

Natural Medicine Center  
449 Bay Area Blvd., Houston, TX 77058  
Phone: 281-286-6040 Fax: 281-286-4120

Dr. Robert Rakowski, DC, CCN, DACBN, DIBAK

---

**Patient Information**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

E-Mail \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Marital Status: (S) \_\_\_\_ (M) \_\_\_\_ (W) \_\_\_\_ (D) \_\_\_\_ (Separated) \_\_\_\_\_

Employer \_\_\_\_\_

Referred by: \_\_\_\_\_

**Authorization to Release Information**

I HEREBY AUTHORIZE THE NATURAL MEDICINE CENTER OR HIS BILLING AGENT TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY DIAGNOSIS OR TREATMENT TO MY INSURANCE COMPANY OR PERSONS REPRESENTING MY CASE.

**Collection Policy**

The office collection policy is to collect full payment for the services rendered at the time of service.

We do accept all major credit cards.

**Cancellation Policy**

Please notify us 48-hours in advance should you need to cancel testing appointments to avoid a \$125 fee (new patient) or \$75 fee (follow up) and 24-hours in advance for all other services. The missed appointment fee for chiropractic services is \$60 for new patients and \$30 for follow up visits. All other services will be assessed a fee of 50% of the appointment charge. Missed appointment fees will be charged to the credit card provided below.

CC number \_\_\_\_\_ Exp. Date \_\_\_\_\_ Sec # \_\_\_\_\_

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCES.

My signature below is proof that I have read and understand the above financial policy for the Natural Medicine Center.

Signature \_\_\_\_\_ Date \_\_\_\_\_

# HEALTH HISTORY

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

Occupation \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Sex \_\_\_\_\_ Number of Children \_\_\_\_\_

Marital Status:  Single  Partner  Married  Separated  Divorced  Widow(er)

Are you recovering from a cold or flu? \_\_\_\_\_ Are you pregnant? \_\_\_\_\_

Reason for office visit: \_\_\_\_\_ Date began: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of last physical exam \_\_\_\_\_ Practitioner name and phone number \_\_\_\_\_

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):  
\_\_\_\_\_  
\_\_\_\_\_

Outcome \_\_\_\_\_

What types of therapy have you tried for this problem(s):

- diet modification  fasting  vitamins/minerals  herbs  homeopathy  chiropractic  acupuncture  conventional drugs  
 other \_\_\_\_\_

List current health problems for which you are being treated: \_\_\_\_\_  
\_\_\_\_\_

Current medications (prescription or over-the-counter): \_\_\_\_\_  
\_\_\_\_\_

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): \_\_\_\_\_

Do you consider yourself:  underweight  overweight  just right Your weight today \_\_\_\_\_

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? \_\_\_\_\_

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, farmer, miner)?

- Corrective lenses  Dentures  Hearing aid  Medical devices/prosthetics/implants, describe: \_\_\_\_\_

Recent changes in your ability to:  see  hear  taste  smell  feel hot/cold sensations

- move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)

Strong like for any of the following flavors:  sour  bitter  sweet  rich/fatty  spicy/pungent  salty

Strong dislike for any one of the following flavors:  sour  bitter  sweet  rich/fatty  spicy/pungent  salty

Do you:  Prefer warmth (i.e., food, drinks, weather, etc.)  Prefer cold (i.e., food, drinks, weather, etc.)  No preference

Is your sleep disturbed at the same time each night? \_\_\_\_\_ If yes, what time? \_\_\_\_\_

Time of day you feel the most energy or the least symptoms:

Time of day you feel the worst or your symptoms are aggravated:

- 7 a.m. - 9 a.m.  9 a.m. - 11 a.m.  11 a.m. - 1 p.m.  
 1 p.m. - 3 p.m.  3 p.m. - 5 p.m.  5 p.m. - 7 p.m.  
 7 p.m. - 9 p.m.  9 p.m. - 11 p.m.  11 p.m. - 1 a.m.  
 1 a.m. - 3 a.m.  3 a.m. - 5 a.m.  5 a.m. - 7 a.m.

