrhea
17. Healthy weight	•	•	•	•	•	•	Overweight
18. Healthy skin	•	•	•	•	•	•	Dry skin
19. Good sleep	•	•	•	•	•	•	Insomnia
20. Daytime alertness	•	•	•	•	•	•	Daytime drowsiness
21. Healthy joints	•	•	•	•	•	•	Joint dysfunction

Patient Name _____

	Health	←-----→	Dis-ease					
22. Allergy-free	•	•	•	•	•	•	•	Allergies
23. Breath freely	•	•	•	•	•	•	•	Wheezing
24. Adequate breath	•	•	•	•	•	•	•	Short of breath
25. Good muscle tone	•	•	•	•	•	•	•	Muscle spasms
26. Itch-free	•	•	•	•	•	•	•	Itchiness
27. Normal cholesterol	•	•	•	•	•	•	•	High cholesterol
28. Strong stomach	•	•	•	•	•	•	•	Gastric pains
29. Nicotine-free	•	•	•	•	•	•	•	Nicotine user
30. Caffeine-free	•	•	•	•	•	•	•	Caffeine user
31. Healthy throat	•	•	•	•	•	•	•	Sore throat
32. Normal sweat	•	•	•	•	•	•	•	Too much or too little sweat
33. Normal body odor	•	•	•	•	•	•	•	Offensive body odor
34. Tolerate cold well	•	•	•	•	•	•	•	Cold intolerant
35. Blood pressure OK	•	•	•	•	•	•	•	Blood pressure high
36. Resistant to colds	•	•	•	•	•	•	•	Over 4 colds a year
37. Normal urination	•	•	•	•	•	•	•	Urination difficulty
38. Normal balance	•	•	•	•	•	•	•	Dizzy, imbalanced
39. No ringing in ears	•	•	•	•	•	•	•	Ringing in ears
40. Heal quickly	•	•	•	•	•	•	•	Heal slowly
41. Rarely bruise	•	•	•	•	•	•	•	Bruise easily
42. Stable body heat	•	•	•	•	•	•	•	Hot flashes/flushing
43. Warm hands/feet	•	•	•	•	•	•	•	Cold hands/feet
44. Skin is clear	•	•	•	•	•	•	•	Rashes, acne

Patient Name _____

	Health	←-----→	Dis-ease					
45. Swallow easily	•	•	•	•	•	•	•	Difficulty swallowing
46. Good skin color	•	•	•	•	•	•	•	Pale, poor color
47. Alert after eating	•	•	•	•	•	•	•	Drowsy after eating
48. Clear vision	•	•	•	•	•	•	•	Poor vision
49. See well at night	•	•	•	•	•	•	•	Poor night vision
50. No hives	•	•	•	•	•	•	•	Hives
51. Fresh breath	•	•	•	•	•	•	•	Bad breath
52. Regular heartbeat	•	•	•	•	•	•	•	Irregularities
53. Dream recall	•	•	•	•	•	•	•	No dream recall
54. Healthy mouth	•	•	•	•	•	•	•	Mouth/lip sores
55. Digest well	•	•	•	•	•	•	•	Indigestion, bloating
56. Normal sensations	•	•	•	•	•	•	•	Numbness or burning
57. Sinuses clear	•	•	•	•	•	•	•	Sinus Congestion
58. Healthy tongue	•	•	•	•	•	•	•	Sore tongue
59. Hands are steady	•	•	•	•	•	•	•	Shakiness, tremor
60. Feel strong	•	•	•	•	•	•	•	Weakness
61. Normal nails	•	•	•	•	•	•	•	White spots on nails
62. Healthy jaws	•	•	•	•	•	•	•	Jaw pain
63. Healthy back	•	•	•	•	•	•	•	Back pain
64. Normal thirst	•	•	•	•	•	•	•	Excessive thirst
65. Healthy gums	•	•	•	•	•	•	•	Bleeding, sore gums
66. Normal teeth	•	•	•	•	•	•	•	Loose teeth
67. Eyes comfortable	•	•	•	•	•	•	•	Eyes dry, irritated
68. Normal taste/smell	•	•	•	•	•	•	•	Diminished taste/smell

