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Leaves of the Tree Health Education Foundation

Dear Prospective Client,

Should you decide to proceed I look forward to working with you. Read the enclosed Information for New Clients carefully before making your decision to work with me. After reading please call if you have questions. All appointments are by phone with follow-up by phone, email, and fax if needed. If you are uncomfortable with this please call and discuss it with me. Charges and payments are explained on the Information for New Clients sheet.

The most important component allowing me to provide you with the information, education, and support you need is your full and detailed reporting of lifestyle, symptoms, conditions, past treatments and outcomes, including a complete medical/health history, current food diary, and a list of current medications and supplements. Following up, asking questions, and providing detailed updates of outcomes is key to your success in discovering and utilizing what works for you. Understand that your initial program is unlikely to be your final maintenance program. Be ready to commit to learning and working until you get the answers you need.

RETURN BY FAX or TAKE A CLEAR PICTURE WITH YOUR PHONE, EACH PAGE, AND SEND TO 775.224.6456

1. The enclosed Client Profile form, both sides and four page questionnaire.
2. A list of all supplements and medications. List how many you take each day. Form is enclosed.
3. A complete health history. Include all of your current concerns, questions, etc. Ask questions. Detail complaints. The more information you provide the better I can serve you. Even if others have told you 'it doesn't mean anything' or 'it's not important' I want to know.
4. A diet diary with 4 typical days of food and drink intake. Include water consumption as well as foods and other liquids, approximate amounts and include the time of consumption. This will allow us to design a program that is comfortable for you. If you have different patterns of food intake, such as weekdays and weekends or home and traveling, give several days of each.
5. The three forms, Under-Methylation; Over-Methylation and Pyroluria. For most scores will be within normal range but for some these forms will uncover hidden causes of ill health.

Required tests:

1. Fasting glucose
2. Fasting Insulin
3. Ferritin
4. Vitamin D 25(OH)D
5. CBC, Chem 27, platelets
6. OmegaQuant Omega-3 Index Plus Test https://omegaquant.com/omega-3-index-plus/

To order your own testing (blood draw at any local LabCorp) call Life Extension http://lef.org and request the Healthy Aging Basic test which contains all of the required tests. The cost is $149 (or less in spring when the have their yearly sale) paid at time of ordering. Their phone order number is 1-800-544-4440 (not available to residents of New York State, however they may suggest an alternative) For fastest response **request the requisition and results be emailed to you** to save time. Sent by mail it will take a long time to get your results. Forward the results to me. The OmegaQuant test is separate. If you order the Life Extension Healthy Aging Basic you will still need to get the Omega-3 Index Plus from OmegaQuant.

OR have your physician order the tests. Some of the required tests may not be covered by your insurance. If true the out-of-pocket *cost may be large so consider the Life Extension panel. Forward these results or if with Kaiser or other health organizations that put your data online allow me access to your results when ready.*

Optional tests: SEND or have your physician email or fax recent blood work or bone scans (within the last 6 months): Chem 27, CBC and platelets. Any tests relating to your concerns/goals should be included. ***Blood tests, other than those listed are not required unless you currently have a diagnosed medical condition.***

REGARDING INSURANCE PLEASE READ: I am not a physician. Insurance rarely reimburses for nutritional programs. Do not expect it. I do not bill insurance companies. Services are to be paid when invoiced.

After sending your information if you do not hear from me within 10 days please call. Your file may have been misplaced (*researchers' buried desk syndrome)* or may have gotten lost in the mail or cyberspace.

Information for New Clients

Please read carefully. It explains what to expect and what you need to send.

WHAT TO EXPECT-- During your first phone appointment we will review your forms, medical information, personal history and special goals. You will be sent a food and supplement plan that will be explained to you during a follow-up phone consult. You will receive a written program, a Practical Nutrition Workbook, and other written information. I am a nutrition educator. You are making an investment in your future. Ask questions. If you do, you will find long-term answers. This information will enable you to take the best possible care of your health.

WHAT TO SEND -- your forms; a four day food diary; a list of your questions; **medical information** including blood tests; a complete **list of supplements** with dose information, those you use *and a separate list of those you have on hand but do not use*; a complete **list of medications** with dose information; any other information you think may be important.

WHAT ABOUT CHARGES? -- Phone/Mail/E-mail Consultations and follow-up support are billed at $150 per hour for actual time used. All consultation and program support billing will include charges for the time it takes to research and write your program in addition to online or phone time. Clients will be invoiced following the consult. **Invoices are due when received. There is no grace period. Please keep your account current.** Phone follow-up time is recorded and an invoice/statement sent due on receipt.

There is consideration for seniors or persons in need. Fill out and return the information along with a request for $$ consideration and I will call you to see what I can do.

WHAT ABOUT TOTAL COSTS? -- Your first consultation will take about one or two hours, on the phone plus program prep and send. You will be charged for 'actual time', your interview plus program preparation. Program support is provided as needed.

Chronic conditions will need more extended support time and will increase the total cost. Suggested supplements or special foods will add to your costs. Supplement costs vary. For some clients exceeding $100 a month for the first few months, longer if serious health issues are present.

I DO NOT SELL VITAMIN, MINERAL OR OTHER HEALTH SUPPLEMENTS.