- 7 a.m. - 9 a.m.  9 a.m. - 11 a.m.  11 a.m. - 1 p.m.  
 1 p.m. - 3 p.m.  3 p.m. - 5 p.m.  5 p.m. - 7 p.m.  
 7 p.m. - 9 p.m.  9 p.m. - 11 p.m.  11 p.m. - 1 a.m.  
 1 a.m. - 3 a.m.  3 a.m. - 5 a.m.  5 a.m. - 7 a.m.

## Do you experience any of these general symptoms EVERY DAY?

- Debilitating fatigue  Shortness of breath  Insomnia  Constipation  Chronic pain/inflammation  
 Depression  Panic attacks  Nausea  Fecal incontinence  Bleeding  
 Disinterest in sex  Headaches  Vomiting  Urinary incontinence  Discharge  
 Disinterest in eating  Dizziness  Diarrhea  Low grade fever  Itching/rash

**Medical History**

- Arthritis
- Allergies/hay fever
- Asthma
- Alcoholism
- Alzheimer's disease
- Autoimmune disease
- Blood pressure problems
- Bronchitis
- Cancer
- Chronic fatigue syndrome
- Carpal tunnel syndrome
- Cholesterol, elevated
- Circulatory problems
- Colitis
- Dental problems
- Depression
- Diabetes
- Diverticular disease
- Drug addiction
- Eating disorder
- Epilepsy
- Emphysema
- Eyes, ears, nose, throat problems
- Environmental sensitivities
- Fibromyalgia
- Food intolerance
- Gastroesophageal reflux disease
- Genetic disorder
- Glaucoma
- Gout
- Heart disease
- Infection, chronic
- Inflammatory bowel disease
- Irritable bowel syndrome
- Kidney or bladder disease
- Learning disabilities
- Liver or gallbladder disease (stones)
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological problems (Parkinson's, paralysis)
- Sinus problems
- Stroke
- Thyroid trouble
- Obesity
- Osteoporosis
- Pneumonia
- Sexually transmitted disease
- Seasonal affective disorder
- Skin problems
- Tuberculosis
- Ulcer
- Urinary tract infection
- Varicose veins
- Other \_\_\_\_\_

**Medical (Men)**

- Benign prostatic hyperplasia (BPH)
- Prostate cancer

- Decreased sex drive
- Infertility
- Sexually transmitted disease
- Other \_\_\_\_\_

**Medical (Women)**

- Menstrual irregularities
- Endometriosis
- Infertility
- Fibrocystic breasts
- Fibroids/ovarian cysts
- Premenstrual syndrome (PMS)
- Breast cancer
- Pelvic inflammatory disease
- Vaginal infections
- Decreased sex drive
- Sexually transmitted disease
- Other \_\_\_\_\_
- Age of first period \_\_\_\_\_
- Date of last gynecological exam \_\_\_\_\_
- Mammogram  +  -
- PAP  +  -
- Form of birth control \_\_\_\_\_
- # of children \_\_\_\_\_
- # of pregnancies \_\_\_\_\_
- C-section \_\_\_\_\_
- Surgical menopause
- Menopause
- Date of last menstrual cycle \_\_\_\_\_
- Length of cycle \_\_\_\_\_ days
- Interval of time between cycles \_\_\_\_\_ days
- Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) \_\_\_\_\_

**Family Health History (Parents and Siblings)**

- Arthritis
- Asthma
- Alcoholism
- Alzheimer's disease
- Cancer
- Depression
- Diabetes
- Drug addiction
- Eating disorder
- Genetic disorder
- Glaucoma
- Heart disease
- Infertility
- Learning disabilities
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological disorders (Parkinson's, paralysis)
- Obesity
- Osteoporosis
- Stroke
- Suicide
- Other \_\_\_\_\_

**Health Habits**

- Tobacco:
- Cigarettes: #/day \_\_\_\_\_
- Cigars: #/day \_\_\_\_\_
- Alcohol:
- Wine: #glasses/d or wk \_\_\_\_\_
- Liquor: #ounces/d or wk \_\_\_\_\_
- Beer: #glasses/d or wk \_\_\_\_\_
- Caffeine:
- Coffee: #6 oz cups/d \_\_\_\_\_
- Tea: #6 oz cups/d \_\_\_\_\_
- Soda w/caffeine: #cans/d \_\_\_\_\_
- Other sources \_\_\_\_\_
- Water: #glasses/d \_\_\_\_\_