Patient Name _____

	Health	←-----→	Dis-ease					
69. Legs relaxed	•	•	•	•	•	•	•	Restless legs
70. Bright lights OK	•	•	•	•	•	•	•	Bright lights bother
71. Normal voice	•	•	•	•	•	•	•	Hoarseness
72. Restful sleep	•	•	•	•	•	•	•	Wake up tired
73. Ache free muscles	•	•	•	•	•	•	•	Muscles ache
74. No craving for sugar	•	•	•	•	•	•	•	Often crave sugar
75. No craving for salt	•	•	•	•	•	•	•	Often crave salt
76. Normal appetite for bread	•	•	•	•	•	•	•	Often crave bread
77. No craving for chocolate	•	•	•	•	•	•	•	Often crave chocolate
78. No craving for coffee	•	•	•	•	•	•	•	Often crave coffee
79. No craving for alcohol	•	•	•	•	•	•	•	Often crave alcohol

For Females Only

80. Premenstrual OK	•	•	•	•	•	•	•	Premenstrual bad
81. Normal menstruation	•	•	•	•	•	•	•	Irregular/heavy flow
82. Normal breasts	•	•	•	•	•	•	•	Breast lumps, pain
83. Vaginal infection free	•	•	•	•	•	•	•	Vaginal infections

For Males Only

84. Normal erections	•	•	•	•	•	•	•	Erection problems
85. Prostate healthy	•	•	•	•	•	•	•	Prostate problems
86. No testicular problems	•	•	•	•	•	•	•	Testicular problems

Please add any important symptoms you have which have not been noted above. You may write them in the format used above if you wish.

Patient Name _____

CURRENT HEALTH BEHAVIORS PROFILE

Please circle the dot that best approximates how you've been doing on each of the following health producing behaviors.
Use margins for comments.

	Health ←-----→ Dis-ease	
1. Drink 8 glasses of water per day	• • • • • • •	Drink very little water per day
2. Rarely salt food	• • • • • • •	Salt food a lot
3. Read food labels	• • • • • • •	Never read food labels
4. Chew food thoroughly	• • • • • • •	Chew food very little
5. Use glass, enamel, or stainless cookware	• • • • • • •	Use aluminum cookware
6. Regular bedtime	• • • • • • •	Very irregular bedtime
7. Sleep 7 or 8 hours	• • • • • • •	Sleep a lot or little
8. Regular time to rise	• • • • • • •	Irregular rising time
9. Two or less alcohol drinks per day	• • • • • • •	More than two alcohol drinks a day
10. Never drive under alcohol influence	• • • • • • •	Drive after drinking alcohol
11. Choose whole foods	• • • • • • •	Eat mostly refined foods
12. Choose wide variety of foods	• • • • • • •	Eat same small group of foods
13. Drink only water or fruit juice	• • • • • • •	Drink many sweetened / caffeinated drinks
14. Never use refined sugar	• • • • • • •	Often add sugar
15. Walk regularly	• • • • • • •	Don't walk regularly
16. Climb stairs when possible	• • • • • • •	Avoid stairs
17. Breathe deeply and fully	• • • • • • •	Breathe shallowly
18. Daily stretching exercises	• • • • • • •	Seldom do stretching
19. Work on good posture	• • • • • • •	Seldom intentionally change posture

Patient Name _____

	Health	←-----→	Dis-ease					
20. Daily exposure to sunlight	•	•	•	•	•	•	•	Seldom outdoors
21. Satisfying job	•	•	•	•	•	•	•	Unsatisfying job
22. Satisfying marriage	•	•	•	•	•	•	•	Unsatisfying marriage
23. Cultivate good friendships	•	•	•	•	•	•	•	No good friends
24. Eat only whole foods	•	•	•	•	•	•	•	Eat many refined foods
25. Eat 2 raw vegetable salads per day	•	•	•	•	•	•	•	Eat no raw vegetables
26. Eat meals in harmonious atmosphere	•	•	•	•	•	•	•	Much stress during meals
27. Meditate or relaxation daily	•	•	•	•	•	•	•	Never stop to relax or meditate
28. Rarely watch TV	•	•	•	•	•	•	•	Spend hours every day watching TV
29. Cultivate personal hobbies or recreation	•	•	•	•	•	•	•	Have no hobby or regular recreation
30. Laugh several times a day	•	•	•	•	•	•	•	Seldom laugh
31. Compliment others regularly	•	•	•	•	•	•	•	Almost never compliment others
32. Listen to body signals	•	•	•	•	•	•	•	Try to ignore body signals
33. Stop eating when comfortably satisfied	•	•	•	•	•	•	•	Consistently overeat
34. Read health-related articles daily	•	•	•	•	•	•	•	Seldom read health related literature
35. Ask doctor questions when curious	•	•	•	•	•	•	•	Afraid to ask doctor questions when curious
36. Take time to evaluate and plan ahead	•	•	•	•	•	•	•	Rushed and seldom take time to plan ahead

List important health behaviors you have done recently which were omitted above:

Patient Name _____

DIAGNOSIS PROFILE

First: If you have ever been diagnosed with any of the items listed below, please indicate the approximate date the diagnosis was made. **Second:** If you are currently still having problems resulting from the disease diagnosed, please indicate how severe those difficulties are by circling the dot which best represents that severity.