TESTING--I use minimal testing as needed determined by your initial interview and questionnaire. Fees are paid to the labs. Tests worth the cost if deemed necessary may include:

Blood tests required of all clients: Recent (less than 6 months old) or request from your physician or order your own from http://lef.org. **Vitamin D 25-hydroxyvitamin-D**; **Ferritin; Fasting Insulin; Fasting Glucose; HgA1c.**

A **standard blood panel** with a **Chemistry 25/27, CBC, Platelet Count and Differential-** This test is similar to your yearly blood test. Cost: Varies with lab, paid by your insurance or by you to the lab. If you have believe you have an issue with thyroid add Free T3; Free T4; TSH and Reverse T3.

You will be expected to update and provide yearly blood work.

On a separate sheet write all the
"Questions I would like to ask about my health and nutrition"

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DATE: /

CLIENT PROFILE

PLEASE FILL OUT COMPLETELY, BOTH SIDES AND SIGN STATEMENT AT BOTTOM OF OTHER SIDE

NAME		MARITAL STATUS (CIRCLE ONE) S / M / D / W
ADDRESS		
CITY	STATE	ZIP
HOME PHONE:	EMAIL	
FAX / CELL PHONE (circle one):	BIRTHDATE:	AGE:
OCCUPATION:	CHILDREN#	AGES:

CHILDHOOD DISEASES/INJURIES/SURGURIES:

Were you abused or neglected?

CHILDHOOD MEDICATIONS:

ADULT DISEASES / ACCIDENTS / SURGERIES: (Women include detailed reproductive history including any pregnancy, miscarriage, abortion or menstrual cycle issues. Men include any sexual, urinary and prostate

ALLERGIES (include age of first occurrance):

ADULT MEDICATIONS PAST with doses and dates (all current medications should be listed on the sheet provided):

Continued on Other Side

CURRENT HEIGHT AND WEIGHT: HGT: WGT:

IDEAL WEIGHT:

WEIGHT HISTORY (if applicable) If long and detailed continue explanation under Major Concerns:

FAVORITE FOODS / CRAVINGS (to give me an idea of foods you like and re cravings to show what your body seeks out. Put all cravings, even for 'bad' things):

CURRENT MAJOR CONCERNS- These are your goals, the things you want to change. Use extra sheets if needed:

SUBSTANCE ABUSE-FOOD / DRUG / ALCOHOL HISTORY (if applicable):

FAMILIAL MEDICAL DISEASES (blood relatives only, parents, grandparents, aunts, uncles, and the like):

I understand that I am the primary person responsible for my health care. In all cases I must make the final decision about what is right for me. It is poss ble that Ms. Sullivan may deem it necessary for me to see a physician, my own or a referral, because of conditions I may report. I agree to follow-up with that advice. I understan that Krispin Sullivan is not a physician and does not diagnose disease nor does she treat disease with diet and supplements. Any program she may suggest for me is not in lieu of competent medical care. Nutrition supprots health. It may also enhance the positive effects and/or help reduce the negative side-effects of medically necessary treatment as prescr bed by a physician. I understand that my refusal to seek medical care, if and when deemed necessary, would make it imposs ble for Ms Sullivan to work with me.

SIGNATURE DATE

NAME:_____ DATE: _____

SUPPLEMENT AND MEDICATION LIST

Make sure to include a copy of the label of any multiple supplements. Include the dose per tablet and number of tablets taken at each time. Example- B-6 50 mg 1 tablet or thyroid 0.125 1 tablet or Inhaler 1 spray or My Favorite Multiple 2 tablets with breakfast and 2 tablets with dinner (include label on this). If medications are taken occasionally put them at the bottom or on the back. If you often miss a daily dose of medications or supplements please note that.

On arising:

With first meal:

With lunch:

With dinner:

Before bed:

Any other times and doses:

Health Appraisal Questionnaire

Name: _____ **Date:** _____

Part I
Circle any of the following medications you are taking:

- Antacids
- Antibiotics / Antifungals
- Antidepressants
- Antidiabetic / Insulin
- Aspirin / Tylenol
- Recreational Drugs
- Cortisone / Anti-inflammatories
- Heart Medications
- High Blood Pressure Medication
- Hormones
- Laxatives
- Lithium
- Ulcer Medication
- Radiation
- Chemotherapy
- Oral Contraceptives Specify Type _____
- Relaxants / Sleeping Pills
- Thyroid Medication
- Other _____

Circle if you eat, drink or use:

- Alcohol
- Candy
- Carbonated beverages
- Cigarettes
- Coffee
- Distilled water
- Fried foods
- Chew tobacco
- Luncheon meats
- Margarine
- Eat at fast food restaurants regularly
- Refined sugars
- Saccharine (Sweet and Low)
- Vitamins and / or minerals (Please List)

_____
_____
_____
_____

Circle if you:

- Diet often
- Do not exercise regularly
- Salt food without tasting
- Are under excessive stress
- Are exposed to chemicals at work
- Are exposed to cigarette smoke

INSTRUCTIONS: Circle the number which best describes the intensity of your symptoms. If you do not know the answer to a question, leave it blank.
0 = Symptom is not present **1 =** Mild **2 =** Moderate **3 =** Severe

Part II

SECTION A:

1. Burping	0	1	2	3
2. Fullness for extended time after meals	0	1	2	3
3. Bloating	0	1	2	3
4. Poor appe ite	0	1	2	3
5. Stomach upsets easily	0	1	2	3
6. History of cons ipation	0	1	2	3
7. Known food allergies	0	1	2	3