**Exercise**

- 5-7 days per week
- 3-4 days per week
- 1-2 days per week
- 45 minutes or more duration per workout
- 30-45 minutes duration per workout
- Less than 30 minutes
- Walk
- Run, jog, jump rope
- Weight lift
- Swim
- Box
- Yoga

**Nutrition & Diet**

- Mixed food diet (animal and vegetable sources)
- Vegetarian
- Vegan
- Salt restriction
- Fat restriction
- Starch/carbohydrate restriction
- The Zone Diet
- Total calorie restriction
- Specific food restrictions:
- dairy  wheat  eggs
- soy  corn  all gluten
- Other \_\_\_\_\_

**Food Frequency**

- Servings per day:
- Fruits (citrus, melons, etc.) \_\_\_\_\_
- Dark green or deep yellow/orange vegetables \_\_\_\_\_
- Grains (unprocessed) \_\_\_\_\_
- Beans, peas, legumes \_\_\_\_\_
- Dairy, eggs \_\_\_\_\_
- Meat, poultry, fish \_\_\_\_\_

**Eating Habits**

- Skip breakfast
- Two meals/day
- One meal/day
- Graze (small frequent meals)
- Food rotation
- Eat constantly whether hungry or not
- Generally eat on the run
- Add salt to food

**Current Supplements**

- Multivitamin/mineral
- Vitamin C
- Vitamin E
- EPA/DHA
- Evening Primrose/GLA
- Calcium, source \_\_\_\_\_
- Magnesium
- Zinc
- Minerals, describe \_\_\_\_\_
- Friendly flora (acidophilus)
- Digestive enzymes
- Amino acids
- CoQ10
- Antioxidants (e.g., lutein, resveratrol, etc.)
- Herbs - teas
- Herbs - extracts
- Chinese herbs
- Ayurvedic herbs
- Homeopathy
- Bach flowers
- Protein shakes
- Superfoods (e.g., bee pollen, phytonutrient blends)
- Liquid meals
- Other \_\_\_\_\_

**Would you like to:**

- Have more energy
- Be stronger
- Have more endurance
- Increase your sex drive
- Be thinner
- Be more muscular
- Improve your complexion
- Have stronger nails
- Have healthier hair
- Be less moody
- Be less depressed
- Be less indecisive
- Feel more motivated
- Be more organized
- Think more clearly and be more focused
- Improve memory
- Do better on tests in school
- Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- Stop using laxatives or stool softeners
- Be free of pain
- Sleep better
- Have agreeable breath
- Have agreeable body odor
- Have stronger teeth
- Get less colds and flus
- Get rid of your allergies
- Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)

# Natural Medicine Center

449 Bay Area Blvd.  
Houston, TX 77058  
281-286-6040

## Informed Consent for Chiropractic, Nutrition, and Acupuncture

**The nature of Chiropractic treatment:** The doctor will use his/her hands or a mechanical device to move your joints in a very specific way. You may feel a “click” or “pop” and you may feel movement of the joint. This is normal, but does not always occur with every adjustment.

**The nature of Acupuncture treatment:** The doctor may also use acupuncture as an adjunct, or in whole, during your care. Acupuncture involves the insertion of tiny needles into the body through the skin. It may also involve the use of pressure or electrical stimulation separately, or in conjunction with needling.

**The nature of Nutrition treatment:** The doctor may also advocate the use of specific nutrients during your care. This involves the prescription of brand name individual or combination products. Rest assured that the Natural Medicine Center uses only the highest quality products. Possible risks as with all health care, complications are possible following a chiropractic, acupuncture, and nutrition therapy.

---Chiropractic complications could include fractures of bone, muscular strain, ligamentous sprain, dislocation of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. These complications are extremely rare occurrences. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

---Acupuncture complications include infection at the needling site, organ perforation, bleeding, and pneumothorax. The style of acupuncture used at Natural Medicine Center is typically more superficial lessening the possibility of complications.