Understanding the seven dot scale:

No problem	<input type="checkbox"/>	•	•	•	•	•	•
Moderate problem	•	•	<input type="checkbox"/>	•	•	•	•
Moderately severe problem	•	•	•	•	<input type="checkbox"/>	•	•
Severe problem	•	•	•	•	•	•	<input type="checkbox"/>

YEAR OF ONSET

CURRENT SEVERITY

None

Severe

_____ Achlorhydria	•	•	•	•	•	•	•
_____ Acne	•	•	•	•	•	•	•
_____ Alcoholism	•	•	•	•	•	•	•
_____ Alcoholism in Remission	•	•	•	•	•	•	•
_____ Allergy, Unknown Origin	•	•	•	•	•	•	•
_____ Alzheimer's	•	•	•	•	•	•	•
_____ Amebiasis	•	•	•	•	•	•	•
_____ Anemia, Iron Deficiency	•	•	•	•	•	•	•
_____ Anemia, General	•	•	•	•	•	•	•
_____ Angina	•	•	•	•	•	•	•
_____ Anxiety Disorder	•	•	•	•	•	•	•
_____ Arrhythmia	•	•	•	•	•	•	•
_____ Arteriosclerosis	•	•	•	•	•	•	•
_____ Arthritis	•	•	•	•	•	•	•
_____ Arthritis, Allergic	•	•	•	•	•	•	•
_____ Arthritis, Psoriatic	•	•	•	•	•	•	•
_____ Arthritis, Rheumatoid	•	•	•	•	•	•	•
_____ Asthma	•	•	•	•	•	•	•
_____ Back Pain	•	•	•	•	•	•	•

Patient Name _____

YEAR OF ONSET	CURRENT SEVERITY						
	None						Severe
_____ Blood Pressure-High	•	•	•	•	•	•	•
_____ Blood Pressure-Low	•	•	•	•	•	•	•
_____ Bronchitis	•	•	•	•	•	•	•
_____ Cancer, Breast	•	•	•	•	•	•	•
_____ Cancer, Bladder	•	•	•	•	•	•	•
_____ Cancer, Prostate	•	•	•	•	•	•	•
_____ Cancer, Cervix/Uterus	•	•	•	•	•	•	•
_____ Cancer, Lung	•	•	•	•	•	•	•
_____ Cancer, Skin	•	•	•	•	•	•	•
_____ Cancer, Other _____	•	•	•	•	•	•	•
_____ Carpal Tunnel Syndrome	•	•	•	•	•	•	•
_____ Chronic Fatigue Syndrome	•	•	•	•	•	•	•
_____ Cirrhosis	•	•	•	•	•	•	•
_____ Colitis	•	•	•	•	•	•	•
_____ Collagen Disease	•	•	•	•	•	•	•
_____ Conjunctivitis	•	•	•	•	•	•	•
_____ Cystitis	•	•	•	•	•	•	•
_____ Depression	•	•	•	•	•	•	•
_____ Diabetes	•	•	•	•	•	•	•
_____ Eczema	•	•	•	•	•	•	•
_____ Edema	•	•	•	•	•	•	•
_____ Fibromyalgia	•	•	•	•	•	•	•
_____ Fluid Retention	•	•	•	•	•	•	•
_____ Emphysema	•	•	•	•	•	•	•
_____ Endometriosis	•	•	•	•	•	•	•
_____ Epilepsy	•	•	•	•	•	•	•
_____ Farsighted	•	•	•	•	•	•	•
_____ Food Allergy	•	•	•	•	•	•	•