SECTION B:

1. Abdominal cramps	0	1	2	3
2. Indigestion 1-3 hours after eating	0	1	2	3
3. Fatigue after eating	0	1	2	3
4. Lower bowel gas (flatulence)	0	1	2	3
5. Alternating constipation and diarrhea	0	1	2	3
6. Diarrhea	0	1	2	3
7. Roughage and fiber causes constipation	0	1	2	3
8. Mucous in stools	0	1	2	3
9. Stool poorly formed	0	1	2	3
10. Shiny stool	0	1	2	3
11. Three or more large bowel movements daily	0	1	2	3
12. Foul smelling stool	0	1	2	3
13. Dry, flaky skin and / or dry brittle hair	0	1	2	3
14. Pain in left side under rib cage	0	1	2	3
15. Acne	0	1	2	3
16. Food allergies	0	1	2	3
17. Difficulty gaining weight	0	1	2	3

SECTION C:

1. Stomach pains	0	1	2	3
2. Stomach pains just before and / or after meals	0	1	2	3
3. Dependency on antacids	0	1	2	3
4. Chronic abdominal pain	0	1	2	3
5. Butterfly sensations in stomach	0	1	2	3
6. Difficulty belching	0	1	2	3
7. Stomach pain when emotionally upset	0	1	2	3
8. Sudden, acute indigestion	NO			YES
9. Relief of symptoms by carbonated beverages	NO			YES
10. Relief of stomach pain by drinking cream / milk	NO			YES
11. History of ulcer or gastritis	NO			YES
12. Current ulcer	NO			$YES_{(10)}$
13. Black stool when not taking iron supplements	NO			$YES_{(10)}$

SECTION D:

1. Seasonal diarrhea	0	1	2	3
2. Frequent and recurrent infections (colds)	0	1	2	3
3. Bladder and kidney infections	0	1	2	3
4. Vaginal yeast infection	0	1	2	3
5. Abdominal cramps	0	1	2	3
6. Toe and fingernail fungus	0	1	2	3
7. Alternating diarrhea / constipation	0	1	2	3
8. Constipation	0	1	2	3
9. History of antibiotic use	NO			YES
10. Meat eater	NO			YES
11. Rapidly failing vision	NO			YES

Part III

SECTION A:

1. Intolerance to greasy foods	0	1	2	3
2. Headaches after eating	0	1	2	3
3. Light coloured stool	0	1	2	3
4. Foul smelling stool	0	1	2	3
5. Less than one bowel movement daily	0	1	2	3
6. Constipation	0	1	2	3
7. Hard stool	0	1	2	3
8. Sour taste in mouth	0	1	2	3
9. Grey coloured skin	0	1	2	3
10. Yellow in whites of eyes	0	1	2	3
11. Bad breath	0	1	2	3
12. Body odor	0	1	2	3
13. Fatigue and sleepiness after eating	0	1	2	3
14. Pain in right side under rib cage	0	1	2	3
15. Painful to pass stool	0	1	2	3
16. Retain water	0	1	2	3
17. Big toe painful	0	1	2	3
18. Pain radiates along outside of leg	0	1	2	3
19. Dry skin / hair	0	1	2	3
20. Red blood in stool	NO			$YES_{(6)}$

Part III Section A (Continued)

21. Have had jaundice or hepatitis ..... NO UNKNOWN YES
22. High blood cholesterol and low HDL cholesterol ... NO UNKNOWN YES(10)
23. Is your cholesterol level above 200?..... NO UNKNOWN YES
24. Is your triglyceride level above 115 ?..... NO UNKNOWN YES

SECTION B:

1. Swollen eyes (bulging) 0 1 2 3
2. Strong smelling urine 0 1 2 3
3. Thick skin and finger nails 0 1 2 3
4. Dry skin 0 1 2 3
5. Sensitive to the cold 0 1 2 3
6. Cold hands and feet 0 1 2 3
7. Excessive menstrual bleeding 0 1 2 3
8. Chronic fatigue 0 1 2 3
9. Trouble waking up in the morning 0 1 2 3
10. Depressed, apathetic 0 1 2 3
11. Low sex drive 0 1 2 3
12. Puffy, wrinkly skin 0 1 2 3
13. Sugar causes irritability and mood swings 0 1 2 3
14. Premenstrual tension 0 1 2 3
15. Constipation 0 1 2 3
16. Thinning or loss of outside portion of eyebrow 0 1 2 3
17. Gain weight easily 0 1 2 3
18. Anemia unaffected by iron ..... NO YES
19. Axillary (armpit) temperature below 36.4ºC (97.6ºF) .. NO YES
20. Slow reflexes ..... NO YES
21. Infertility ..... NO YES

Part IV

SECTION A:

1. Sensitive to exhaust fumes, smoke, smog and / or petrochemicals 0 1 2 3
2. Periodic constipation 0 1 2 3
3. Cannot tolerate much exercise 0 1 2 3
4. Depression or rapid mood swings 0 1 2 3
5. Dark circles under he eyes 0 1 2 3
6. Dizziness upon standing 0 1 2 3
7. Lack of mental alertness 0 1 2 3
8. Catch colds easily when weather changes 0 1 2 3
9. Headaches 0 1 2 3
10. Difficulty breathing 0 1 2 3
11. Water retention 0 1 2 3
12. Eyes sensitive to bright light 0 1 2 3
13. Feel weak and shaky 0 1 2 3