---Nutritional complications include the risk of adverse nutrient-reactions and hypersensitivity. Nutrients are in general well tolerated, however as with any medication, if any adverse symptoms occur with nutrient use, discontinue immediately and consult you treating doctor.

The risks of complications due to Chiropractic treatment have been described as “rare”. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. It is safer to get adjusted than it was to get in your car and drive to our clinic! The probability of adverse reaction due to acupuncture and nutrient therapy are also considered “rare”. They would be significantly less than the chance of adverse complications due to prescription medication use or surgery.

\*\*Please see reverse and sign-----

### **Risks of remaining untreated:**

Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite possible that delay of treatment will complicate the condition and make further rehabilitation more difficult. Delaying treatment of nutrient therapy can lead to a variety of chronic diseases such as diabetes, heart disease, cancer, stroke, death etc.

**Unusual risks:**

I have had any unusual risks of my case explained to me. I have read the explanation above of Chiropractic, nutrition, and acupuncture treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment and understand that no guarantees of outcome have been made. I have also disclosed all medical information to the doctor.

By signing this document, I have freely decided to undergo the recommended treatment, and hereby give my full consent for treatment. I accept the risks and release Dr. Rakowski/Romportl of any liability for any injury or loss directly related to care I have received at this clinic.

\_\_\_\_\_  
Patient Name:

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Legal Guardian's Signature (if patient is under 18)

\_\_\_\_\_  
Date

# Natural Medicine Center

## Phone Consult Information

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Name of Caller: \_\_\_\_\_

Phone #: \_\_\_\_\_

Responsible Party: \_\_\_\_\_

Credit Card #: \_\_\_\_\_ Exp. \_\_\_\_\_ Sec. \_\_\_\_\_

The amount for the **Initial Phone Consult** is \$140.00 in addition to \$70 for every 15 minutes for reviewing medical records. The credit card number provided will be charged accordingly. This rate also applies to the exchange of emails. Please be advised that any returned products must be returned within 30 days, unopened, and will incur a 15% restocking fee. Shipping, review time and phone consult fees are non-refundable.

Phone consults will be scheduled once **all completed paperwork** is received as well as any **pertinent medical records**.

Mail Receipt To:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(Address)

Phone consults **must** be cancelled at least **24 hours** prior to the appointment time to avoid the missed appointment fee equal to the amount of time scheduled. Missed appointments will be billed to the credit card number provided.

Signature of cardholder: \_\_\_\_\_ Date: \_\_\_\_\_

**Notice of Financial Agreement**

*To our patients:*

*The Natural Medicine Center is very pleased to have you as a new patient. We are honored you have selected our clinic for your care.*

*We do not file Insurance claims however, we will work with you to insure that you have all the necessary documentation to file with your insurance carrier so they can process and pay your claims in a timely manner. Should you be covered by Medicare, you will not be eligible to submit your claims to them since we are not a Medicare provider.*

*If you are receiving treatment as a result of a motor vehicle accident, you are responsible for paying all costs at the time of treatment. A statement will be provided for you to file with the responsible party for reimbursement purposes.*

*If it is necessary to initiate action to collect any unpaid balance on your account, you agree to pay reasonable costs of collection, including necessary attorney fees and court costs.*