Patient Name _____

YEAR OF ONSET	CURRENT SEVERITY						
	None						Severe
_____ Gall Bladder Disease	•	•	•	•	•	•	•
_____ Headache, Migraine	•	•	•	•	•	•	•
_____ Headache, Tension	•	•	•	•	•	•	•
_____ Heart Disease	•	•	•	•	•	•	•
_____ Heavy Metal Poisoning	•	•	•	•	•	•	•
_____ Hepatitis	•	•	•	•	•	•	•
_____ Hypercholesterolemia	•	•	•	•	•	•	•
_____ Hypothyroid	•	•	•	•	•	•	•
_____ Hypochlorhydria	•	•	•	•	•	•	•
_____ Hypoglycemia	•	•	•	•	•	•	•
_____ Intestinal Candidiasis	•	•	•	•	•	•	•
_____ Intestinal Malabsorption	•	•	•	•	•	•	•
_____ Intestinal Parasites	•	•	•	•	•	•	•
_____ Irritable Bowel Syndrome	•	•	•	•	•	•	•
_____ Lead Poisoning	•	•	•	•	•	•	•
_____ Lumbar Sprain	•	•	•	•	•	•	•
_____ Lupus	•	•	•	•	•	•	•
_____ Manic Depressive	•	•	•	•	•	•	•
_____ Mitral Valve Prolapse	•	•	•	•	•	•	•
_____ Multiple Sclerosis	•	•	•	•	•	•	•
_____ Myositis	•	•	•	•	•	•	•
_____ Nearsightedness	•	•	•	•	•	•	•
_____ Nervousness	•	•	•	•	•	•	•
_____ Obesity	•	•	•	•	•	•	•
_____ Osteoarthritis	•	•	•	•	•	•	•
_____ Panic Attacks	•	•	•	•	•	•	•

Patient Name _____

YEAR OF ONSET	CURRENT SEVERITY						
	None						Severe
_____ Parasitic Disease NEC	•	•	•	•	•	•	•
_____ Phlebitis	•	•	•	•	•	•	•
_____ Pneumonia	•	•	•	•	•	•	•
_____ Premenstrual Syndrome	•	•	•	•	•	•	•
_____ Prostatitis	•	•	•	•	•	•	•
_____ Rash, Unspecified	•	•	•	•	•	•	•
_____ Scurvy	•	•	•	•	•	•	•
_____ Seizure Disorder w/convulsions	•	•	•	•	•	•	•
_____ Senile Dementia	•	•	•	•	•	•	•
_____ Sinusitis	•	•	•	•	•	•	•
_____ Sjogren's Disease	•	•	•	•	•	•	•
_____ Tachycardia	•	•	•	•	•	•	•
_____ Tenosynovitis	•	•	•	•	•	•	•
_____ Thyroid Disease Unspecified	•	•	•	•	•	•	•
_____ Tinnitus	•	•	•	•	•	•	•
_____ Tonsillitis	•	•	•	•	•	•	•
_____ Ulcer, Bleeding, Chronic	•	•	•	•	•	•	•
_____ Urinary Tract Infection	•	•	•	•	•	•	•
_____ Vasomotor Rhinitis	•	•	•	•	•	•	•
_____ Vertigo	•	•	•	•	•	•	•
_____ Viral Infection, Unspecified	•	•	•	•	•	•	•
_____ Vitiligo	•	•	•	•	•	•	•
_____ Weakness, General	•	•	•	•	•	•	•
_____ Weight Gain, Abnormal	•	•	•	•	•	•	•
_____ Wheezing Respiration	•	•	•	•	•	•	•

Diagnoses (*write in*):

3 Day Diet Diary / Exercise Log

Provide Info For: 2 weekdays + 1 weekend day

Name _____

Please complete your “Diet Diary / Exercise Log” every day.

1. Make note of the time you wake up.

2. List and describe in detail all foods and drinks including the amount of each.
 Make note as to whether the food was fresh, frozen, canned, raw, cooked, baked, fried, etc. Note the time of each meal or snack. Be sure to list everything you eat or drink, including any condiments used (i.e. mayonnaise, mustard, relish, etc.).

3. Keep track of how much water you drink and list the amount in ounces in the section provided. Also note the type and amount of any other drinks you consume.

4. Write down any activity or exercise you do in the section at the bottom, listing the kind of exercise you did and for how long you did it.

5. Note any periods of relaxation and what kind of relaxation it was.

6. Note the time you go to sleep.

Day 1	Date:
Wake up:	
Morning Meal	
Time:	
Snack	
Time:	
Mid-Day Meal	
Time:	
Snack	
Time:	
Evening Meal	
Time:	
Snack	
Time:	
Water (ounces)	
Other Drinks (that are not listed with meals or snacks above)	
Activity/Exercise	
What kind:	
How long:	
Relaxation type:	
How long:	
Sleep time:	

Patient Name _____

3 Day Diet Diary / Exercise Log
Provide Info For: 2 weekdays + 1 weekend day

	Day 2 - Date:	Day 3 - Date:
Wake up:		
Morning Meal Time:		
Snack Time:		
Mid-Day Meal Time:		
Snack Time:		
Evening Meal Time:		
Snack Time:		
Water (ounces)		
Other Drinks (that are not listed with meals or snacks above)		
Activity/Exercise What kind: How long:		
Relaxation type: How long:		
Sleep time:		