SECTION B:

1. Inflamed or bleeding gums 0 1 2 3
2. Running nose 0 1 2 3
3. Get boils or styes 0 1 2 3
4. Nose bleeds 0 1 2 3
5. Loss of smell 0 1 2 3
6. Throat infections 0 1 2 3
7. Cold sores, fever blisters 0 1 2 3
8. Loss of taste 0 1 2 3
9. Poor wound healing 0 1 2 3
10. Hair falls out 0 1 2 3
11. Swollen lymph glands 0 1 2 3
12. Ear infections 0 1 2 3
13. Hair grows slowly 0 1 2 3
14. Slow to recover from cold or flu 0 1 2 3
15. Catch colds or flu easily 0 1 2 3
16. Bumpy skin on back of arms 0 1 2 3

SECTION C:

1. Itching of nose or eyes 0 1 2 3
2. Itching of roof of mouth or throat 0 1 2 3
3. Migraine headaches 0 1 2 3
4. Entire body aches, painful to touch 0 1 2 3
5. Swollen joints 0 1 2 3
6. Food sensitivity or allergy 0 1 2 3
7. Certain foods make you sick, depressed, jittery 0 1 2 3
8. Chronic pain 0 1 2 3
9. Painful stomach and / or intestine 0 1 2 3
10. Alternating constipation and diarrhea 0 1 2 3
11. Mucous in throat 0 1 2 3
12. Post nasal drip 0 1 2 3
13. Discharge from eyes 0 1 2 3
14. Watery eyes 0 1 2 3
15. Puffiness or dark circles under eyes 0 1 2 3
16. Ear discharge or ears stuffed up 0 1 2 3
17. Nasal congestion 0 1 2 3
18. Running nose 0 1 2 3
19. Breathe through mouth 0 1 2 3
20. Swollen tongue 0 1 2 3
21. Difficulty swallowing 0 1 2 3
22. Bedwetting 0 1 2 3
23. Hyperactivity 0 1 2 3
24. Chronic lung congestion 0 1 2 3
25. Use aspirin or Tylenol regularly 0 1 2 3
26. Wheezing 0 1 2 3
27. Skin rashes 0 1 2 3
28. Sneezing 0 1 2 3

Part V

SECTION A:

1. Difficulty brea hing at night 0 1 2 3
2. Chest pain while waking 0 1 2 3
3. Heaviness in legs 0 1 2 3
4. Calf muscles cramp while walking 0 1 2 3
5. Heart pounds easily 0 1 2 3
6. Feel jittery 0 1 2 3
7. Heart misses beats or has extra beats 0 1 2 3
8. Swelling of feet and ankles 0 1 2 3
9. Rapid beating heart 0 1 2 3
10. Heartburn after eating 0 1 2 3
11. Pain in left arm 0 1 2 3
12. Exhaust with minor exertion 0 1 2 3
13. Do you do aerobic exercise? ..... YES NO
14. Have you ever exercised regularly? ..... YES NO
15. Drink 5 or more cups of coffee daily ..... NO YES
16. Severe cough ..... NO YES
17. Has a doctor ever told you that you have heart trouble? ..... NO YES(6)

SECTION B:

1. Cold hands and feet 0 1 2 3
2. Slurred speech 0 1 2 3
3. Calf muscles cramps while walking 0 1 2 3
4. Headaches 0 1 2 3
5. Numbness 0 1 2 3
6. Poor concentration 0 1 2 3
7. Ringing in ears 0 1 2 3
8. Ear canal hair ..... NO YES
9. Tingling and / or burning in hands or feet ..... NO YES
10. Spider veins on nose and / or face ..... NO YES

SECTION C:

1. Pain when getting up in morning in back of head and neck 0 1 2 3
2. Dizziness 0 1 2 3
3. Ver igo 0 1 2 3
4. Blushing with no apparent cause 0 1 2 3
5. Is your blood pressure high? ..... NO YES(10)

Part VI

SECTION A:

1. Dizziness when standing suddenly 0 1 2 3
2. Loss of vision when standing suddenly 0 1 2 3
3. Crave sweets 0 1 2 3
4. Headaches relieved by eating sweets or alcohol .. 0 1 2 3
5. Feel shaky or jittery 0 1 2 3
6. Irritable if a meal is missed 0 1 2 3
7. Wake up in middle of night craving sweets 0 1 2 3
8. Feel tired or weak if a meal is missed 0 1 2 3
9. Heart palpitations after eating sweets 0 1 2 3
10. Need to drink coffee to get started 0 1 2 3
11. Impatient, moody, nervous 0 1 2 3
12. Feel tired 1 to 3 hours after eating 0 1 2 3
13. Poor memory 0 1 2 3
14. Feel faint 0 1 2 3
15. Poor concentration 0 1 2 3
16. Forgetful 0 1 2 3
17. Calmer after eating ..... NO YES

SECTION B:

1. Night sweats 0 1 2 3
2. Increased thirst 0 1 2 3
3. Lowered resistance to infection 0 1 2 3
4. Fatigue 0 1 2 3
5. Boils and leg sores 0 1 2 3
6. Lesions, cuts take a long time to heal 0 1 2 3
7. Overweight 0 1 2 3
8. Feel pick up from exercise 0 1 2 3
9. Failing eyesight 0 1 2 3
10. Crave sweets, but eating sweets does not relieve symptoms 0 1 2 3
11. Family history of diabetes ..... NO YES
12. Sugar in urine ..... NO YES