*Agreed:*

*Patient Signature* \_\_\_\_\_ *Date* \_\_\_\_\_

*Patient Name (print)* \_\_\_\_\_

*Witness* \_\_\_\_\_





## Detoxification Questionnaire, page 2

### II. Xenobiotic Tolerability Test (XTT)

<p>1. Are you presently using prescription drugs?  <input type="checkbox"/> Yes (1 pt.)                  If yes, how many are you currently taking? ____ (1 pt. each)  <input type="checkbox"/> No (0 pt.)</p> <hr/> <p>2. Are you presently taking one or more of the following over-the-counter drugs?  <input type="checkbox"/> Cimetidine (2 pts.)  <input type="checkbox"/> Acetaminophen (2 pts.)  <input type="checkbox"/> Estradiol (2 pts.)</p> <hr/> <p>3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them:  <input type="checkbox"/> Experience side effects, drug(s) is (are) efficacious at lowered dose(s) (3 pts.)  <input type="checkbox"/> Experience side effects, drug(s) is (are) efficacious at usual dose(s) (2 pts.)  <input type="checkbox"/> Experience no side effects, drug(s) is (are) usually not efficacious (2 pts.)  <input type="checkbox"/> Experience <i>no</i> side effects, drug(s) is (are) usually efficacious (0 pt.)</p> <hr/> <p>4. Do you currently use or within the last 6 months had you regularly used tobacco products?  <input type="checkbox"/> Yes (2 pts.)   <input type="checkbox"/> No (0 pt.)</p> <hr/> <p>5. Do you have strong negative reactions to caffeine or caffeine containing products?  <input type="checkbox"/> Yes (1 pt.)   <input type="checkbox"/> No (0 pt.)   <input type="checkbox"/> Don't know (0 pt.)</p>	<p>6. Do you commonly experience "brain fog," fatigue, or drowsiness?  <input type="checkbox"/> Yes (1 pt.)   <input type="checkbox"/> No (0 pt.)</p> <hr/> <p>7. Do you develop symptoms on exposure to fragrances, exhaust fumes, or strong odors?  <input type="checkbox"/> Yes (1 pt.)   <input type="checkbox"/> No (0 pt.)   <input type="checkbox"/> Don't know (0 pt.)</p> <hr/> <p>8. Do you feel ill after you consume even small amounts of alcohol?  <input type="checkbox"/> Yes (1 pt.)   <input type="checkbox"/> No (0 pt.)   <input type="checkbox"/> Don't know (0 pt.)</p> <hr/> <p>10. Do you have a personal history of  <input type="checkbox"/> Environmental and/or chemical sensitivities (5 pts.)  <input type="checkbox"/> Chronic fatigue syndrome (5 pts.)  <input type="checkbox"/> Multiple chemical sensitivity (5 pts.)  <input type="checkbox"/> Fibromyalgia (3 pts.)  <input type="checkbox"/> Parkinson's type symptoms (3 pts.)  <input type="checkbox"/> Alcohol or chemical dependence (2 pts.)  <input type="checkbox"/> Asthma (1 pt.)</p> <hr/> <p>11. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?  <input type="checkbox"/> Yes (1 pt.)   <input type="checkbox"/> No (0 pt.)</p> <hr/> <p>12. Do you have an adverse or allergic reaction when you consume sulfite containing foods such as wine, dried fruit, salad bar vegetables, etc?  <input type="checkbox"/> Yes (1 pt.)   <input type="checkbox"/> No (0 pt.)   <input type="checkbox"/> Don't know (0 pt.)</p> <p><b>GRAND TOTAL:</b> _____</p>
--	---

*For Practitioner Use Only:*

#### OVERALL SCORE TABULATION

Recommended protocols based on new detoxification questionnaire (MSQ and XTT) MSQ SCORE _____ (High >50; moderate 15-49; Low <14) XTT SCORE _____ (High >10; moderate 5-9; Low <4)					
MSQ Score	XTT Score	Description	Functional Medicine Protocol		
			Medical Food	Diet	Additional Nutraceutical Support
50 or >	10 or >	High level of general symptoms and indicated symptoms of elevated toxic load	Medical food for imbalanced detoxifiers	28-day elimination diet	Bifunctional, antioxidant, and chlorophyllin nutraceuticals
15-49	5-9	Moderate level of general symptoms with moderate symptoms of toxic load	Medical food for imbalanced detoxifiers	10-day elimination diet	Consider bifunctional, antioxidant, and chlorophyllin nutraceuticals
14 or <	4 or <	Low level of general symptoms and minimal indicators of toxic load			Maintenance
Additional Symptom-Specific Support					
Symptom			Nutraceutical Support		
Water retention and/or frequent or urgent urination			Kidney support nutraceuticals		
Heartburn and/or intestinal/stomach pain			Functional dyspepsia nutraceuticals		
Diarrhea, constipation, and/or intestinal/stomach pain			Probiotics		

**Note:** Patients with high MSQ but low XTT may be exhibiting pathology that is not related to toxic load. Other mechanisms should be considered such as inflammation/immune/allergic gastrointestinal dysfunction, oxidative stress, hormonal/neurotransmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.