Part VII

1. Chest pain 0 1 2 3
2. Chronic cough 0 1 2 3
3. Difficulty breathing 0 1 2 3
4. Coughing up blood 0 1 2 3
5. Coughing up phlegm 0 1 2 3
6. Pain around ribs 0 1 2 3
7. Shortness of breath 0 1 2 3
8. Rattling mucous when you breathe 0 1 2 3
9. Sensitive to smog 0 1 2 3
10. Infections settle in lungs 0 1 2 3
11. Live or work around people who smoke 0 1 2 3
12. Bronchitis ..... NO $YES_{(10)}$
13. Exposed to chemicals and / or radiation ..... NO $YES_{(6)}$
14. Smoker ..... NO $YES_{(6)}$

Part VIII

1. Frequent urination 0 1 2 3
2. Frequent bladder infections 0 1 2 3
3. Rarely need to urinate 0 1 2 3
4. Urination when you cough or sneeze 0 1 2 3
5. Painful / burning when passing urine 0 1 2 3
6. Difficulty passing urine 0 1 2 3
7. Dripping after urination 0 1 2 3
8. Can't hold urine 0 1 2 3
9. Rose coloured (bloody) urine 0 1 2 3
10. Cloudy urine 0 1 2 3
11. Strong smelling urine 0 1 2 3
12. Back or leg pains associated with dripping after urination 0 1 2 3
13. History of kidney or bladder infec ions ..... NO YES
14. Have used antibiotics to control urinary tract infections ..... NO YES
    IF YES, when did you last use them? _____
    TREATMENT DURATION _____
15. Back pain in the kidney area 0 1 2 3
16. General water retention 0 1 2 3

MALES ONLY

Part IX

SECTION A:

1. Difficulty urinating 0 1 2 3
2. A sense of bladder fullness 0 1 2 3
3. Increased straining with smaller and smaller amounts of urine passed 0 1 2 3
4. Rose coloured (bloody) urine 0 1 2 3
5. Pain or burning while urinating 0 1 2 3
6. Wake up to urinate at night 0 1 2 3
7. Dripping after urination 0 1 2 3
8. Pain or fatigue in the legs or back 0 1 2 3
9. Lack of sex drive 0 1 2 3
10. Ejaculation causes pain 0 1 2 3

SECTION B:

1. Difficulty attaining and / or maintaining an erection 0 1 2 3
2. Low sexual drive 0 1 2 3
3. Premature ejaculation 0 1 2 3
4. Pain / coldness in genital area 0 1 2 3
5. Infertile ..... NO $YES_{(5)}$
6. Varicose veins on scrotum ..... NO YES
7. Low sperm count ..... NO $YES_{(5)}$

SECTION C:

1. Discharge from penis 0 1 2 3
2. Past or present rash on penis 0 1 2 3
3. Swollen genitals 0 1 2 3
4. Swelling in groin 0 1 2 3
5. Venereal disease (gonorrhea, syphilis, herpes, other) ..... NO $YES_{(9)}$

Have V.D. now?_____Had in past? _____

Part X

SECTION A: Circle if you experience any of these symptoms within approximately 2 weeks (ovulation) prior to menstruation. (Section A ONLY)

1. Monthly weight gain 0 1 2 3
2. Depression 0 1 2 3
3. Moodiness / irritability 0 1 2 3
4. Bloating and swelling 0 1 2 3
5. Nausea and / or vomiting 0 1 2 3
6. Suicidal feeling ..... NO $YES_{(10)}$
7. Anxiety 0 1 2 3
8. Leg cramps and tenderness 0 1 2 3
9. Asthma attacks ..... NO $YES_{(10)}$
10. Headaches 0 1 2 3
11. Easily distracted 0 1 2 3
12. Angry 0 1 2 3
13. Tender breasts 0 1 2 3
14. Low backache 0 1 2 3
15. Other _____

SECTION B:

1. Vaginal itching 0 1 2 3
2. Vaginal discharge 0 1 2 3
3. Low or no desire for sex 0 1 2 3
4. Dislike for intercourse 0 1 2 3
5. Missed periods ..... NO YES
6. Over 15 years of age and have not begun menstruation ..... NO YES

Part X Section B (Continued) **Females Only**

7. Unable to get pregnant ..... NO YES
8. Miscarriages ..... NO YES How many
9. Abortion ..... NO YES How many

SECTION C:

Check if you experience any of these symptoms during menstruation (Section C ONLY)

1. Low abdominal pain 0 1 2 3
2. Dull ache radiating to low back or legs 0 1 2 3
3. Increased urinary frequency 0 1 2 3
4. Pelvic soreness 0 1 2 3
5. Diarrhea 0 1 2 3
6. Headaches 0 1 2 3
7. Abdominal bloa ing 0 1 2 3
8. Menstrual pain 0 1 2 3
9. Nausea and / or vomiting 0 1 2 3
10. Have to lie down on first 1 or 2 days 0 1 2 3
11. Craving for sweets 0 1 2 3
12. Insomnia 0 1 2 3
13. Light scanty blood flow 0 1 2 3
14. Pain and cramps without blood flow 0 1 2 3
15. Heavy menstrual bleeding 0 1 2 3
16. Anxiety about menstrual cycle 0 1 2 3
17. Pain during period is progressively getting worse with time 0 1 2 3

SECTION D:

1. Vaginal bumps and sores 0 1 2 3
2. Pubic area sore 0 1 2 3
3. Ovarian cysts ..... NO YES(10)
4. Uterine cysts ..... NO YES(10)
5. Pain in ovaries 0 1 2 3
6. Breast lumps ..... NO YES(10)
7. Breasts sore to touch 0 1 2 3
8. Breasts painful 0 1 2 3
9. Water retention 0 1 2 3
10. Swollen feeling 0 1 2 3
11. Premenstrual breast pain or discomfort 0 1 2 3
12. Mother used D.E.S. (hormones) while pregnant ..... NO YES
13. Recent pap smear positive ..... NO YES(15)
14. Family history of breast cancer ..... NO YES
15. Form of birth control: None Pill IUD Sponge Diaphragm Foam O her: _____

SECTION E:

1. Hot flashes 0 1 2 3
2. Night sweats 0 1 2 3
3. Hysterectomy ..... NO YES
4. Depression / Mood swings 0 1 2 3
5. Insomnia 0 1 2 3
6. Craving for sweats 0 1 2 3
7. Heavy bleeding two weeks / months 0 1 2 3
8. Sweating throughout day 0 1 2 3
9. Dryness of skin, hair and vagina 0 1 2 3
10. Painful intercourse 0 1 2 3
11. Vaginal pain 0 1 2 3
12. Vaginal itching 0 1 2 3
13. Osteoporosis (bone loss) ..... NO YES

Part XI

SECTION A:

1. Pain in fingers 0 1 2 3
2. Bones sore / painful 0 1 2 3
3. Eat meat 0 1 2 3
4. Cavities 0 1 2 3
5. Arthritis 0 1 2 3
6. Drink carbonated beverages / soda ..... NO YES ___ oz./week
7. Gum disease ..... NO YES
8. Bone loss ..... NO YES
9. Calcium deposits ..... NO YES
10. Use antacids ..... NO YES ___ # /week
11. Dentures ..... NO YES
12. Bone deformities ..... NO YES
13. Told you have osteoporosis / osteomalacia ..... NO YES(5)
14. Recent bone fracture ..... NO YES
15. Are you post menopausal ..... NO YES

SECTION B:

1. Muscle spasms 0 1 2 3
2. Tightness in shoulder muscles 0 1 2 3
3. Muscle cramps 0 1 2 3
4. Pain in arms and / or hands 0 1 2 3
5. Leg cramps at night 0 1 2 3
6. Stiff all over 0 1 2 3
7. Stiff in morning 0 1 2 3
8. Unable to sit straight 0 1 2 3
9. Pain in neck and / or shoulders 0 1 2 3
10. Back pain 0 1 2 3

SECTION C:

1. Over flexible joints (double-jointed) 0 1 2 3
2. Back pain 0 1 2 3
3. Swollen knees / elbows 0 1 2 3
4. Athletic injury 0 1 2 3
5. Bursitis 0 1 2 3
6. Tendonitis 0 1 2 3
7. Joint pain 0 1 2 3
8. Slipped disc ..... NO YES(5)
9. Herniated disc ..... NO YES(10)
10. Loss in height ..... NO YES
11. Injure easily ..... NO YES

Part XII

1. Head feels heavy 0 1 2 3
2. Light headedness / fainting 0 1 2 3
3. Loss of balance 0 1 2 3
4. Dizziness 0 1 2 3
5. Ringing / buzzing in ears 0 1 2 3
6. Trembling hands 0 1 2 3
7. Loss of feeling in hands and / or feet (toes) 0 1 2 3
8. Exhaus ion on slightest effort 0 1 2 3
9. Limbs feel to heavy to hold up 0 1 2 3
10. Loss of grip strength 0 1 2 3
11. Tingling pain sensation 0 1 2 3
12. Convulsions ..... NO YES(10)
13. Incoordination 0 1 2 3
14. Nervousness 0 1 2 3
15. Accident prone ..... NO YES
16. Loss of muscle tone ..... NO YES
17. Need for 10-12 hours sleep ..... NO YES
18. Have had shingles ..... NO YES

Part XIII

1. Nightmares 0 1 2 3
2. Can't fall asleep 0 1 2 3
3. Intense dreams 0 1 2 3
4. Leg cramps / restless leg at night 0 1 2 3
5. Restless, uneasy sleeper 0 1 2 3
6. Awake frequently throughout night ..... NO YES
7. Wake up in the middle of night, can't fall back to sleep ..... NO YES
8. Sleep walk ..... NO YES

Do you have any other symptoms that have not been covered in the questionnaire?

_____

_____

Creating a Food Diary

- It is best to record what you eat as soon as you can and record all foods that are eaten.
- Remember to include the beverages you drink as part of what you consume for meals and snacks.
- If you eat a "mixed food" such as a sandwich, include the mayo or butter that you might add to the bread. Include butter that you might put on cooked veggies or dressing that might top off a salad.

Portion Size Guidelines

Here are some portion size guidelines to help you in determining how much you might be eating. Keep in mind, a portion of food is fairly small. The amounts you normally eat probably constitute more than one serving. For example, a typical portion of cooked spaghetti noodles, cereal, or cooked rice equals about 2.5 cups. That's how much we would normally eat! Yet, the correct portion is one half cup. This means that under typical circumstances, we're eating five servings but count it as ONE!