# Identi-T™ Stress Assessment

Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Date \_\_\_\_\_

Stress is a normal part of life. Every day, we're faced with stimuli, called stressors, which can elicit the body's "fight or flight" response, setting off a cascade of physiological reactions and resulting in emotions ranging from mild to intense. But while occasional stress is natural and even healthy, chronic or acute stress can be harmful.

Please take a few moments to discover your body's response to situations you perceive as stressful. By honestly assessing how you feel, your healthcare provider can create a natural stress relief program for your individual needs.

**Directions:**

Please read each statement and circle the number 0, 1, 2, or 3 that best describes your feelings or reactions throughout the course of the day. Determine the subtotal score for each section, then determine the total scores for sections A-C and C-E. Some questions may appear redundant between sections. There's a reason for each question. Don't spend much time on any one question.

0 = Never true    1 = Seldom true    2 = Sometimes true    3 = Often true

*When under stress for two weeks or longer, I...*

**Section A:**

- |   |   |   |   |   |
|---|---|---|---|---|
| 1. Get wound up when I get tired and have trouble calming down.....       | 0 | 1 | 2 | 3 |
| 2. Feel driven, appear energetic but feel "burned out" and exhausted..... | 0 | 1 | 2 | 3 |
| 3. Feel restless, agitated, anxious, and uneasy.....                      | 0 | 1 | 2 | 3 |
| 4. Feel easily overwhelmed by emotion.....                                | 0 | 1 | 2 | 3 |
| 5. Feel emotional — cry easily or laugh inappropriately.....              | 0 | 1 | 2 | 3 |
| 6. Experience heart palpitations or a pounding in my chest.....           | 0 | 1 | 2 | 3 |
| 7. Am short of breath.....  | 0 | 1 | 2 | 3 |
| 8. Am constipated.....  | 0 | 1 | 2 | 3 |
| 9. Feel warm, over-heated, and dry all over.....                          | 0 | 1 | 2 | 3 |
| 10. Get mouth sores or sore tongue.....                                   | 0 | 1 | 2 | 3 |
| 11. Get hot flashes.....  | 0 | 1 | 2 | 3 |
| 12. Sleep less than seven hours a night.....                              | 0 | 1 | 2 | 3 |
| 13. Have trouble falling asleep and staying asleep.....                   | 0 | 1 | 2 | 3 |
| 14. Worry about high blood pressure, cholesterol, and triglycerides.....  | 0 | 1 | 2 | 3 |
| 15. Forget to eat and feel little hunger.....                             | 0 | 1 | 2 | 3 |

Total points: \_\_\_\_\_

**Section B:**

- |  |   |   |   |   |
|--|---|---|---|---|
| 1. Find myself worrying about things big and small.....  | 0 | 1 | 2 | 3 |
| 2. Feel like I can't stop worrying, even though I want to.....   | 0 | 1 | 2 | 3 |
| 3. Feel impulsive, pent up, and ready to explode.....  | 0 | 1 | 2 | 3 |
| 4. Get muscle spasms.....  | 0 | 1 | 2 | 3 |
| 5. Feel aggressive, unyielding, or inflexible when pressed for time.....   | 0 | 1 | 2 | 3 |
| 6. See, hear, and smell things that others do not.....   | 0 | 1 | 2 | 3 |
| 7. Stay awake replaying the events of the day or planning for tomorrow.....  | 0 | 1 | 2 | 3 |
| 8. Have upsetting thoughts or images enter my mind again and again.....  | 0 | 1 | 2 | 3 |
| 9. Have a hard time stopping myself from doing things again and again, like checking on things or rearranging objects over and over..... | 0 | 1 | 2 | 3 |
| 10. Worry a lot about terrible things that could happen if I'm not careful.....  | 0 | 1 | 2 | 3 |