Portions of food: Food Size of one serving easy way to assess

Breads 1 slice store cut slices of loaf bread
Hot dog bun 1/2 of bun whole bun = 2 servings
Hamburger bun 1/2 of bun whole bun = 2 servings
Sub roll 1/2 of a 4" roll whole sub roll = 4+ servings
Cereal 3/4 cup amount to fill a cupcake liner
pasta, beans 1/2 cup cooked size of a tangerine
Cooked veggies 1/2 cup size of a tangerine
Raw veggies 1 cup size of a tennis ball
Fruit 1 small 4" banana or half a fist
Canned fruit 1/2 cup half a fist
Fruit juice 3/4 cup size of a medium potato
Dried fruits or nuts 1/4 cup sprinkle over the palm
Milk or yogurt 1 cup size of tennis ball
Cheese 11/2–2 ounces size of small bar of soap Rice,
Turkey or chicken 3 ounces size of a small cell phone
Beef, pork, fish 3 ounces same as above
Butter, margarine, oil 1 tablespoon top of your thumb with nail

Following is an example of a page from a food diary and a blank form for you to start your own.

Diet Diary for John Hancock Date June 5, 2005

Food Item Eaten/Beverage Consumed Portion Size

Breakfast: 8AM blueberry yogurt—1 serving (6 oz); whole wheat toast—1 piece with butter—1 pat

Snack: 10:30 AM cranberries—1 cup; coffee—1 cup with 2 creams added

Lunch: 1:00 PM turkey sandwich (2 slices wheat bread, 1 tbsp mayonnaise, 1 leaf of lettuce, 1 slice Swiss cheese, about 1 serving of sliced turkey); 1 bag potato chips; 1 medium apple; 1 soda Coke (12-ounce can); and 1 chocolate chip cookie

Snack: 3:30 PM microwave popcorn—1 bag; 1 soda (12-ounce can),

Dinner: 8:00 PM homemade turkey pot pie—2 servings (mixed vegetables—corn, peas, carrots, potatoes; pastry crust; gravy); 1 glass of milk (8 ounces); 1 white dinner roll with butter—1 pat

Snack: 9:30 PM ice cream---3 scoops; 1 soda (12-ounce can),

Water- total daily intake in ounces: 64 ounces

Note: To create a food diary, use the enclosed pages or make multiple copies of the form on the reverse side or make your own equivalent. Please make sure it is readable and that your name and the date are on each page. Please provide a minimum of 3 days. If possible providing 7 days is better.

Record your mood, energy, and cravings for each day and how you slept the night before. Use the back or extra sheets if needed.

Food Diary for_____Date _____

Time / Food or Beverage / Portion Size

Breakfast:

Snack:

Lunch:

Snack:

Dinner:

Water consumed (just plain water)- daily total in ounces:_____

Cravings:

Energy:

Mood:

Sleep:

Make as many copies as you need for each day or use plain paper but use the same format.

Food Diary for_____Date _____

Time / Food or Beverage / Portion Size

Breakfast:

Snack:

Lunch:

Snack:

Dinner:

Water consumed (just plain water)- daily total in ounces:_____

Cravings:

Energy:

Mood:

Sleep:

Make as many copies as you need for each day or use plain paper but use the same format.

Food Diary for_____Date _____

Time / Food or Beverage / Portion Size

Breakfast:

Snack:

Lunch:

Snack:

Dinner:

Water consumed (just plain water)- daily total in ounces:_____

Cravings:

Energy:

Mood:

Sleep:

Make as many copies as you need for each day or use plain paper but use the same format.

Food Diary for_____Date _____

Time / Food or Beverage / Portion Size

Breakfast:

Snack:

Lunch:

Snack:

Dinner:

Water consumed (just plain water)- daily total in ounces:_____

Cravings:

Energy:

Mood:

Sleep:

Over-Methylation Questionnaire

Methylation is an intracellular, metabolic process that supports thousands of body functions including turning stress on and off, turning genes one and off that express diseases, and other health regulatory functions. An overactive methylation processes is an imbalance that results in symptoms and can be improved with nutrition and supplements.

Please write your name here:_____**Check all that apply:**

1. ____ Elevated neurotransmitters Serotonin, Dopamine? Norepinephrine?
2. ____ Highly artistic, highly musical? Can have grandiose thoughts?
3. ____ Multiple chemical sensitivities?
4. ____ Often obsessive, but not compulsive? Somewhat paranoid?
5. ____ Many food sensitivities?
6. ____ Depression? Despair?
7. ____ Fidgety? Restless legs?
8. ____ Anxiety? Wound up? Anxiousness observable by other people? Panic Attacks? Nervous?
9. ____ Difficult to break a sweat? Low perspiration?
10. ____Poor reactions to taking SAM-e, inositol, methionine, tri-methyl-glycine supplements?
11. ____Low libido, low sex drive?
12. ____Depression? Thoughts of suicide?
13. ____Insomnia? Not need much sleep? Light sleeper?
14. ____Highly religious?
15. ____Dry eyes and mouth? Low tears. Impeded lacrimation? Dry mouth? Low salivation?
16. ____Underachiever as a child?
17. ____Hyperactive? Learning disabilities?
18. ____Apathy? Low Motivation?
19. ____Low libido (low sex drive?)
20. ____Hairy body? Hirsute?
21. ____Hear things that did not occur? Auditory hallucinations?
22. ____Spacey? Often distracted and unaware of ambient surroundings?
23. ____High tolerance to pain?
24. ____Can injure self? Self mutilation?