Total points: \_\_\_\_\_

**Section C:**

- |  |   |   |   |   |
|--|---|---|---|---|
| 1. Have muscle and joint pains.....  | 0 | 1 | 2 | 3 |
| 2. Have muscle weakness.....   | 0 | 1 | 2 | 3 |
| 3. Crave salt or salty things.....   | 0 | 1 | 2 | 3 |
| 4. Have multiple points on my body that when touched are tender or painful.....          | 0 | 1 | 2 | 3 |
| 5. Have dark circles under my eyes.....  | 0 | 1 | 2 | 3 |
| 6. Feel a sudden sense of anxiety when I get hungry.....                                 | 0 | 1 | 2 | 3 |
| 7. Use medications to manage pain.....   | 0 | 1 | 2 | 3 |
| 8. Get dizzy when rising or standing up from a kneeling or sitting position.....         | 0 | 1 | 2 | 3 |
| 9. Have diarrhea or bouts of nausea with or without vomiting for no apparent reason..... | 0 | 1 | 2 | 3 |
| 10. Have headaches.....  | 0 | 1 | 2 | 3 |

Total points: \_\_\_\_\_

**Section D:**

1. Have trouble organizing my thoughts.....0 1 2 3
2. Get easily distracted and lose focus.....0 1 2 3
3. Have difficulty making decisions and mistrust my judgment.....0 1 2 3
4. Feel depressed and apathetic.....0 1 2 3
5. Lack the motivation and energy to stay on task and pay attention.....0 1 2 3
6. Am forgetful.....0 1 2 3
7. Feel unsettled, restless, and anxious.....0 1 2 3
8. Wake up tired and unrefreshed.....0 1 2 3
9. Experience heartburn and indigestion.....0 1 2 3
10. Catch colds or infections easily.....0 1 2 3

Total points: \_\_\_\_\_

**Section E:**

1. Feel tired for no apparent reason.....0 1 2 3
2. Experience lingering mild fatigue after exertion or physical activity.....0 1 2 3
3. Find it difficult to concentrate and complete tasks.....0 1 2 3
4. Feel depressed and apathetic.....0 1 2 3
5. Feel cold or chilled – hands, feet, or all over – for no apparent reason.....0 1 2 3
6. Have little or no interest in sex.....0 1 2 3
7. Sweat spontaneously during the day.....0 1 2 3
8. Feel puffy and retain fluids.....0 1 2 3
9. Sleep more than nine hours a night.....0 1 2 3
10. Have poor muscle tone.....0 1 2 3
11. Have trouble losing weight.....0 1 2 3
12. Wake up tired even though I seem to get plenty of sleep.....0 1 2 3
13. Have no energy and feel physically weak.....0 1 2 3
14. Am susceptible to colds and the flu.....0 1 2 3
15. Feel dragged down by multiple symptoms, such as poor digestion and body aches.....0 1 2 3

Total points: \_\_\_\_\_

Add points from sections A, B & C

**Total for A, B & C:** \_\_\_\_\_

Add points from sections C, D & E

**Total for C, D & E:** \_\_\_\_\_

**Lifestyle and Health Status:**

1. Circle the level of stress you experience on the scale of 1-10, 10 being the worst:

1      2      3      4      5      6      7      8      9      10

2. What do you consider to be the major causes of your stress (for example – spouse, family, friends, work, finances, wedding, pregnancy, legal, commute):

\_\_\_\_\_

3. I eat breakfast \_\_\_\_\_ times a week. My typical breakfast is: \_\_\_\_\_

4. I take a multiple vitamin/mineral \_\_\_\_\_ days per week. I take a fish oil supplement \_\_\_\_\_ days per week.

5. I participate in 30 minutes of physical activity such as walking, aerobics (e.g., running), resistance training (e.g., weights, pilates), sports (e.g. biking), or yoga:

Daily       5-6 times per week       3-4 times per week       1-2 times per week       Less than once a week

6. I smoke \_\_\_\_\_ cigarettes daily.

7. I drink two or more 8 ounce cups of caffeinated coffee or other caffeinated beverages like energy/diet drinks, colas, or black or green teas:

Daily       5-6 times per week       3-4 times per week       1-2 times per week       Less than once a week

8. I drink two or more ounces of alcoholic beverages:

Daily       5-6 times per week       3-4 times per week       1-2 times per week       Less than once a week

9. List your current health problems and any over-the-counter or prescription medications that you are now taking:

Current health problem(s)	Date of onset	List all current medication(s)
_____	_____	_____
_____	_____	_____
_____	_____	_____



Metagenics is committed to using only environmentally-friendly papers and inks.