_____Total number of statements checked.

Scoring: More than 4—supplementation indicated.

Pyroluria Questionnaire:

Poor stress control, nervousness, anxiety, mood swings, inner tension, anger, depression, aggressiveness, learning problems? Pyroluria runs in families, so if you are pyroluric, chances are the same anxiety and poor stress responses will occur in other family members. Take the self-test below. CHECK YES TO ANY OF THE FOLLOWING QUESTIONS:

o 1. When you were young, did you sunburn easily? Do you have fair or pale skin?

o 2. Do you have a reduced amount of head hair, eyebrows, or eyelashes, or do you have prematurely gray hair?

o 3. Do you have poor dream recall or nightmares?

o 4. Are you becoming more of a loner as you age? Do you avoid outside stress because it upsets your emotional balance?

o 5. Have you been anxious, fearful, or felt a lot of inner tension since childhood but mostly hide these inner feelings from others?

o 6. Is it hard to clearly recall past events and people in your life? o 7. Do you have bouts of depression and/or nervous exhaustion? o 8. Do you have cluster headaches?

o 9. Are your eyes sensitive to sunlight?

o 10. Do you belong to an all-girl family, or have look-alike sisters?

o 11. Do you get frequent colds or infections, or unexplained chills or fevers?

o 12. Do you dislike eating protein? Have you ever been a vegetarian?

o 13. Did you reach puberty later than normal?

o 14. Are there white spots/flecks on your fingernails, or do you have opaquely or paper- thin nails?

o 15. Are you prone to acne, eczema, or psoriasis?

o 16. Do you prefer the company of one or two close friends rather than a gathering of friends?

o 17. Do you have stretch marks on your skin?

o 18. Have you noticed a sweet smell (fruity odor) to your breath or sweat when ill or stressed?

o 19. Do you have or did you have, before braces crowded upper front teeth?

o 20. Do you prefer not to eat breakfast, or even experience light nausea in the morning?

o 21. Does your face sometimes look swollen while under a lot of stress?

o 22. Do you have a poor appetite, or a poor sense of smell or taste?

o 23. Do you have any up per abdominal, splenic pain? As a child, did you get a "stitch" in your side when you ran?

o 24. Do you tend to focus internally (on yourself) rather than on the external world?

o 25. Do you frequently experience fatigue?

o 26. Do you feel uncomfortable with strangers?

o 27. Do your knees crack or ache?

o 28. Do you overreact to tranquilizers, barbiturates, alcohol, or other drugs-(does a little produce a powerful response)?

o 29. Does it bother you to be seated in a restaurant in the middle of the room?

o 30. Are you anemic?

o 31 Do you have cold hands and/or feet?

o 32. Are you easily upset (internally) by criticism?

o 33. Do you have a tendency toward morning constipation?

o 34. Do you have tingling sensations or muscle spasms in your legs or arms?

o 35. Do changes in your routine (traveling, new situations) provoke stress?

o 36. Do you tend to become dependent on one person whom you build your life around?

Score_____If you scored 15 or more, it would be worth your while to get needed biochemical repair.

Write your name here:_____

Under-Methylation Questionnaire

Methylation is an intracellular, metabolic process that supports thousands of body functions via chemical reactions including turning stress on and off, neutralizing genes that express diseases, and detoxification. Methyl donors (vitamins and compounds such as SAMe, homocysteine, methylcobalamine, and folate) help regulate methylation processes that control neurotransmitters, immunological responses, nerve function, and detoxification. A lack of methyl molecules (CH3) in the body is an underlying cause of hundreds of symptoms and directly relates to the aging processes.

Please write your name here :_____Check All That Apply:

1. ____Type A personality, perfectionistic, driven, obsessive, compulsive?
2. ____Impulsive? Do you have impulses to do things that you know you shouldn't?
3. ____If more than three brothers/sisters, are most of your siblings males?
4. ____Large ears?
5. ____Second toe as long or longer than your big toe?
6. ____Do you need large doses of supplements or medications to get an impact?
7. ____Do you struggle with excessive sugar, alcohol or drug use?
8. ____Does your mind race? Hyperactive?
9. ____Inwardly tense? Oppositional Defiance?
10. ____Respiratory allergies? Asthma? Histamine reactions? Hives? Histadelia? Inhalant allergies?
11. ____High sex drive, excessive libido? Easy to reach orgasm?
12. ____Depression? Thoughts of suicide?
13. ____Insomnia? Not need much sleep? Light sleeper?
14. ____Headaches, chronic?
15. ____Easily become aggressive?
16. ____Need to eat frequently?
17. ____Dry, cracked fingers, fingertips, heels?
18. ____Chicken skin, areas of fatty bumps, lipomas?
19. ____Dandruff?
20. ____Neurological, brain, or nerve concerns?
21. ____High libido (lhigh sex drive?)
22. ____High salivary flow? High tear flow.
23. ____Anxiety? Depression? Panic disorder? Phobias? Gambling/shopping disorder?
24. ____Smoke tobacco?

_____Total number of statements checked. *Scoring: More than 4—supplementation indicated.*

Your list of questions/concerns: